

## Research



# Why Are Hospitals Buying Physician Practices and Forming Insurance Companies?

ROBERT BOOK | FEBRUARY 11, 2016

For the last half-century or longer, one of the most notable features of the U.S. health care system has been the fact that very few physicians are employed by hospitals. The vast majority of physicians are members of independent or solo practices. Even physicians who work exclusively in hospitals, such as emergency physicians, are typically members of small group practices that contract with one or more hospitals to staff their departments. Hospitals typically employ nurses, technicians, and support staff – but not physicians.

For the most part, physicians have practice privileges at hospitals, but are neither suppliers, contractors, nor employees of hospitals – a fact most people don't realize until they become a hospital patient, and receive separate bills from the hospital, and from every physician who treated them there. It's almost as if hospitals merely provide a venue for physicians and patients to meet, with the patient paying separately for the physicians' services and for the use of the meeting place.

There are a few integrated medical systems, such as Kaiser Permanente (in some states) that have mutually exclusive contracts with a single physicians group, and operate as a single integrated unit – but this is a small minority of U.S. physicians (and for that matter, a small minority of U.S. hospitals).

In the 1990s there was a wave of hospital mergers, leading to local near-monopolies of hospital services in some metropolitan areas. Recently, however, many hospital organizations – particularly those with local near-monopolies – have been forming physician groups, which have in turn been buying up physician practices at a rapid rate. For example, Inova owns all but two hospitals in the Northern Virginia region, and recently started the Inova Medical Group. Inova Medical Group has acquired numerous office-based physician practices across the region, including over 400 office-based physicians – as well as primary care and most major specialties.

Hospital groups across the country have also started forming their own health insurance companies – either on their own, or as joint ventures with established insurance companies – with their own facilities and physicians as the main in-network providers.

This vertical consolidation of health care appears to be a rational response – from a business point of view – to two aspects of the Affordable Care Act (ACA).

For the non-Medicare sector of the market, the ACA incentivizes health plans with narrow networks. By forming their own insurance plans with their own facilities and employees as the main in-network providers, they can assure themselves of a patient base, while simultaneously reducing competition at the provider level.

Not only is this encouraged by the ACA's preference for narrow networks; it is synergistic with the effects of the ACA's Medicare Shared Savings Program (MSSP)

The MSSP establishes the notion of [Accountable Care Organizations](#) (ACOs). These are groups of providers

(hospitals, physicians, other providers) who join together for purposes of a Medicare fee-for-service incentive program. ACOs are paid to “reduce costs” for treating their patients. This sounds like a reasonable goal, but the ACO system has a number of odd and unique quirks. First of all, patients don’t “enroll” in an ACO – they are assigned to an ACO *ex post* based on the preponderance of their utilization. That is, at the end of the year, if a patient happens to have had a plurality of care (measured by either service counts or dollars of Medicare claims), from physicians who are members of a particular ACO, then that patient is assigned to that ACO.[1] Not only do patients not enroll in ACOs; they might not even be aware of them, as assignments may take place after the fact.

For patients assigned to ACOs, the ACO receives bonus payments based on the total amount Medicare pays for care of those patients. That total includes *all* care those patients receive from all providers – specifically, including providers who are not members of the ACO. Bonuses are based on reducing total costs relative to what would be expected risk-adjusted cost based on each patient’s health status.

Because this program is part of Medicare’s fee-for-service system, “reduce costs” means “reduce services” – that is, “give patients less care.”

The idea is to incentivize providers to encourage patients to utilize less care – say, to recommend fewer surgeries, fewer hospital stays, less frequent follow-up visits, and so on. ACO participants can certainly refer patients to other participants in the same ACO when another type of care is needed, so that the ACO can deal with the patient in a consistent manner.

One might ask how an ACO is supposed to reduce patients’ utilization of health care in a fee-for-service system in which patients are, in principle, free to obtain services whenever they want from providers outside the ACO’s control – and indeed, may not even be aware of whether they are in an ACO, let alone what providers are members.

Indeed, this could be very difficult for a small ACO consisting of only a few physicians and one hospital in a large metropolitan area.

*HOWEVER* – if an ACO controls a large percentage of the available providers, it gets a lot easier to reduce patient utilization. If an ACO wants to, say, try to limit patients to 12 specialty visits a year, it’s much easier if they “own” most of the specialists in the area. If an ACO includes many of the major hospitals, and a significant number of physicians in every major practice area – including, say, imaging facilities and labs (possibly a hospital outpatient lab), then it becomes a lot easier to guide patients to the level and type of utilization desired – which is, for purposes of the Medicare Shared Savings Program, always *less* utilization. And of course, it is much easier to enforce referral and utilization policies on physicians who are employees of a group running the ACO, rather than simply independent businesses who happen to join an ACO at a given moment in time.

In other words, the Medicare Shared Savings Program encourages hospitals and physicians of different specialties to join together in order to encourage patients to use less health care.

It is highly ironic that a law proposed, in part, because of the allegation health insurance companies were increasing their profits by denying care to patients – is now the means by which the federal government pays physicians to, in effect, deny care to patients.

[1] The methodology for assignment is detailed here:  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V4.pdf>