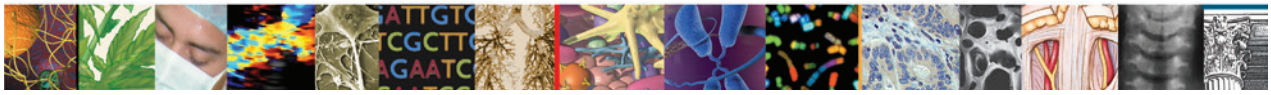

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Perspective

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Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All

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UnitedHealth Group has recently come under fire. In February 2024, a ransomware attack on Change Healthcare, the medical claims clearinghouse owned by UnitedHealth, created a cash-flow crisis for hospitals, medical practices, and pharmacies. State and federal regulators are scrutinizing numerous high-profile acquisitions by UnitedHealth's provider-side subsidiary, Optum Health, and the U.S. Department of Justice (DOJ) is undertaking a broader antitrust probe of the parent company. In addition to owning Change Healthcare and an extensive data-analytics arm, UnitedHealth is the largest insurance company and the largest employer of physicians in the United States. It is also the third-largest pharmacy benefits manager (PBM), and it operates pharmacies and a bank.

This type of vertical consolidation is not exclusive to UnitedHealth. Humana is now the largest provider of "senior focused" primary care and post-acute care in-home services. CVS, after purchasing Aetna in 2018, has acquired physician practices and companies that provide in-home primary care services, which complement its PBM and pharmacy chains. Major insurers Cigna, Centene, and Elevance are pursuing similar vertical growth strategies. Although this new frontier of consolidation has the potential to generate efficiencies, there are also risks: vertically integrated conglomerates can deploy a range of financial tactics and engage in market abuses that raise costs, undermine fair competition, and erode the quality of patient care and physician morale.

Driving this vertical consolidation has been the tidal shift from fee for service toward "capitation based" financing in public programs. Under these financing models, the federal government and state governments delegate the management of a patient's total health care costs to a private "risk-bearing entity," such as Medicare Advantage or a managed Medicaid insurance company or an accountable care organization in traditional Medicare. The proportion of Medicare beneficiaries who are enrolled in Medicare Advantage plans has more than doubled since 2010 and now exceeds 50%. Such plans have become exceedingly profitable: the government will pay roughly $500 billion to insurance companies in 2024 to administer

the Medicare Advantage program, including 23% more per beneficiary than it spends on traditional Medicare — equivalent to an extra $88 billion per year.[1] This trend has occurred alongside a decades-long privatization of state Medicaid programs, from which insurance companies receive another roughly $500 billion per year.

This vertical consolidation furthers the broader trend of health care corporatization, which pits corporations' goal of maximizing profit against physicians' professional ethical obligation to prioritize patients' interests.

With this capital, insurance companies are acquiring physician practices and care-delivery companies in order to execute a two-pronged strategy that involves maximizing capitated payments and reducing costs by means of utilization controls and "intercompany transfers" (i.e., paying their provider-side subsidiaries). These dual aims are also the keys to success for other entities participating in risk-bearing, value-based payment models, such as accountable care organizations, which are poised to cover all traditional Medicare beneficiaries by 2030. Insurers can gain access to these "risk dollars" — now approximately $150 billion per year — by acquiring providers and contracting directly with the government.

This wave of payer-led consolidation represents a new spin on an old concept. Since the advent of managed care, policymakers and regulators have encouraged vertical integration. Vertically integrated health care entities — which combine multiple aspects of the supply chain — have promised to facilitate care coordination and generate increased efficiencies owing to reduced transaction costs and economies of scale. Yet there remains little evidence that such desired efficiencies have resulted.[2] It's plausible that this new wave of consolidation — which largely excludes hospitals — will be different. Since insurers seek to reduce the total cost of their beneficiaries' care, they can implement incentives for providers to prevent expensive emergency department visits and hospitalizations and can steer patients toward lower-cost sites of care. Furthermore, in the context of rampant market consolidation, payer-led integration may offer physician organizations an alternative to hospital or private-equity–backed acquisitions.

We believe, however, that lawmakers ought to be wary of the risks posed by a policy strategy that encourages payer-led consolidation. One concern is that by controlling physicians and patient data in medical practices, conglomerates can maximize diagnosis coding and inflate risk-adjusted government payments. Transactions such as UnitedHealth's acquisition of Change Healthcare can supercharge these efforts; because of this acquisition, UnitedHealth and its subsidiaries have access to diagnosis codes, claims histories, and other information for tens of millions of patients. In Medicare Advantage, abuse of risk adjustment accounts for $54 billion in overspending per year, relative to traditional Medicare.[1]

Gaming of medical loss ratio (MLR) requirements is another concern. This regulation is intended to cap insurers' profits and administrative costs and ensure that at least 85% (in most cases) of premium revenue is spent on patient care. But vertical consolidation allows insurers to move profits to the provider side of the ledger by means of intercompany transfers and thereby evade MLR caps.[3] Indeed, UnitedHealth pays a quarter of the premium revenue it takes in to itself by means of intercompany transfers.

Patient steering and anticompetitive behavior are other causes of concern. Insurance conglomerates can coordinate among subsidiaries to drive out competitors and encourage patients to use their services and products. The insurer can cut reimbursements to independent practices to pressure them to sell.[4] Then, upon acquisition, it can shift the practice's patients into the insurance plan. Insurance conglomerates that own PBMs use similar strategies to cut payments to local pharmacies and steer patients, often toward their own subsidiaries. These tactics deprive patients of access to and choice of clinicians, disrupting longstanding care relationships.

Finally, this vertical consolidation furthers the broader trend of health care corporatization, which pits corporations' goal of maximizing profit against physicians' professional ethical obligation to prioritize patients' interests. Corporate ownership promises to unburden physicians from administrative responsibilities, but it may be a Faustian bargain. With control of practice operations, corporate owners can direct staffing and scheduling, dictate the duration and number of patient visits, and conscript physicians into adopting billing- and coding-related strategies for maximizing profit. As practice owners, insurers can deny coverage of or discourage use of necessary services. They can oust existing leaders, bind physicians to noncompete clauses and to gag clauses that prevent voicing of concerns about patient care, and replace physicians with lower-cost clinicians.

For policymakers and regulators, various tools exist to address this new frontier of consolidation. Although we believe the Biden administration's recent Medicare Advantage rulemaking targeting inappropriate coding in risk adjustment is a good first step, more forceful congressional action is needed to curb Medicare Advantage overpayments. Congress could also direct resources to support increased antitrust scrutiny of anticompetitive transactions and behavior by vertically consolidated entities and give antitrust regulators more authority over this behavior. Although 2023 merger guidelines from the DOJ and the Federal Trade Commission (FTC) are more skeptical of vertical consolidation than previous guidelines, the lack of precedent for blocking such consolidation will make it difficult to persuade courts to halt anticompetitive transactions. Indeed, the DOJ lost its challenge to UnitedHealth's acquisition of Change Healthcare in 2022.

An audio interview with Erin Fuse Brown is available at NEJM.org

Congress could pursue a more proactive antitrust approach by prohibiting insurers and PBMs from owning medical practices, pharmacies, and other provider entities in the care-delivery chain. Short of enforcing such bright-line separation, Congress could strengthen MLR laws by regulating intercompany transfers and requiring that payers offer the same prices to affiliated and unaffiliated providers.

Another approach would be to reinvigorate bans on the corporate practice of medicine that, before the managed care revolution, barred corporations such as insurance companies from employing or controlling physicians. Many states still have these laws on the books, but legal engineering has rendered them ineffectual. Revamped legislation, along the lines of a bill that policymakers in Oregon recently attempted to pass, could limit corporate control of physician practices.[5] A milder approach would involve outlawing contract provisions that cede control to corporate entities, such as restrictions on physicians' ability to control shares of their practice, gag clauses, and, as recently finalized in FTC rulemaking, noncompete agreements.

Deliberately or not, policymakers' shift toward capitation-based financing, particularly in Medicare Advantage, is spawning a wave of vertical consolidation, putting a handful of insurance companies increasingly in control of the care-delivery system. Policymakers face a choice: they can continue to support this consolidation, betting on the promises of vertical integration, or they can pursue an alternative vision for the structure of the health care economy.

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