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Consolidation and Integration in Health Care: What It Means for Patients, Payers, and Policy

Larry Levitt: Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of the Health Wonk Shop, where we regularly dive into timely and complex health policy topics with experts from a variety of perspectives and experiences.

Consolidation and integration in the healthcare industry is nothing new. For decades, hospital systems and insurers have each gotten bigger in a sort of arms race to gain pricing leverage. Vertical integration involving health plans and physician groups goes back many years to the earliest staff and group model HMOs, like Kaiser Permanente, but what we've seen more recently is somewhat different. Hospitals have bought clinics and medical groups, paving the way for higher prices that often include facility fees even when the care isn't provided in an actual facility. Some insurers have gobbled up physician practices and they've also merged with pharmacy benefit managers and pharmacies, making it even more difficult to follow the dollars through the drug supply chain.

All segments of the healthcare industry have come into greater political scrutiny for their role in driving up the cost of healthcare. There have been calls from both Democrats and Republicans to break up big healthcare conglomerates or curb their pricing power. At the same time, there can be benefits to larger and more integrated healthcare companies in terms of efficiency, data collection, better alignment of incentives, and accessibility for patients. This is no doubt a big topic, and we have three experienced experts to help sort it out. Erin Fuse Brown is a professor at the Brown University School of Public Health, Cory Capps is a partner at Bates White Economic Consulting, and Elizabeth Mitchell is president and CEO of the Purchaser Business Group on Health, otherwise known as PBGH.

A little bit of housekeeping before we get to the discussion. If you have questions, submit them at any time through the Q&A button in Zoom. We'll get to as many of them as we can. Also note that the session is being recorded and an archived version should be available later today. And we have ASL interpretation available. To access it, click on the globe icon in the Zoom control panel.

Now, let's jump in.

Erin, let me start with you. To set the stage, describe the types of consolidation we've seen in healthcare recently, in particular, the forms of vertical integration that have emerged. What evidence do you think we have in terms of what it's meant for healthcare prices and costs?

Erin Fuse Brown: Great. Thanks so much, Larry, and I'm so happy to be here talking with you. Your introduction actually did a great job about laying out the landscape of some of these forms of vertical consolidation or integration that we've seen over the past few years, decades, leading up to this stage where we now have these large healthcare conglomerates that are this vertically integrated platform that reaches into every aspect of the healthcare delivery system. The original form of vertical integration or consolidation that we've still seen a large amount of effort to consolidate is through the sort of health system acquiring physician practices or outpatient clinics. That form of vertical consolidation, again, was in many respects driven by efforts to achieve scale, to comply with value-based payment models, to also kind of eliminate some of the difficulties with fragmentation and care coordination across different care settings. That type of consolidation originally was seen as something that was maybe potentially pro-competitive or good for patients, particularly if they can kind of get an integrated care experience from their doctor's office all the way through their health system and post-acute. So that's one form.

We know that hospital physician integration or consolidation is associated with, in some cases, double-digit price increases both for the hospital services and for the physician services themselves. In the commercial market, we know that that type of vertical consolidation, though it promises efficiencies, tends to also produce higher levels of spending, higher within referral capture, and also just higher levels of utilization of higher intensity services. The other form of vertical consolidation I think that is emerging is the one you referenced, which is the large insurance-backed conglomerate, the case in point being UnitedHealthcare, but a lot of the large insurance companies are following this model. Buying up not only physician practices, United is now also the largest employer or affiliate or investor in physician practices through Optum, but also controlling pharmacy benefit managers, also controlling specialty pharmacies, home health, also the care delivery data that delivers all of the data infrastructure through something like Change Health.

Again, United is not the only one doing this. Humana, CVS, Aetna, they're all pursuing a similar model of large vertical consolidation, and we know that the evidence here is just emerging, that this too is associated with higher levels of maybe not commercial prices per se, but more risk coding, and so higher capitated payments of the Medicare Advantage system. There's a degree to which United will maybe pay Optum physicians more than independent rivals. We see that, again, the promises of efficiencies, the emerging evidence is not

bearing out that the efficiencies are produced by this. In fact, spending is going up.

Larry Levitt: Well, thanks, a nice roadmap to our next hour of discussion.

Cory and Erin referenced some of this. Companies, whenever they announce a merger or a purchase, a consolidation, they always tout them as improving value, being good for patients. Erin talked about some examples where that hasn't necessarily been the case. In your experience, can you point to some examples where this type of vertical integration has actually fulfilled that promise of efficiency, value, better care for patients?

Cory Capps: Sure. I think you sort of previewed one of them at the outset when you mentioned the roots of group risk medicine. We can look to Kaiser in California. One thing we know in general is that employers and consumers need a lower premium in order to purchase a narrow network plan. They usually don't like restrictions on choice. Yet when we look to California, Kaiser has a fully integrated enclosed model, meaning they have the physicians, they have the hospitals, they sell the insurance, they actually contract for the PBM side. They've got about over 40% of Medicare Advantage enrollment in the state, meaning seniors are picking the Kaiser model for a mixture of the benefits that they offer, the care experience, and the price by far more than any other individual insurer offering Medicare Advantage. That's one where there's no issue. We may talk soon about foreclosure or the like, at least not in the last seven decades, because Kaiser has built everything rather than acquiring groups. Occasionally, they will contract with hospitals to fill a gap where they don't have a footprint.

That's sort of been a tantalizing model for policymakers in the healthcare arena saying, "Can we get more systems to move in the direction of Kaiser?" and that's been some of the promise of vertical integration where it fails to fully manifest. There's a question of saying, "Did we go too far, or did we go not far enough in the vertical integration spectrum in the sense of adding the payer function to the provider and the hospital?"

Second example I'll give is Highmark, which acquired the thin struggling West Penn Allegheny Health system, which had expanded and gotten into great financial difficulty. It was not quite bankrupt, but it was struggling to make investment and keeping it up with its rival in the Pittsburgh area, which is UPMC, which is a hospital system that had forward-integrated into insurance. If West Penn had gone under or continued to diminish, there was going to be very little head-to-head hospital system competition in the Pittsburgh area.

When you looked at that system and how far ahead it was, you would say no one in their right mind would want to come in and invest the resources to turn West Penn around, until you realize that the insurer, because it cares both about insurer profits and the hospital system, Highmark as a competitor to UPMC, the health plan did not want to be solely reliant on UPMC instead of hospitals. It had an extra incentive as a vertically integrated entity to make the investments in the West Penn system, now known as Allegheny Health Network, and bring those hospitals back up and modernize them and it's done. As a result of that, you have two vertically integrated systems competing with each other as payers, providers, and hospitals, and you have more hospital competition than would've otherwise existed.

Larry Levitt: Great, thanks.

Elizabeth, let me bring you in. You represent employers who were [inaudible 00:11:03]-

Elizabeth Mitchell: Paying for all this.

Larry Levitt: Employers obviously foot much of the bill for healthcare spending. What leverage do you and your employers have in the face of these consolidations? Are you looking to government for help here?

Elizabeth Mitchell: Well, I think the whole point of consolidation is to minimize purchaser leverage, right? So if you are the only game in town, you set your prices, and there is evidence all over of how that has actually driven up costs. RAND said, in I think 2022, that price increases related to hospital consolidation range from like 3% to 60%. We're having these massive price increases for the people paying for care. There is absolutely no evidence that quality has improved. We know access has diminished. So they're able to leverage higher prices without the benefits. Everybody wants integrated care, of course. That is not what is happening. We are having integrated business models, but the care is not improving. Employers who may have been negotiating with a smaller system or a regional health plan, now that they're all consolidated, the receptivity to employer interests has diminished in a corresponding way.

There are so many anti-competitive business practices happening right now. We literally just did a RFI on behalf of six of our members, big purchasing power, and the plans don't even want to grant data access or audit rights or the ability to tier or do direct contracts. Those are being prohibited in their contracts by these enormous health plans who are then vertically integrated, and it is very hard to find an alternative. If you look at the health system, it's not affordable and quality isn't great. So I think it's time to really revisit this whole idea that consolidation is making anything better, because we're not seeing it.

Larry Levitt: As you all talked about, consolidation and healthcare is as old as time, but it seems like there's been this ramp up, let's say, in the last decade or two.

Erin, you kind of referenced the push towards accountable care and some of that driving it. It has been talked that the ACA, which encouraged ACOs and Medicare, may have been a factor here. What do you think has been driving this kind of latest wave of consolidation and integration?

Erin Fuse Brown: Yeah. I think in some ways, a lot of the latest wave of vertical consolidation is in part due to the need to grow big in scale in order to really manage the operational and administrative and technological capacity you need to really function in a value-based care environment, whether it's you're participating as an ACO or whether it's you're trying to manage capitated payments under the Medicare Advantage program, which has also grown to eclipse traditional Medicare. In both of those spaces, we see this risk shifting. When you ask providers, especially clinicians and independent practices, to assume almost like a risk-bearing insurance function, then the natural partner for that, they have to grow big in order to manage that, they need the technology infrastructure, and then they need sort of a deep-pocketed partner to manage all of that risk. Insurance companies have been really accelerating the move into the vertical consolidation space, in part driven by this move toward value-based care toward capitated and accountable care models. I think that that has certainly been driving the latest push.

Elizabeth Mitchell: Larry, can I just jump in and say... I don't think value-based care really exists. I have heard about it for 20 years. Everybody says they're doing it, but we don't see the outcomes. I can't name many patients who say they have had high-value care or that it has been well coordinated or integrated. I understand the argument, but we don't have evidence of it.

Larry Levitt: The lady over at Reinhardt always talked about, "There is a formula for value. There's a numerator and a denominator. You can improve value by lowering cost or improving access and outcomes of care." Not clear we've seen either of those happen in this case, but potentially.

Cory, you look like you wanted to jump in as well.

Cory Capps: Yeah, I was going to add an antitrust component to Erin's answer, which I think is right on point, which is that there was a desire, there is a desire, I think to get scale, and that's for bearing risk. It's maybe for leverage, in some cases. It's for integration and coordination. Separately, providers and payers alike have learned that horizontal mergers, meaning mergers with direct competitors, can run into antitrust challenges, meaning more than a dozen hospital mergers have been blocked over the last 15 years. Likewise, in 2017-ish, two large insurer

mergers were also blocked by the Department of Justice. But in some sense, if you learn that the horizontal merger with rival stove is hot, you decide not to touch that again. I think that may have been part of the impetus towards some of the vertical integration, which has a different set of probably lower antitrust risks associated with it.

Larry Levitt: There have been calls recently to address this. There's a proposal from the odd couple of Senators Hawley and Warren break up these big vertically integrated companies, prohibit insurers from owning physician practices or PBMs.

Erin, is it viable to break up these big companies? Is it advisable to try to break them up? Is that the right lever to think about?

Erin Fuse Brown: I think one of the concerns is that, again, if you think of your regulatory toolbox or enforcement toolbox as being primarily an antitrust one to deal with consolidation and market power, as Cory pointed out, antitrust has really been sleeping on vertical consolidation. It is basically [inaudible 00:17:44]. It's allowed it to go forward. It's looked the other way. And then even when it's attempted to bring certain cases, it's not convinced courts and judges that there's a competitive risk. I think that there's this sort of limitation of what is left. If you can't really bring a credible antitrust challenge, then we've seen these vertical conglomerates grow in market power. It's gotten to the point where I think that there's this sense that these conglomerates are exercising market power not just in one market, but in multiple markets. They're using it, and to Elizabeth's point, anti-competitively potentially to not just harm rivals, but to basically out-compete in many different areas of the healthcare supply chain.

We see that this impetus towards structural solutions, breaking up conglomerates, it's sort of the only solution I think that policymakers have been reaching for when they realize it's like the antitrust tools are just not up to the task. So you break up big conglomerates. We've seen this done in other market segments throughout our history with the AT&T or other types of structural transformations or this concept of the Glass-Steagall for healthcare, breaking up different entities that are conflicted. Because they're supposed to be bargaining competitively with each other, but they're really supplying and buying from itself. So there's a lot of opportunity to preference your own self, to harm your rivals in different market areas. I think that's pushing this idea to break up big medicine because, frankly, the antitrust tools are just not appealing.

Elizabeth Mitchell: Larry, can I just add that, from 2000 to 2020, according to a recent paper in '24, 13 mergers out of 1,164 were challenged by the FTC, right, 13. We also know, because KFF published this, that in 82% of metropolitan areas, health systems control 75% of their market. We are fully consolidated. I think AGs have been completely asleep at the wheel. They think this is all benign. They buy the line

that it is about better care. I think we have got to change our approach to regulating this. If we want to market, we have to have a competitive market and there has to be rules that enable that. Otherwise, to your earlier question, I think there will be a growing appetite for policy intervention around price caps or price setting. That is not where we're at. But if we continue on this track, that will be I think where people want to go.

Larry Levitt: Elizabeth, there was an effort in California to a case against Sutter to not so much break them up, but restrict some of their anti-competitive practices. Could you just quickly go through what those anti-competitive practices were and what the settlement ended up being?

Elizabeth Mitchell: Sure. As sort of a poster child for all of these dynamics, things like saying, "If you want access to this one maternity hospital, you have to buy our whole network," so anti-steerage, anti-tiering, and evidence of really inappropriate clinical practices. Now, I want to be clear that there was no finding because they settled, but they settled and returned over $500 million to the employers who had been paying this. I think that's a clue that they might've been overcharging. It's just one story though. Sutter is not unique. This is happening everywhere, and that's the health system side. When you combine it with the vertical integration of the insurers, and in many cases the insurers are teaming up with the systems, this is what the people paying for care are up against. One last point, and I'll stop talking. When we say, "Who's bearing the risk?" Self-insured employers bear 100% of the risk, right? I'm not talking about the fully insured. Self-insured employers are the ones paying for this. I just think that we need to keep that in mind.

Larry Levitt: Cory, Erin mentioned earlier Medicare Advantage being a potential impetus to this. What role does the desire to increase risk scores in Medicare Advantage to try to increase payments from the government play in this?

Cory Capps: Well, certainly if a payer can increase the risk score, they increase the revenue associated with whatever membership they have. The costs are going to be what they are, so that would increase profits. At the same time, if you uncover conditions that were not previously diagnosed, increase preventive care, you can also get more risk coding, higher payment, and maybe a better care experience. You have to have risk scoring of some sort or else you will end up with a [inaudible 00:22:52] game, the old example from the early '90s of the HMO putting the sign-up office on the second floor of a building with no elevator and then you get healthy patients. There's no alternative, but to do risk scoring. The question for CMS is how can they improve it over time to try to better distinguish between legitimate looking for conditions and diagnoses and providing care in response to that versus potentially suspect identification of codes that aren't there.

Larry Levitt: Great. Well, we have a ton of questions from the audience, which I want to start to get to.

Erin, one talks about... You talked about vertical integration being not a focus of antitrust. In your view, what would be an appropriate antitrust lens to view this vertical integration or these different kinds of vertical integration?

Erin Fuse Brown: Yeah, and I think, in some ways, just because it historically has not been the focus of antitrust enforcement, it doesn't mean it couldn't, right? The 2023 merger guidelines, the updated merger guidelines, I think really did start to embrace this concept that vertical consolidation is not by definition pro-competitive and try to evaluate tools to look at different ways that vertical consolidation in many markets, but healthcare being a prime example, might be anti-competitive, and look for this evidence, for example, for things looking for evidence of foreclosure of rivals, looking for evidence of steering or self-preferencing, look for workforce harm. There's a monopsony power story in terms of the ability to control the workforce and control the supply of where the clinicians are.

We see that that may be the case, and using it to evade other types of regulatory constraint. For example, the medical loss ratio, if you are both an insurer and a provider in the same entity, you can basically just move money from one side of the ledger to the other and comply with the medical loss ratio requirements that cap insurer premium profit, without necessarily actually complying with the spirit of the law. These are all sort of factors that the 2023 merger guidelines, for example, would say, "These are things that the antitrust enforcers could look at." Again, maybe we haven't seen a successful winning case yet that actually convinces a court of this, but I think that there is certainly an opportunity for antitrust to use its existing tools to refocus and to think about vertical consolidation differently, especially as the economic evidence emerges.

Cory Capps: Erin's right that the 2023 guidelines have new language about vertical mergers. However, and these have been mostly outside of healthcare, with the exception of United Change, the FTC and DOJ are bringing vertical merger challenges, but they're losing them. There's really only been one win, and that was sort of only half of a win. What's important about that is wins and losses in court have an effect beyond the individual transaction at issue. When Elizabeth says there were only 13 merger challenges to hospital merger, she's right. But when the FTC, mostly the FTC, started winning all of those, hospitals shifted the distribution of types of mergers they were pursuing to avoid the ones that would result in losing a merger challenge. In the same way, when the agencies keep bringing vertical merger challenges and they're losing them, then that's

going to basically have the opposite of a deterrent value on that. It's kind of a challenging spot for the agencies to prevail in vertical merger challenges now.

Larry Levitt: Elizabeth, we have a question about the role of state attorneys general. You work with employers, many of which are multi-state employers. Are you looking to states, and what do you think states can do here, looking to the federal government, as Erin and Cory were talking about?

Elizabeth Mitchell: Well, our members are all national. They're in almost every state, and so we have primarily focused on federal policy. There's a bill, Healthy Competition Act, that we think would help. We think all of the movement towards transparency at the objection of the industry is really important. If we can start getting visibility into not only prices, but fees and these transactions, we think that will be pro-competitive. My point about the state attorneys general is more that no one has tackled this. This happens in states and regions. I used to be a state legislator, and this just was beyond the scope of what most state AGs would do. And also the hospitals are very powerful in the states. I think it has been a combination of federal and state failure.

Larry Levitt: Elizabeth, you mentioned transparency. The Congress, in a rare bit of bipartisan action on healthcare-

Elizabeth Mitchell: Right? Amazing.

Larry Levitt: ... recently started to address PBMs, pharmacy benefit managers, with greater transparency, a requirement that they pass back 100% of rebates to group purchasers and employers, dealing with compensation in Medicare Part D from rebates. Do you think this will make a difference?

Elizabeth Mitchell: Well, I think it'll make a dent. It's certainly not going to fix everything. We're also really encouraged with the hospital price transparency requirements and the hope that they might actually enforce those requirements. The TIC reporting from health plans, that was put in place five years ago. It is still remarkably challenging to get the needed data. But as that changes and as the new rules come out, making it even clearer that folks are entitled to this transparent pricing information, that can be used to actually shift the market from the buy side. Purchasers are using that information. Who is a fairly priced and high quality provider partner?

I want to just make sure everyone understands also the new environment that self-insured employers are operating in. After the Consolidated Appropriations Act of 2021, self-insured employers are required to actually ensure they are only paying fair prices. That gets very hard in a highly consolidated system that is not even transparent about their prices. We do believe that the combination of

price transparency and some of these other federal policy interventions, like with PBMs, will move us in the right direction.

Larry Levitt: Erin, let me turn back to you. We also had questions about the role of private equity here. How does that plan to... Some of these vertical integrations we've talked about are very big insurance companies, not private equity-driven. Are there elements of this that are driven by private equity?

Erin Fuse Brown: Yeah. In some ways, private equity can be seen as one of the transactional lubricants toward vertical consolidation. I think we see, generally speaking, when private equity is moved into a particular market segment, whether it's hospitals or nursing homes or physician, specialty groups, it tends to pursue more of a horizontal consolidation, maybe cross-market if it spans geographic regions, where it's really just sort of like buying up an existing hospital chain or it's moving, buying up through serial transactions, a bunch of the same specialty of physician practice in a particular region, and growing market power that way, which is more of a horizontal story. It still has its anti-competitive impact, but it is more of a horizontal story.

Where we see it starting to play into a vertical consolidation trend is that, often, private equity, of course, has to sell its investment within a relatively short time period to return money to its investors. At that exit, a lot of times, private equity is selling to a vertically consolidated buyer, meaning it might be buying up physician practices and then it sells it to an insurance company at primary care practices. And then the prime buyer, after that, is an insurance company, or it's buying up oncology practices and it's selling to drug wholesalers who are, again, vertically related to these physician practices. Again, it's seen as sort of a market aggregating function, and then it packages it all up. Usually, when it then exits the investment to the extent that it exits to another entity, it's probably a vertical move.

Elizabeth Mitchell: I live in the Bay Area, and most of the health tech startup entrepreneurs want to sell to Optum. That's the path, and you get innovation and competition and then it gets acquired.

Larry Levitt: Cory, we also had a question back to your first set of comments about cases where this type of consolidation has improved competition. Have you seen evidence of how that translates into lower costs for employers, lower costs for out-of-pocket costs for patients?

Cory Capps: Kaiser is one that's not well studied. It is hard, I think, to come up with a control group. By well studied, I mean there are tons of qualitative examinations of it, but sort of a regression analysis comparing Kaiser to other similar systems. It's rare if it even exists in the health economics literature, and that's because

they're sort of sui generis. The inference really is drawn from the fact that a lot of seniors choose Kaiser even though it has a narrow network, which in general people don't like. If you're getting something that is lacking in one attribute, but it's still very popular overall, there must be something about it, whether price or quality, that is making people choose it. They also do well in California on the private insurance sector as well. That's more of an inferential argument.

In terms of the other example I gave with Highmark, it's more driven by the fact that there would be markedly less hospital competition without that particular vertical merger. There's good evidence to say that with sharply reduced hospital competition, one system having 60, 70% of the Pittsburgh area, maybe more, depending on the path, there would've been higher hospital prices. That didn't happen, and so the lack of that price has flowed down into benefits to the purchasers of health insurance. Again, that's also an inferential argument. There are not as many studies that go all the way down to the end consumer level, and part of that is that economists look for their keys where the light is, and they do write papers where the data are. It's hard to get data that go all the way down to the employer premium, the employee out-of-pocket payments, and then up to the back end payments to providers because that lives with the health insurance.

Elizabeth Mitchell: Can I just build on that point just from... This may also be anecdotal, but my members, many of them, have loved Kaiser because they do have integrated care, and that is a choice. But what's also happening in the last two or three years is double-digit cost increases. I don't know that that is a necessary outcome of consolidation, but that is what is happening, and what you're seeing is more and more employers questioning the value. Because everyone has liked the clear integration from a patient perspective, but at some point the cost increases will still outweigh that.

Larry Levitt: We have a question from a journalist getting at this issue of cost increases from vertical integration, kind of wanting a number, Erin, Cory, Elizabeth, anywhere you could point that has effectively quantified that effect or the effect of any one type of vertical integration?

Cory Capps: Sure. The hospital physician integration is the best studied. To toot my own horn and then someone else's, I have a paper with David Dranove and Chris Ody in 2018, Journal of Health Economics, that finds basically on the order of 10 to 14% price increases for physician services following hospital acquisitions of physician groups and some increase in total medical expenditures as well, meaning for the patients who were managed by the physician groups that were acquired, what happened to their medical spending relative to other groups.

In case you don't believe me, Zack Cooper and, I don't know, six or seven other authors have another working paper out that finds, it's hot off the presses, different data and find similar results, but that is the best studied one. And it's also something to keep in mind when you say, "How do we think about other forms of vertical integration, like payers acquiring physician groups?" Because the [inaudible 00:36:06] world may not be that the group just cruises along solo as it always had been, but that it becomes acquired by a hospital system or some other type of transaction. There may be a bit of a horse race. But in any event, the hospital position is the best studied, and maybe because that type of integration started 10 or 15 years earlier than insurer physician integration.

Larry Levitt: We believe you, certainly. We also had a question about physician ownership of hospitals. We've talked a lot about hospital ownership of physician practices. Question about that prohibition, could flipping that narrative, would that make it better, worse?

Erin, any thoughts about that?

Erin Fuse Brown: Yeah, I think that there's an open question about whether or not it makes sense to persist on the current regulatory prohibition on physician-owned hospitals, on new physician-owned hospitals. I think that there's this idea of, "Well, why would we block any form of market entry? Why are physicians any different than other types of investors who are buying up hospitals?" I think the original idea was that physicians would use their prescribing power and their referral power to basically capture the whole health system. But I think in the scheme of the landscape that we're playing in now with these large vertically consolidated entities, I'm not sure that the physician-owned hospital is the one I'm most worried about in terms of the type of vertical consolidation.

That said, I think that there's only some early evidence about whether that would actually functionally change the market because mostly, particularly the hospital market, is so consolidated that, if a physician group were to enter and have enough capital to buy up a health system and keep it afloat, it probably would need to partner with some other source of capital, whether that's private equity or otherwise. What you're really doing is moving players on the deck chair, but it doesn't change the fact that we have this large consolidated entity and just introducing another form. It may on the margins, in some markets, as Cory mentioned, keep certain systems afloat or introduce new forms of competition, but I don't think it's a panacea.

Elizabeth Mitchell: I would just add. I think it's ironic that we're worried about this problem if physicians led when we are seeing it all over the place with the current set of administrators. We know there's a practice that a hospital acquires primary care, so they get the referrals. This is well established. I would welcome the

introduction of physician-led organizations. I think clinical leadership may actually be a healthy antidote to some of this. That said, I understand the concerns about self-referrals, but that is happening now.

Larry Levitt: Elizabeth, let me follow up on that. You talked about hospital markets being so consolidated, and we at KFF have done work on that. Erin talked about that as well. We've seen these hearings on Capitol Hill, bringing insurance company CEOs in, pharmaceutical companies' CEOs, PBMs. Hospitals themselves have driven the largest share of the increase in health spending in recent years. Have hospitals somehow escaped scrutiny here? And should there be more scrutiny of hospitals or at least equal scrutiny with some of these other sectors?

Elizabeth Mitchell: Yes, there needs to be scrutiny of the health plans. I think that is long overdue. If you look at... I think we are so behind the public frustration that we're having this polite conversation. People can't access or afford care right now. Finally, there seems to be just this hint of urgency from Congress to take on some of the challenges. I think they absolutely need to look at the consolidation of the health plans and the health systems. We have actually not looked at some of the consultants. Some of the disclosures going back to the CAA of 2021 are now requiring some of these consultants and advisors to disclose how they're being paid. And guess what? They are actually also promoting these consolidated health plans and health systems. There is plenty of scrutiny required, and I think, frankly, it's the least we can do. Someone has to get underneath what is happening because, right now, the system is not working for the people using it or paying for it.

Larry Levitt: We talked earlier about efficiency, it's just scale, or potential efficiencies of scale in some of this. We had a question about electronic medical records and whether that is somehow an impetus or a good reason for some of these mergers or integrations.

Cory, leaving aside market forces, are there efficiencies that come from some of these integrations?

Cory Capps: There are certainly measures that you see systems pursuing that are likely to create efficiencies. We don't have sort of formal regression style before and after analyses to necessarily prove it. Even though when you see the referral goes smoothly from the primary care physician to the specialist, the x-ray, whatever, imaging goes directly back to the referring physician, and it all happens without paper, and maybe on a single portal, that seems like a better thing for patients. But proving that that reduction of fragmentation and frictions leads to lower overall costs has proven elusive. There's no real proof that electronic medical records, even though everyone has great, great hope for them and has for several decades now... When you compare a system that's an

early mover to a late mover on that, you don't necessarily see strong cost savings from systems that were earlier to adopt EMR than the ones that were later to. By now, almost everyone is having to adopt it, and I think that is part of the driver of consolidation.

Physician groups, your solo practice or your smaller group practice, that is a daunting amount of expenditure to take on. But if you're left behind, then you'll be less popular with patients if you don't keep up with technology. So that, plus I think physicians coming out of their residency more often want more of a salary-based model, both of those are pushing small groups to become larger in one way or another. The vertical transactions are one path. The other one is horizontal.

Larry Levitt: We have a lot of questions about single-payer Medicare for all payment changes on the payment side, reimbursement side, and whether that's a lever to address some of this. Certainly, pure Medicare for All plans would eliminate insurance companies. That would be out of the equation. Hospitals would still exist.

Erin, it's a big topic, but maybe if I could rephrase it from the payment side as opposed to the antitrust side, are there ways to at least take away the incentive to consolidate or integrate to gain pricing leverage?

Erin Fuse Brown: I think, certainly, that there are lots of opportunities to change payment policy to take away certain incentives or payment opportunities that are being exploited through vertical consolidation. For example, I'll just name two low-hanging fruit. It's not on the magnitude of reform as single-payer, but even something like site-neutral payment. The fact that you pay our health system, Medicare in particular, but that leads commercial insurers as well to pay more for the "same outpatient service in hospital-based," and I'm putting that in air quotes, acquired a vertically consolidated physician setting, our office-based setting... The site of service differential is a low-hanging fruit, and it's driving a lot of vertical consolidation on the health system side. We know that that sort of type of reform on the payment side could potentially blunt some of these incentives and also eliminate some of the cost, the excess costs, that are probably not paying for much in terms of value. Those types of policy and payment moves, again, don't solve the problem, but could go a long way to eking out some of the savings and eliminating the waste.

Cory Capps: It does show how slow and challenging I think the legislative process can be because people, economists and other policy makers and advocates, have been talking about site-neutral payment for a very long time. It was a driver of hospitals acquisitions of certain types of physician groups because it was a pile of money created by CMS. Yeah, and even some of the reforms that have happened had pretty expansive grandfather provisions in there that dulled their

effect. So even on sort of a fairly narrow targeted area, like site-neutral payment, reform is very, very slow.

Larry Levitt: I think we might need an effort to rebrand site-neutral. It doesn't exactly work on a bumper sticker, but...

Elizabeth, you wanted to jump in?

Elizabeth Mitchell: Yeah, I was going to say we actively supported site-neutral payment. I completely agree. It took forever. It's a pretty basic change and it was logically compelling, and yet it took a really long time. What we do think, it will at least diminish some of the incentives for vertical consolidation. We're also really supportive of Senator Cassidy and Hassan's site-neutral payment framework. We do think that there is a there there. We just hope it moves a little faster.

Larry Levitt: Elizabeth, let me stick with you. We had some questions about the role of employers here as purchasers. We have these very consolidated insurance companies. The insurance industry has been consolidating for years now, vertically integrating as well. But there are a number of national players that are available to employers, large national players. What is it about that market that still doesn't feel competitive, being able to switch from United to Cigna to Humana to the Blues?

Elizabeth Mitchell: There's about four or five big BUCAs, right? What people should keep in mind... Even my largest members I represent, some of the largest employers in the world, are smaller than UnitedHealthcare or smaller than some of these huge conglomerates. Frankly, they're just not terribly responsive. What we are seeing, which I think is somewhat encouraging, is sort of the entrance into the market of new entities, XO Firefly, Collective. There are these new TPA entities that are starting to become an alternative, but they've got to be big enough to serve a jumbo employer, but also innovative enough to not do what the incumbents are doing. We saw that in the PBM sector, I don't know, a few years ago. You started to see these new transparent PBMs, and it starts to introduce just at least a little competition. They're starting to get more and more traction, though they are... Again, going back to the consultants. First, you got to get into the bid, which is not easy. But as these new market entrants create real alternatives, I think you will start to see a shift, but the incumbents don't make it easy.

Larry Levitt: Erin, we haven't talked a lot about the PBMs, dominated by three big players. Is there a potential for new entrants there to shake it up as well? Mark Cuban low-cost drugs, for example?

Erin Fuse Brown: Yeah, I think certainly... I'm always for introducing new market competition. New innovative models, as Elizabeth mentioned, can have an impact even if you have a market that's dominated by three large companies, and these are three large PBMs that are not themselves standalone PBMs. They are vertically integrated into an insurance company. They have specialty pharmacies. The thing that makes an entry difficult is you can't just build a better PBM. You have to build a better PBM that has all the existing relationships up and down the healthcare supply chain with the insurance company, with the specialty pharmacy, with the wholesalers, with the distributors, with the consultants. I think that's what we're seeing. The sort of ecosystem effect or the platform effect of this vertical consolidation is yes, there are some great ArrayRx and other types of public PBMs or nonprofit PBMs or other types of models that are much more transparent, much more administrative-only fee schedules, and yet it's still hard for them to really break in if they don't have those preexisting embedded relationships up and down the healthcare supply chain.

Larry Levitt: Similar with these ASO startups that Elizabeth talked about, trying to break into the self-funded employer market. They need a network of providers as well, and those networks are, for the most part, controlled by... back to these big insurance companies.

Elizabeth Mitchell: Larry, I will add though that, every one of our members, about 20% of our members, do direct contracting. In every case, they have better outcomes, better access, and lower total cost. It is possible if a jumbo employer or even a mid-sized employer can find a regional partner who will meet their standards of quality, access, cost. Those tend to be very successful. The challenge has been scaling those. But in every case, when our members do do that, they get a better outcome than they do from the bogus.

Larry Levitt: We also had a question about remedies here, and maybe back to the Hawley-Warren plan, the idea of breaking up big medicine, breaking up these big healthcare companies.

Cory, what would that look like in practice? How would that actually work?

Cory Capps: Well, it would not proceed through antitrust litigation, I think, because each one of those would take years from start to finish to sort of sew and unwind a transaction, which is why ex-post antitrust enforcement is rare. I think the Hawley-Warren type of approach would have to be purely regulatory and sort of by legislative fiat, I guess. I'm not really sure how that would work. The one thing I would warn is to be careful of unintended consequences because the linkages are complex. When you break them, adverse things can happen. Some of this is more complicated than you think because Elizabeth mentions direct contracting, but we also saw the example of Haven, which was the joint venture

between JP Morgan, Amazon and Berkshire Hathaway, to try to make healthcare more efficient. First, focusing on self-providing to their employees. Five years later, I don't think anything is left of that effort. It is hard to do. When you apply legislation, you may break things that you wish you hadn't.

Larry Levitt: We're coming towards the end of the hour. I wanted to give each of you an opportunity to talk about one thing. If you could name one thing you think we should be doing policy-wise to address consolidation and integration, to promote better integration, what would that be?

Elizabeth, let me start with you.

Elizabeth Mitchell: Well, at the very least, table stakes, we need full transparency. We need transparency into ownership, into prices, into outcomes. If you want a market, you have to at least have the basic information. And then you can allow the people paying for care, choosing care, to use that information. We have got to sort of tackle this consolidation in a way that is pro-competitive and pro-consumer. Transparency would help. I think we're seeing legislation that goes after the anti-competitive practices that are protecting the incumbents. That's also important.

I know you didn't ask me this, but I'll say that. About five years ago, we partnered with KFF to do a survey of the C-suite of Fortune 50 companies, Fortune 100 companies, and they said they want more intervention by the federal government. These are captains of industry, they're not socialists, and they are saying they have got to... Someone has to weigh in and control pricing. And if not, I think they may walk away. I'm not saying that, no employers that I'm talking to are saying that, but at some point this becomes unsustainable for employers.

Larry Levitt: Yeah. I should say that there was a survey not of people who run health benefits, but C-suite-

Elizabeth Mitchell: Right, C-suite, CFOs, CHROs, right?

Larry Levitt: Yep.

Erin?

Erin Fuse Brown: Yeah, I was thinking about it, and I think that... Again, it hasn't been studied in the healthcare space, but I do think that there's a lot of promise to this idea of structural separation. Again, it's not just breaking up anything that's big, but it's breaking up these conglomerates along lines where there are conflicts, where you shouldn't be on both. One entity shouldn't be able to do business with itself

to the detriment of its rivals, and I think that there is certainly some promise there. I think Cory's point is well taken, be careful how you do it. It's a blunt instrument. But I think we've gotten to the point where there aren't really availing, again, antitrust tools or other types of regulatory tools to truly regulate this type of anti-competitive conduct by vertically consolidated entities. I think we're at the point where we're things like price caps and structural separations are on the table.

Larry Levitt: Cory, you get the last word here.

Cory Capps: I think I'm maybe more of an incrementalist. There are lots of... to make progress through lots of small things that hopefully add up to a big effect. Site-neutral payment is one that we talked about before. You're seeing more states enact mini, like small, HSR notification programs that alert the state AGs or other agency created by a state to transactions within the state that would be too small to normally attract federal notice. Not that all of them will be blocked, but that they will at least be reviewed. And then the last thing I will add in the incrementalist vein is to make sure that FTC and DOJ have the funding because horizontal mergers are bad, except for when they're not. I think verticals are good except for when they're not. So it takes time and resources and expertise to do the work to evaluate each one on the merits and proceed accordingly.

Larry Levitt: Well, thank you. This was a big topic. I feel like we corralled it in reasonably well in a short hour of discussion. Thanks to you all for a great discussion, great insights, and great ideas.

And thanks to the audience as well.