JOINT COMMISSION ON HEALTH CARE

VERTICALLY INTEGRATED CARRIERS AND PROVIDERS

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #501

COMMONWEALTH OF VIRGINIA
RICHMOND
2023

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Vertically Integrated Carriers and Providers

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Key terms and definitions

Access – Availability of providers who can deliver services patients need (e.g., how many hospitals exist within a geographic region) as well as adequacy of patients' health insurance coverage (e.g., whether an insurance plan sufficiently covers the services and doctors that members need); for the purposes of this report, JCHC staff assessed Virginians' ability to choose between available health care providers and health plans to understand the impact of vertical integration on access to care.

Core Based Statistical Area (CBSA) – A geographic region of the United States designated by the Office of Management and Budget consisting of at least one core urban area of 10,000 inhabitants and adjacent counties with a high degree of social and economic integration to the core urban area

Cost – Expenses related to the provision of health care, incurred by the patient for insurance premiums and health care bills, by the health system to provide services, and by the insurance carrier to administer plans and reimburse for services

Health region – Classification by the Virginia Department of Health designating localities to Central, Eastern, Northern, Northwestern, or Southwestern Virginia based on geography

Medical Loss Ratio (MLR) – A financial measurement of how much health insurers spend on medical claims and quality of care improvements in relation to the premium dollars received

Metropolitan Statistical Area (MSA) – A type of CBSA (see above); a geographic multi-county region designated by the Office of Management and Budget with at least one core urban area of 50,000 or more inhabitants

Quality – The degree to which health care and services increases the likelihood of desired health outcomes, often measured by how safe, effective, patient-centered, timely, efficient, and equitable the care is

Vertically Integrated Carrier (VIC) – A health insurer or other carrier that owns an interest in an acute care hospital

Vertically Integrated Provider (VIP) – Acute care hospital that owns an interest in a health insurer or other carrier

Vertically Integrated Carriers and Providers

DEFINITIONS

Vertically integrated carriers are health insurers or other carriers with ownership interests in acute care hospitals (as defined by the Virginia Health Insurance Reform Commission).

Vertically integrated providers are acute care hospitals with ownership interests in health insurers or other carriers.

Vertically integrated systems refer to the integrated carriers and hospitals as one entity.

FINDINGS IN BRIEF

Vertical integration does not limit access to health care in Virginia
Most of Virginia's vertically integrated providers operate within limited geographic regions of the state. Eastern Virginia residents have the least choice between vertically integrated providers and other providers. All vertically integrated carriers in Virginia operate in markets where they face competition from other carriers. While Virginians generally have a choice among carriers, vertically integrated carriers have larger proportions of Medicaid and exchange enrollees than other carriers.

The impact of vertical integration on costs to patients, providers, and payers is variable and inconsistent across systems
In theory, vertically integrated systems can generate cost benefits for patients, providers, and carriers through better care management, reduced health care utilization, economies of scale in administration, and lower premiums. However, most stakeholders JCHC staff spoke with said that true savings and total impact on cost can be difficult to quantify. In addition, market dominance, along with a multitude of other factors, interacts with vertical integration to influence cost. Vertically integrated carriers reimburse their affiliated providers differently, though there are no consistent patterns across systems. They also do not report significantly different medical loss ratios from other carriers.

The relationship between vertical integration and quality is mixed
Vertically integrated providers in Virginia have significantly higher quality ratings than other acute care hospitals, and moderately higher patient satisfaction ratings. These findings are in alignment with research that indicates vertically integrated systems perform better than competitors in quality and member satisfaction. Vertically integrated carriers also spend a higher percentage of revenue from member premiums on quality improvement, though their plan quality ratings are not significantly different from those of other health plans.

Vertically Integrated Carriers and Providers

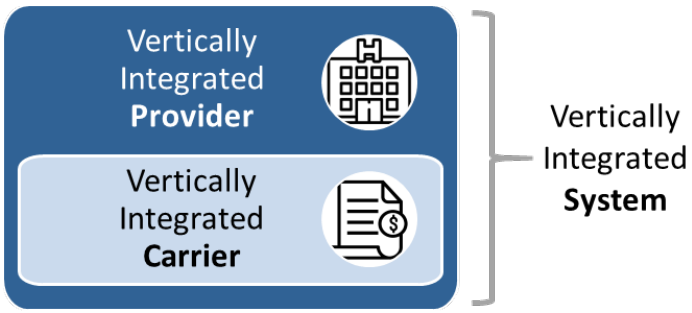
There is strong interest in understanding how consolidation among health care entities impacts consumers. Integration can either be horizontal, where similar entities consolidate, or vertical, where differing health care industries consolidate (e.g., health insurance plans acquiring retail pharmacies). In December of 2022, the Joint Commission on Health Care directed staff to study vertically integrated systems, where there is a joint ownership interest between insurance carriers and providers (specifically health systems, including hospitals) in Virginia.

The General Assembly has considered legislation on the operations of vertically integrated carriers over the last five years. In 2020, the Virginia Health Insurance Reform Commission (HIRC) received testimony from stakeholders on concerns with contract negotiations and conflict of interest within vertically integrated systems. To further inform these issues, the JCHC directed staff to evaluate the scope and impact of vertical integration between health insurance carriers and acute care hospitals in Virginia and nationally; and to determine, where possible, the impact of vertical integration on access to services, health care costs, and quality of care (See Appendix 1 for study resolution).

Vertically integrated carriers and vertically integrated providers share ownership interests

Vertical integration in health care has increased since the passage of the Affordable Care Act, renewing interest in the impact of integration between health insurance carriers and acute care hospitals (See Appendix 2 for national context and history). For the purposes of this study, JCHC staff used the HIRC definition of **vertically integrated carriers** to focus exclusively on health insurers or other carriers with ownership interests in acute care hospitals. Subsequently, **vertically integrated providers** refer to the acute care hospitals that own an interest in health insurers or other carriers. The **vertically integrated system** refers to the entirety of the integrated carrier and hospitals as one entity (FIGURE 1).

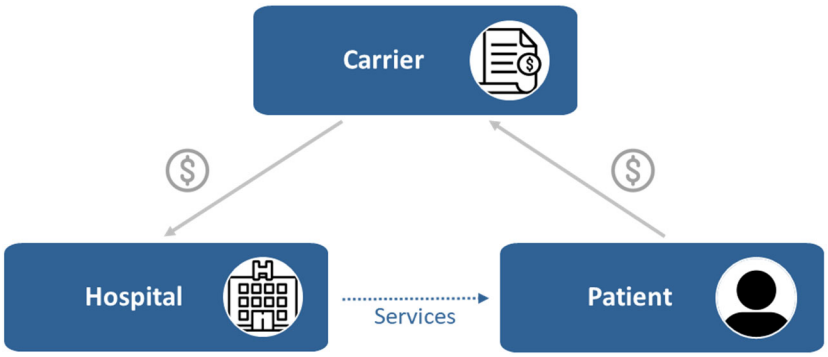
FIGURE 1: Vertically integrated systems refer to the integrated carriers and hospitals as one entity



Vertical integration can provide financial stability and incentivize value-based care, though it requires significant risk and investment

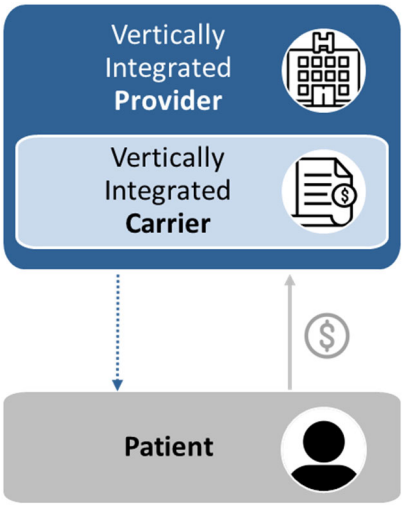
In non-integrated systems, hospitals bill carriers for services rendered to their members. Health insurance carriers collect premiums from their plan members and in turn, negotiate payment rates with providers and send reimbursement for their members' service utilization (FIGURE 2).

FIGURE 2: In non-integrated models, hospitals are reimbursed by insurance carriers for services provided



In vertically integrated systems, where hospitals and insurance carriers have shared ownership interests, hospitals can access the revenue that carriers receive from premiums paid by plan members (FIGURE 3). This integrated business model reduces hospitals' reliance solely on reimbursement for services. In interviews with JCHC staff, former and currently vertically integrated systems cited financial stability, specifically the ability to balance cyclical ups and downs in health care, as an incentive to become vertically integrated. One example often cited by stakeholders was the different financial realities for hospitals and insurance carriers during the height of the COVID-19 pandemic. Hospitals saw a dramatic drop in health care utilization and their revenue, totaling an estimated $323 billion nationally, as patients avoided all but the most essential health care services. At the same time, health insurance plans reported record profits, up to 200% of prior year earnings, as they continued collecting member premiums while paying a fraction of usual member health care costs.

FIGURE 3: Vertical integration allows hospitals to access premiums paid to carriers



Shared incentives can support value-based care

Stakeholders believe that shared interests between carriers and hospitals can facilitate the adoption of value-based care and allow hospital systems to better manage population health. In non-integrated systems, hospitals' investments in community health are often realized through cost savings by the insurer due to reduced health care utilization. In vertically integrated systems, the incentives are aligned. Half of the former or currently vertically integrated systems interviewed described being able to provide innovative services and activities that would otherwise not be financially feasible. Vertical integration meant that, in addition to traditional services, hospitals had the capital and support to pilot new value-based programs with their affiliated carriers. For example, one hospital system described approaching their vertically integrated carrier to receive reimbursement for centering midwifery prenatal care in which a group of pregnant people receive care together, rather than the traditional individual prenatal visit.

It can take time for systems to see returns on investment from vertical integration

While vertically integrated systems have an increased potential for financial stability and value-based care, the model does require hospitals to take on more risk. Half of the stakeholders interviewed noted the large financial investment required, as well as the slow return on investment. First, hospitals must be able to provide up-front capital as well as keep large cash reserves required by insurance regulations. Then, they must be able to manage potentially years of financial losses as they build plan membership and understand their true actuarial risk. It can be many years before they begin to see a return on their initial investment. One vertically integrated system interviewed described it as "building an asset over time," saying it will take five years before the product is profitable, and another few years after that to earn back the initial investment costs. Some systems are not able to manage the capital requirements for that long, or struggle to gain enough plan enrollees to cover fixed costs and effectively manage their risks. One study found that between 2010 and 2016, health systems had established 37 new health insurance companies and acquired five existing ones. Of those, only four were profitable, and five went out of business.

There are currently three vertically integrated systems in Virginia where hospital systems have ownership interests in a carrier

All three vertically integrated systems in Virginia consist of a hospital system that fully or partially owns an insurance carrier (TABLE 1). Virginia's vertically integrated providers are all nonprofit health systems with strong community presence, multiple hospitals, and additional health care facilities including ambulatory surgical centers, imaging centers, and physician practices (see Appendix 3 for additional organizational information). Virginia's vertically integrated carriers are subsidiaries of nonprofit health systems. As such, all but

one of the vertically integrated carriers in Virginia are also nonprofits. The one exception is Piedmont Community Health Plan, a for-profit health insurance carrier wholly owned by the nonprofit Centra Health system.

TABLE 1: There are three vertically integrated systems in Virginia, comprised of four providers with full or joint ownership of four carriers

Vertically Integrated System	Vertically Integrated Provider (percent ownership)	Vertically Integrated Carrier (year established)	Insurance Product Types
1. Sentara-Optima	1. Sentara Healthcare (100%)	1a. Optima Health (1984) 1b. Virginia Premier (1995)	Commercial Medicaid Medicare
2. Centra-Piedmont	2. Centra Health (100%)	2. Piedmont Community Health Plan (1997)	Commercial
3. Mary Washington	3a. Mary Washington Healthcare (80%) 3b. Riverside Health System (20%)	3. Mary Washington Health Plan (2019)	Medicare

SOURCE: State Corporation Commission, Virginia Bureau of Insurance, 2023.

There are currently no instances of vertical integration in Virginia in which an insurance carrier owns acute care hospitals (see Appendix 3, Figure 6b). The closest example is Kaiser Permanente, which owns acute care hospitals on the West Coast. However, their Virginia operations do not include ownership of any acute care hospitals, so they did not meet the HIRC definition of vertically integrated carriers and were not included in this study.

Carriers and providers in Virginia frequently change vertical integration status

Many providers and insurers in Virginia have experimented with various forms of vertical integration over the last 40 years. Their ownership status and product offerings often change over time, due to financial hardship, leadership changes, changing partnership dynamics, and shifting priorities. The most prominent and recent examples include:

- **Carilion Clinic** offered both Medicare Advantage and Medicaid lines of business, though the health system now no longer provides either. They stopped providing Medicare Advantage in 2013, citing government cuts that would have required reduction of benefits and "significantly higher" premiums. They discontinued their Medicaid managed care line in 2014 due to "continuing losses".
- **Centra Health** launched **Piedmont Community Health Plan** as a joint venture with **Individual Network Physicians** in 1997, before taking full ownership in 2015.

- **Inova Health System** partnered with **Aetna** to launch **Innovation Health** as a joint venture in 2013, before transitioning to 100% ownership by Aetna in February 2023.
- **Mary Washington Health Care** launched **Mary Washington Health Plan** in 2019 to offer Medicare Advantage plans.
- **Riverside Health System** previously partnered with Blue Cross Blue Shield to offer insurance from 1994 to 2013. In 2022, they acquired a 10% ownership stake in Mary Washington Health Plan, facilitating the carrier's expansion to the Riverside market and administration of Riverside Advantage, a Riverside Health System Medicare Advantage product. In 2023, Riverside Health System acquired an additional 10% ownership for a total of 20% equity in Mary Washington Health Plan.
- **Sentara Healthcare** owns **Optima Health**, the longest-standing vertically integrated carrier in Virginia. Optima Health's Health Maintenance Organization (HMO) line of business was established in 1984 as a partnership with Bon Secours. In 2003, Sentara Healthcare purchased Bon Secours' minority share and took full ownership.
- **Virginia Commonwealth University Health System** established **Virginia Premier**, the second longest-standing vertically integrated carrier in Virginia, in 1995. Sentara Healthcare acquired 80% ownership of Virginia Premier in 2020, and 100% ownership in 2022. Sentara Healthcare has combined the Optima Health and Virginia Premier plans under Optima Health Plan as of July 1 of this year and will rebrand its insurance business as Sentara Health Plans beginning in 2024.
- And most recently, **Valley Health** is now a joint owner in **Peak Health Insurance Corporation**. While they are not yet licensed to start selling insurance in Virginia, the health system released public communications about their intent to begin offering a Medicare Advantage Plan.

The landscape of vertically integrated systems continues to shift as providers and carriers enter and exit the market. This instability in partners, products, or service areas makes understanding the long-term impacts of vertical integration in Virginia challenging.

Vertical integration could impact access to health care, though there is no evidence to suggest this is happening in Virginia

In considering health care access, it is important to look at both the availability of providers that can deliver services patients need (e.g., how many hospitals exist within a geographic region) as well as the adequacy of patients' health insurance coverage (e.g., whether an insurance plan sufficiently covers the services and doctors that members need). There is very limited research on the impact of vertical integration on health care access. One study of relationships between provider-led health plans and patient utilization found no differences in access, while another found that vertically integrated Medicare Advantage plans had higher rates of members with issues accessing providers, potentially due to narrow networks.

Virginians have a choice between vertically integrated providers and other acute care hospitals in most health regions

To assess the impact of vertical integration on provider availability, JCHC staff examined how much choice patients have in each health region between vertically integrated health systems and other health systems. Of the 79 acute care hospitals across the state, just over a quarter (27%) are owned by vertically integrated providers – Centra Health, Mary Washington Healthcare, Riverside Health System, and Sentara Healthcare. Most of Virginia's vertically integrated providers operate within limited geographic regions of the state. However, when a vertically integrated provider dominates a health region's market share, individuals' choices become limited.

Vertically integrated providers dominate in Eastern Virginia

In all health regions except Eastern Virginia, vertically integrated providers are only a minor share of total acute care hospitals. Eastern Virginia residents are most limited in their choice between vertically integrated providers and other providers because 11 of the 17 total acute care hospitals (65%) are owned by a vertically integrated provider, either Riverside Health System or Sentara Healthcare (TABLE 2). These two vertically integrated providers operate nearly three-quarters of staffed acute hospital beds in the region, defined as the number of beds able to receive patients during the reporting period, and also manage 80% of the region's acute hospital patient days, defined as the number of days of patient care provided during the report period.[i] There are no data yet to indicate this dominance is problematic; however, it may be an area for further study as additional data about the impact of vertically integrated systems are made available.

[i] This metric excludes days in a nursing facility unit of the hospital, and excludes days in a regular (i.e., not intensive care) newborn nursery while the mother is still in the hospital.

TABLE 2: Vertically integrated providers operate in all five Virginia health regions

Hospital System	Number of Acute Hospitals by Health Region					
	Central	Eastern	Northern	Northwest	Southwest	Total
Total VIP Acute Care Hospitals	2	11	1	4	3	21
Centra Health	1	-	-	-	3	4
Mary Washington Healthcare	-	-	-	2	-	2
Riverside Health System	-	4	-	-	-	4
Sentara Healthcare	1	7	1	2	-	11
Total Non-VIP Acute Care Hospitals	14	6	10	7	21	58
Total Hospitals	16	17	11	11	24	79

SOURCE: Virginia Health Information, 2023. Efficiency and Productivity Information Collection System (EPICS) hospital information.

NOTE: VIP = Vertically Integrated Provider

Virginians have a choice between vertically integrated carrier insurance plans and other insurance plans

JCHC staff assessed insurance coverage across markets to look at dominant carriers and identify where Virginians may face limited choice between vertically integrated carriers and others. Virginia is organized into Metropolitan Statistical Areas (MSAs), some of which overlap with neighboring states, that are used to identify where carriers offer health insurance. All vertically integrated carriers in Virginia operate in markets where they face competition from other carriers. There are currently no markets where Virginians are limited to just vertically integrated carriers. However, vertically integrated carriers have larger proportions of Medicaid and exchange enrollees than other carriers.

The four vertically integrated carriers in Virginia all offer different lines of business, but most frequently provide Medicare Advantage products (TABLE 3). Only Optima Health has commercial, Medicare, and Medicaid lines.

TABLE 3: Vertically integrated carriers in Virginia most frequently offer commercial and Medicare products

Vertically Integrated Carrier	Medicare	Medicaid	Commercial
Mary Washington Health Plan	Yes		
Optima Health	Yes	Yes	Individual Group
Piedmont Community Health			Individual Group
Virginia Premier Health Plan	Yes	Yes	

SOURCE: State Corporation Commission, Virginia Bureau of Insurance, 2021 and 2022. Annual Statements of Mary Washington Health Plan, Piedmont Community HealthCare HMO, Virginia Premier Health Plan, and Optima Health Group.

Vertically integrated carriers in Virginia make up only a fraction of the total Medicare Advantage market

Currently, three vertically integrated carriers in Virginia, Mary Washington Health Plan, Optima Health, and Virginia Premier, offer Medicare products. In 2022, there were 18 carriers that provided Medicare Advantage Part C and/or Medicare Part D plans and reported premiums to the Virginia State Corporation Commission. Enrollees of vertically integrated carrier plans made up only 5.5% of the roughly 550,000 total enrollees.

Instead, Virginia's Medicare Advantage landscape is dominated by Humana and UnitedHealth Group across all MSAs except Washington-Arlington-Alexandria (See Appendix 4 for dominant carriers by MSA).

One-third of Virginia's Medicaid enrollees are served by a vertically integrated carrier

Medicaid enrollees in Virginia are covered by one of six carriers. Anthem was the dominant carrier with more than one-quarter (27%) of all Virginia's Medicaid enrollees until recently. Following Sentara Healthcare's purchase of Virginia Premier, as of July 2023, Optima Health and Virginia Premier now operate as a combined carrier under Optima Health Plan. As a result, Optima Health has surpassed Anthem as the dominant insurer with one-third of the Virginia Medicaid market (TABLE 4).

TABLE 4: Vertically integrated carriers have the largest share of Medicaid enrollees as of July 2023

Carrier	VIC?	Share of Total Virginia Enrollees
Optima Health	Yes	725,972 (34%)
Anthem	No	588,523 (27%)
Aetna	No	275,085 (13%)
United Healthcare	No	224,982 (10%)
Fee for Service	No	208,208 (10%)
Molina	No	137,428 (6%)
Total Enrollees		2,160,198

SOURCE: Virginia Department of Medical Assistance Services, July 2023. Virginia Medicaid and FAMIS Enrollment data. https://dmas.virginia.gov/data/medicaid-famis-enrollment/.

NOTE: VIC = vertically integrated carrier

Vertically integrated carriers have smaller shares of the commercial market than current dominant carriers

In 2022, Anthem had the largest commercial market share in most MSAs in Virginia, with a 43% share of the entire state. The second largest insurer in three of the ten MSAs was a vertically integrated carrier, either Optima Health, owned by Sentara Healthcare, or Piedmont Community Health Plan, owned by Centra Health (TABLE 5). Optima Health was the second largest commercial insurer in the Harrisonburg and Virginia Beach-Norfolk-Newport News MSAs, while Piedmont was the second largest commercial insurer in the Lynchburg MSA.

TABLE 5: Vertically integrated carriers are the second largest commercial insurer in three Virginia MSAs

Metropolitan Statistical Area	1st Largest Insurer	VIC	Share	2nd Largest Insurer	VIC	Share
Blacksburg-Christiansburg	Anthem	No	68%	CVS Health	No	16%
Charlottesville	Anthem	No	42%	CVS Health	No	34%
Harrisonburg	Anthem	No	64%	Optima Health (Sentara Healthcare)	Yes	12%
Lynchburg	Anthem	No	66%	Piedmont Community Health Plan (Centra)	Yes	11%

Metropolitan Statistical Area	1st Largest Insurer	VIC	Share	2nd Largest Insurer	VIC	Share
Richmond	Anthem	No	59%	Cigna	No	19%
Roanoke	Anthem	No	61%	CVS Health	No	21%
Staunton	Anthem	No	49%	CVS Health	No	32%
Virginia Beach-Norfolk-Newport News (VA-NC)	Anthem	No	52%	Optima Health (Sentara Healthcare)	Yes	22%
Winchester (VA-WV)	Anthem	No	46%	Cigna	No	18%
Washington-Arlington-Alexandria (DC-VA-MD-WV)	CareFirst	No	26%	Cigna	No	15%

SOURCE: American Medical Association, 2022. "Competition in Health Insurance: A comprehensive study of U.S. markets."

NOTE: Commercial enrollment includes individual, group, federal employee health benefit plan, consumer driven health plan, state/local employee plan, Blue Card HOME, student health, EPO, and public health exchange enrollees.

Vertically integrated carriers have much larger shares of the Virginia exchange market than in any other line of business

In half of Virginia's MSAs, a vertically integrated carrier, either Optima Health or Piedmont Community Health Plan, was the second largest insurer on the Virginia Health Exchange in 2022 (TABLE 6). Optima Health and Piedmont Community Health Plan had larger shares of the exchange market in their operating MSAs than they have of the total commercial market. In the Charlottesville, Harrisonburg, and Virginia Beach-Norfolk-Newport News MSAs, Optima Health consistently had close to one-third of the enrollees. In the Lynchburg and Staunton MSAs, Piedmont Community Health Plan held one-quarter of the market.

TABLE 6: Vertically integrated carriers are the second largest individual exchange insurer in half of Virginia MSAs

Metropolitan Statistical Area	1st Largest Insurer	VIC	Share	2nd Largest Insurer	VIC	Share
Blacksburg-Christiansburg	Anthem		100%	-		-
Charlottesville	Anthem		70%	Optima Health (Sentara Healthcare)	Yes	28%
Harrisonburg	Anthem		66%	Optima Health (Sentara Healthcare)	Yes	34%

Metropolitan Statistical Area	1st Largest Insurer	VIC	Share	2nd Largest Insurer	VIC	Share
Lynchburg	Anthem		75%	Piedmont Community Health Plan (Centra)	Yes	25%
Richmond	Cigna		50%	Anthem		45%
Roanoke	Anthem		100%	-		-
Staunton	Anthem		75%	Piedmont Community Health Plan (Centra)	Yes	25%
Virginia Beach-Norfolk-Newport News (VA-NC)	Anthem		58%	Optima Health (Sentara Healthcare)	Yes	35%
Winchester (VA-WV)	Anthem		53%	Cigna		33%
Washington-Arlington-Alexandria (DC-VA-MD-WV)	Kaiser		32%	CareFirst		29%

SOURCE: American Medical Association, 2022. "Competition in Health Insurance: A comprehensive study of U.S. markets."

Vertical integrated carriers do not inherently change how plan members access health care in Virginia

Most stakeholders JCHC staff spoke with did not believe vertical integration significantly impacted patient access to care. Plan ratings support this; JCHC staff found no difference in plan ratings between vertically integrated carriers and other carriers by members' ability to get care easily and quickly (i.e., get appointments, preventive care, tests, and treatment easily and quickly).

There is also no difference in plan members' access to health care services within vertically integrated carrier plans and other plans. Virginia's vertically integrated systems are open, meaning patients are not limited to seeing affiliated providers and can usually have their care covered by their vertically integrated carrier even if received in a different health system. Even so, two stakeholders noted that some vertically integrated carriers contractually prohibit providers from sending patients to receive care outside of the vertically integrated system with anti-steering language (see sidebar), creating

Steerage. Health insurance plans may practice steerage, to direct members to receive care from certain providers. This may involve directing members to different in-network providers and facilities that are more affordable. Some health care contracts have **anti-steering** language that restricts health insurance carriers from encouraging members to receive care from competing providers.

a narrow network that may not be the best choice for patient outcomes or costs. Three other stakeholders shared that while they may have narrower networks, they do not have contractual language around steerage, or will contract with community providers outside of the system to fill gaps in services.

Vertically integrated carriers may focus on streamlining care for their plan members and encouraging members to receive care from affiliated providers. Two stakeholders emphasized their goal was to create a seamless, streamlined continuity of care experience for their members. A carrier's plan design could also help members access care from affiliated providers that they may not have otherwise sought. For example, one vertically integrated carrier required all members to select a primary care provider upon plan enrollment and then incentivized affiliated providers to see enrollees as new patients within three months. So, while members' ability to access care may not be significantly different from others, their access experience may be better.

Vertical integration could impact costs to patients, providers, and carriers, though specific mechanisms are difficult to track

To examine the potential impact of vertically integrated systems on health care costs, JCHC staff considered costs to the patient, costs to the health system to provide services, and costs to the insurance carrier to administer plans and reimburse for services. In theory, vertically integrated systems can generate cost benefits for patients, providers, and carriers through better care management, reduced health care utilization, economies of scale in administration, and lower premiums. The appeal of early models of vertically integrated carriers relied on lower premiums for members, who had better cost-sharing, and received care from a smaller network through the vertically integrated provider. However, an American Hospital Association study of vertically integrated carriers found they had worse financial performance than other carriers, with higher administrative costs, higher medical loss ratios, and higher premiums.

Vertical integration has the potential to affect patients' insurance premiums

In theory, cost savings generated by a vertically integrated system should be reflected in lower premiums for plan members. One stakeholder interviewed claimed their premiums were 10% lower than competitors' products. However, the research is mixed on whether vertical integration status positively or negatively affects premiums. One study of Medicare Advantage plans found that vertically integrated carriers charged higher premiums than others, while another study of individual insurance market plans found no significant difference in premiums between plans offered by traditional carriers in comparison to vertically integrated carriers. Yet another study found that Innovation Health's PPO plan, a vertically integrated carrier in Virginia at the time of the study, offered the lowest monthly premium compared to similar plans in the region. Innovation Health kept premium rates

low because some affiliated providers agreed to accept lower reimbursement rates for a set period as a strategy to remain competitive in their market and gain enrollees. The study concluded that while effective in reducing premiums, this was not a sustainable long-term strategy.

While vertically integrated carriers can use well-priced contracts with their affiliated providers to reduce premiums, as Innovation Health did with Inova Health System, this advantage could be offset by higher pricing in contracts with other non-affiliated providers, ultimately leading to minimal changes to premium costs. Even if vertically integrated systems can sustainably generate cost savings through better care management and reduced health care utilization, market dynamics also play a significant role in premium prices. One study found that even with lower provider prices, insurance premiums do not tend to be lower unless there is sufficient competition among insurers. Therefore, vertical integration status alone cannot be deemed responsible for premium prices.

Vertically integrated carriers in Virginia do not report significantly different medical loss ratios from other carriers

Carriers report how much revenue they receive from insurance premiums, how much is spent on provision of health care (paid out as health care claims), and how much is spent on quality improvement as part of Medical Loss Ratio (MLR) regulations (see sidebar). Based on commercial MLRs reported to the Centers for Medicare & Medicaid Services (CMS) for 2021, while vertically integrated carriers in Virginia reported slightly higher MLRs with an average of 87.5%, these numbers were not significantly different from the average MLR of 83.8% for other carriers.

Medical Loss Ratio. The Affordable Care Act establishes a standard called the medical loss ratio (MLR), which requires insurers to spend at least 80-85% of the revenue they receive in member premiums on the actual provision of health care (paid out in the form of health care claims) and quality improvement. The remaining 15-20% of their revenue can be spent on overhead (administration, marketing) and profit (for stakeholder dividends or reinvestment). Insurers submit annual reports to the Department of Health and Human Services – those who do not meet the MLR requirements must issue refunds to their members. The regulation does not apply to self-funded health insurance plans (e.g., large employers).

One criticism of vertically integrated systems is the potential for vertically integrated carriers to circumvent profit caps by making additional payments to their affiliated vertically integrated provider, which would count as spending on provision of health care. In doing so, vertically integrated carriers could potentially avoid the requirement to refund members or return state funds for Medicaid plans. While profits for the vertically integrated carrier would be lower, the integrated system would keep more of the premium revenue.

This possibility is supported by a Brookings analysis of vertically integrated Medicare Advantage plans owned by parent companies with multiple related health care businesses. Their cost analysis found that Medicare Advantage plans that purchased more than 10% of their expenditures from related businesses have 4.6% higher gross health expenditures per

enrollee. These expenses count toward health care spending for the MLR calculation and potentially represent profits to the parent company across its related businesses. For carriers that would have faced penalties for not spending enough of their premiums on health care, increasing payments to related businesses can increase their MLR to meet the standard.

In addition, a CMS investigation of reported quality improvement spending found cases of inappropriate use of provider incentives or bonus payments to transfer excess premium revenue and circumvent member refund requirements. They found that carriers had incentive and bonus agreements so that if their MLR fell below a specific threshold, excess profits were to be paid to a provider group or hospital system. These payments were not tied to any quality or performance metrics, artificially increased carrier spending on health care claims, and eliminated most or all of the refund owed to enrollees. CMS acknowledged "the incentive for such arrangements is particularly high for integrated medical systems where the issuer is the subsidiary, owner, or affiliate of a provider group or a hospital system" such as vertically integrated carriers.

Federal price transparency requirements. The Centers for Medicare & Medicaid Services Transparency in Coverage Final Rule was designed to increase health care price transparency by making cost data available to consumers and stakeholders.

Beginning in 2021, **hospitals** were required to post public, machine-readable files with different types of "standard charges" for hospital items and services. Required data included gross charges, negotiated rates with payers, minimum negotiated rates, maximum negotiated rates, and cash prices.

Beginning in 2022, health insurance **carriers** were required to post in-network prices negotiated with providers for covered items and services, as well as out-of-network allowed amounts and historic reimbursements.

Vertically integrated providers receive significantly different reimbursements from their affiliated vertically integrated carriers

JCHC staff analyzed publicly posted hospital and carrier prices (see sidebar) to assess whether vertically integrated providers in Virginia receive different reimbursement amounts from their vertically integrated carriers compared to other carriers' reimbursements (see Appendix 5 for methodology and data limitations). There are a multitude of factors that influence health care pricing, such as geography, provider market share, payer market share, and patient demographics, making it difficult to attribute price differences, or lack thereof, to vertical integration status. Based on the limited data available, staff found significant differences but no consistent trends in vertically integrated provider reimbursements from vertically integrated carriers compared to other carriers.

Sentara Healthcare hospitals received lower reimbursement from Optima Health than from other payers for the same services

In the available cost data, JCHC staff found that Optima Health's negotiated rates at Sentara Healthcare acute care hospitals in the Tidewater region were consistently and statistically significantly lower than other payers' negotiated rates for the same service at the same

Sentara Healthcare acute care hospitals. For example, for a level 3 Emergency Department visit (CPT Code 99283), staff analyzed 131 reported rates in the Virginia Beach-Norfolk-Newport News area and found that Optima Health paid Sentara Healthcare an average of $629, while other payers would pay Sentara Healthcare an average of $1,159 for a visit (TABLE 7). This pattern was similar for non-hospital settings, although not statistically significant.

TABLE 7: Sentara Healthcare providers received lower average reimbursements from Optima Health than from other carriers

Core Based Statistical Area 47260 (Virginia Beach-Norfolk-Newport News) Average rates for CPT Code 99283 (Emergency Department visit, level 3)		Carrier	
		Optima Health	Other Payer
Provider	Sentara Healthcare	$629	$1,159
	Other Acute Care Hospitals	$954	$1,418

SOURCE: JCHC staff analysis of February 2023 Turquoise hospital price transparency data

NOTE: Table shows mean prices calculated from 131 reported rates.

TABLE 7 displays differences in the average reimbursement rate for one CPT code, selected to illustrate patterns from the full analysis. In total, JCHC staff analyzed 631 hospital-reported rates for five CPT codes, and 3,728 payer-reported rates for five CPT codes. Across most services analyzed, Optima Health paid lower prices than other payers for the same services, though it paid the lowest prices to Sentara Healthcare hospitals.

Inova Health System hospitals received higher reimbursement from Innovation Health than from other payers for the same services

JCHC staff found that Innovation Health Plan's negotiated rates at Inova Health System acute care hospitals in the Northern Virginia region were consistently and statistically significantly higher than other payers' negotiated rates for the same services at the same Inova Health System acute care hospitals. For example, for occupational therapy exercise (CPT Code 97110), staff analyzed 363 reported rates in the Washington-Arlington-Alexandria area and found that Innovation Health paid Inova Health System hospitals an average of $127, while other payers would pay Inova Health System hospitals an average of $89 for the same service (TABLE 8). This pattern was similar for non-hospital settings, though less consistent.

TABLE 8: Inova Health providers received higher average reimbursements from Innovation Health than from other carriers

Core Based Statistical Area 47894 (Washington-Arlington-Alexandria-DC-VA-MD-WV) Average rates for CPT Code 97110 (Occupational therapy exercise)		Carrier	
		Innovation Health	Other Payer
Provider	Inova Health	$127	$89
	Other Acute Care Hospitals	$104	$97

SOURCE: JCHC staff analysis of February 2023 Turquoise hospital price transparency data

NOTE: Table shows mean prices calculated from 363 reported rates.

TABLE 8 displays differences in the average reimbursement rate for one CPT code, selected to illustrate patterns from the full analysis. In total, JCHC staff analyzed 1,916 hospital-reported rates for five CPT codes, and 3,427 payer-reported rates for seven CPT codes. Across most services analyzed, Innovation Health paid higher prices than other payers for the same services, though it paid the highest prices to Inova Health System hospitals.

Centra Health hospitals received lower reimbursement from Piedmont Community Health Plan than from other payers for the same services

Similar to the Optima-Sentara dynamic, JCHC staff found that Centra Health hospitals received significantly lower reimbursements from Piedmont Community Health Plan compared to what other payers reimbursed. For example, for an MRI of a lower joint or extremity (CPT Code 73721), staff analyzed 464 reported rates in the Lynchburg area and found that Piedmont Community Health Plan paid Centra Health hospitals an average of $1,408, while other carriers paid Centra Health an average of $2,091 for the same service (TABLE 9).

TABLE 9: Centra Health providers received lower average reimbursements from Piedmont Community Health Plan than from other carriers

Core Based Statistical Area 31340 (Lynchburg)		Carrier	
Average rates for CPT Code 73721 (MRI, Lower joint or extremity)		Piedmont Community Health Plan	Other Payer
Provider	Centra Health	$1,408	$2,091
	Other Acute Care Hospitals	N/A	N/A

SOURCE: JCHC staff analysis of February 2023 Turquoise hospital price transparency data

NOTE: There are no other acute care hospitals in this region that are not part of the Centra Health system. Table shows mean prices calculated from 464 reported rates.

TABLE 9 displays differences in the average reimbursement rate for one CPT code, selected to illustrate patterns from the full analysis. In total, JCHC staff analyzed 2,494 hospital-reported rates for five CPT codes and 707 payer-reported rates for nine CPT codes. There were no other acute care hospitals in the Lynchburg area that were external to Centra Health, negating additional cost comparisons in that area.

The presence of vertically integrated systems changes the dynamics of market competition

One stakeholder interviewed by JCHC staff shared concerns that the presence of a vertically integrated carrier leads to increased health care costs, with integrated providers expecting the same or higher reimbursement from unaffiliated carriers as what they receive from their affiliated carrier. In contrast, two other stakeholders claimed the presence of vertically integrated carriers helps foster competition that keeps negotiated rates lower by acting as a "counterweight" to dominant, national insurers. One integrated system shared that being able to offer their own health insurance plans means they can go "from price takers to price makers."

While stakeholders did not identify increased conflict in contract negotiations, a few acknowledged that a system's vertical integration status can change how they approach negotiations. One felt that vertically integrated systems understand the carrier's perspective and have greater willingness to come to the negotiating table than other non-integrated systems. Another noted that vertically integrated providers can compare how their affiliated vertically integrated carrier manages care to how other carriers manage care. A third said that being a vertically integrated provider makes them more willing to walk away from unappealing proposals from other carriers.

Market dominance interacts with vertical integration to influence cost

The impact of vertical integration status alone on costs is difficult to assess given the importance of market dominance on price negotiations. Two vertically integrated stakeholders that JCHC staff spoke with mentioned market dominance as a large factor in understanding costs. For vertically integrated systems, this requires examination of both health insurance market dominance, and hospital market dominance.

Research supports that hospital prices are lower when there is greater dominance by fewer health insurers in the market, i.e., when a dominant health insurer can apply pressure to hospitals to pay lower rates. Research also supports that hospital prices are higher when there are fewer providers with market dominance. Hospitals that do not have competitors within a 15-mile radius were found to have higher prices than hospitals in markets with more competitors. Additionally, larger health systems with more providers and wider geographic breadth are at more of an advantage to limit their network and drive services to the vertically integrated provider.

Vertically integrated systems in Virginia did not have clear cost savings

Three former and currently vertically integrated systems that JCHC staff spoke with said they saw reduced spending and improved outcomes for their patients. However, most also said that true savings and total impact on cost can be difficult to quantify. Two stakeholders noted they only documented clear cost savings in pilot programs or their total plan enrollee numbers were too small to see savings, while another noted that many other factors in health care in the last decade have influenced cost, making it impossible to attribute changes in costs exclusively to vertical integration.

Shared administration between the carrier and provider could generate cost savings

One stakeholder noted that “administrative bloat” was the biggest opportunity for cost savings. Systems with tightly integrated back-office functions could share data and streamline patient processes effectively to generate cost savings. Most vertically integrated systems in Virginia are not this tightly integrated, though the Sentara-Optima system came up frequently in interviews as a model.

Vertically integrated systems in Virginia tend to have overlapping leadership between the vertically integrated carrier and the vertically integrated provider. One or more individuals usually have dual roles, with the carrier and the provider, at the executive or board level. All but one of the current and formerly vertically integrated systems that JCHC staff interviewed described organizational structures that utilized joint board members and shared staff, e.g., the Virginia Premier health plan board was a committee of the VCU Health System board. The only exception was Piedmont Community Health Plan, which has a separate board from its vertically integrated provider, Centra Health. In turn, stakeholders shared that Centra and Piedmont Community Health Plan tend to function separately

though Centra ultimately controls the Piedmont Community Health Plan board as the 100% owner of the carrier.

While one stakeholder expressed concerns about the potential overlap in leadership between integrated carriers and providers, four current and former integrated systems noted that shared leadership was an advantage of being vertically integrated. Staff in vertically integrated systems emphasized that while there were appropriate controls in place to protect confidential information (e.g., contract details) between the two entities, organizational overlap facilitated frequent conversation and collaboration on other topics, such as improvements in patient care. Stakeholders said this allowed them to try new strategies, track outcomes and savings, and then use those learnings to inform where they could expand and invest with other partners. Conversely, lack of alignment and communication organizationally can mean that "interests are not always aligned" between the integrated carrier and provider.

Vertical integration has the potential to improve quality and health care outcomes

In vertically integrated systems, both health insurance plan quality and provider quality must be taken into consideration. Proponents of vertical integration often point to Kaiser Permanente as an indication of the potential for a tightly integrated payer-provider system to provide high quality, cost-effective care. Kaiser Foundation Health Plan consistently tops the National Committee for Quality Assurance's (NCQA) health plan ratings. In 2022, NCQA rated 1,048 health plans. Four of the only six plans to receive a 5-star overall rating were Kaiser plans; and the other two plans were also offered by vertically integrated systems.

Research indicates that vertically integrated systems perform better than their competitors on quality and member satisfaction. Specifically, vertically integrated systems are better at care delivery, care management, disease prevention, and patient safety. There is less evidence to indicate vertically integrated systems improve mortality or morbidity outcomes. One study of Medicare Advantage plans found vertically integrated systems had greater quality, patient satisfaction, and decreased procedures, but no difference in terms of inpatient days, discharges, and readmissions.

Researchers acknowledge the performance of vertically integrated systems is also affected by enrollment numbers, nonprofit status, and health system size. For example, nonprofit vertically integrated systems perform better on quality measures and member satisfaction than their for-profit vertically integrated peers. There may be other differences, such as differing patient demographics and needs, and varying levels of vertical integration, that make it difficult to determine what aspects of performance are attributed to vertical integration.

Vertically integrated acute care hospitals in Virginia have higher quality and patient ratings

Vertically integrated providers in Virginia perform much better on their quality ratings than other acute care hospitals. These results are in alignment with trends in the literature, though there is not enough evidence to suggest this is a result of vertical integration. It may be that in Virginia, higher quality health systems are more likely to vertically integrate with a carrier.

Vertically integrated providers in Virginia have significantly higher quality ratings than other acute care hospitals

CMS provides each hospital with an overall quality star rating from 1 to 5 based on a wide variety of measures related to mortality, safety, readmission, timely and effective care, and patient experience. Hospitals with 5-star ratings have the highest quality. Vertically integrated providers in Virginia, with an average star rating of 3.9, scored significantly higher than other acute care hospitals in Virginia, which averaged 3.1 stars (TABLE 10).

TABLE 10: Vertically integrated acute care hospitals in Virginia have higher overall star ratings

Health System Type	Average Rating	Median Rating
Vertically integrated providers	3.9	4
All other acute care hospitals	3.1	3

SOURCE: JCHC staff analysis of the Centers for Medicare & Medicaid Services 2021 hospital overall star ratings

Vertically integrated providers in Virginia have moderately higher patient satisfaction ratings than other acute care hospitals

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a survey of hospital patients asking about their experience, including comfort, communication, and satisfaction. Vertically integrated providers in Virginia received slightly better patient responses than other acute care hospitals, with a range between 64-80% of responding patients reporting they would give their hospital a 9 or 10 rating on a scale from 1-10. In contrast, patients reported a range of 47-81% for other acute care hospitals. Patients served by vertically integrated providers were also more likely to report they would definitely recommend the hospital (range of 57-82% of responses) compared to other acute care hospitals (range of 36-82% of responses).

While vertically integrated carriers in Virginia spend more on quality improvement, plan quality does not significantly differ

Carrier spending on quality improvement includes a wide range of expenses to improve patient outcomes or patient safety, reduce readmissions, promote wellness, enhance health

information technology for quality, transparency, or patient outcomes, and do provider credentialing. Two vertically integrated systems JCHC staff spoke with indicated they did not feel their vertical integration status impacted care quality or patient outcomes. Conversely, two other stakeholders felt their vertical integration status contributed to higher patient satisfaction and health system performance. Two others demonstrated improved quality in specific populations or through specific quality improvement programs.

Vertically integrated carriers in Virginia spend more of their premium revenues on quality improvement

Across all carriers, spending on quality improvement is a small fraction of premium earnings compared to spending on the provision of services. In 2021, vertically integrated carriers reported spending an average of one percent of their earned premium on quality improvement, while other carriers spent significantly less at an average of 0.7% of their earned premium. And among vertically integrated carriers, Optima Health reported the highest spending with 2.96% of their small group premium revenues spent on quality improvement (TABLE 11).

TABLE 11: Vertically integrated carriers spent more of their commercial plan premium revenue on quality improvement than other carriers

	Individual	Small Group	Large Group
Vertically Integrated Carrier			
Innovation Health Insurance Company	-	0.74%	0.81%
Innovation Health Plan	-	0.73%	0.79%
Optima Health Insurance Company	-	2.96%	1.71%
Optima Health Plan	0.89%	0.97%	1.01%
Piedmont Community HealthCare	-	-	0.80%
Piedmont Community HealthCare HMO	0.85%	0.77%	0.80%
Other Carriers			
Aetna Health Inc.	-	0.67%	0.64%
Aetna Life Insurance Company	-	0.61%	0.68%
Anthem Health Plans of Virginia	0.90%	1.24%	0.84%
CareFirst Blue Choice	0.50%	0.47%	0.55%
Cigna Health and Life Insurance Company	0.49%	-	0.49%
Kaiser Foundation Health Plan of Mid-Atlantic States	0.30%	0.24%	0.26%

SOURCE: JCHC staff analysis of 2021 commercial Medical Loss Ratio reports to the Centers for Medicare & Medicaid Services

Vertically integrated carriers are not better or worse quality than other carriers

Despite higher spending on quality improvement, vertically integrated carriers in Virginia do not have significantly different health plan ratings compared to other carriers. NCQA ratings for each health plan are based on quality, outcomes, and patient experience metrics (Appendix 6). Commercial plans in Virginia had an average rating of 3.6 out of a possible 5 stars, with no significant difference between vertically integrated carriers and other carriers. Similarly, Medicaid plans in Virginia had an average rating of 3.3 out of a possible 5 stars, with no significant difference between vertically integrated carriers and other carriers.

CMS also provides a rating for each Medicare Advantage plan based on various metrics for quality, outcomes, patient experience, and other federal reporting requirements. Medicare Advantage plans in Virginia had an average rating of 3.3 out of a possible 5 stars. There was no significant difference in health plan ratings of the vertically integrated carriers compared to other carriers.

Appendix 1. JCHC Study Resolution

Vertically Integrated Carriers and Providers

Authorized by the Joint Commission on Healthcare on December 7, 2022

WHEREAS, consolidation of the health care industry is an increasing trend nationally and in Virginia; and

WHEREAS, there are several types of consolidation, including vertically integrated carriers, where there is a joint ownership interest between payers (insurance carriers) and providers (health systems, including hospitals); and

WHEREAS, several health systems in Virginia may be considered vertically integrated carriers because they own, are owned by, or are under common ownership or control with insurance providers; and

WHEREAS, vertical integration is intended to reduce health care expenditures by utilizing economies of scale, improving care coordination for patients, and streamlining the delivery of care; and

WHEREAS, vertical integration also creates the potential for exclusion of non-integrated carriers and providers from the integrated carrier's health plan or services, thereby restraining competition in the health care market; and

WHEREAS, the effects of vertically integrated carriers on the quality and affordability of health care are largely unknown; and

WHEREAS, legislation to increase state regulation and oversight of vertically integrated carriers has been introduced in the Virginia General Assembly for the last five years and was referred to the Joint Commission on Health Care during the 2022 session, now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study the extent of vertically integrated carriers in Virginia's health care market and the impact on patients.

In conducting its study, staff shall (i) evaluate the scope of vertically integrated carriers in Virginia and nationally over time; and (ii) determine, where possible, the impact of vertically integrated carriers on patients' access to services, costs (including any differences in reimbursement for services between affiliated and non-affiliated providers), and quality of care.

The Joint Commission on Health Care shall review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Bureau of Insurance, the Virginia Department of Health, the Virginia Department of Medical Assistance Services, and Virginia Health Information and shall provide assistance, information, and data to the Joint Commission on Health Care for this study upon request.

Appendix 2: National history of vertical integration

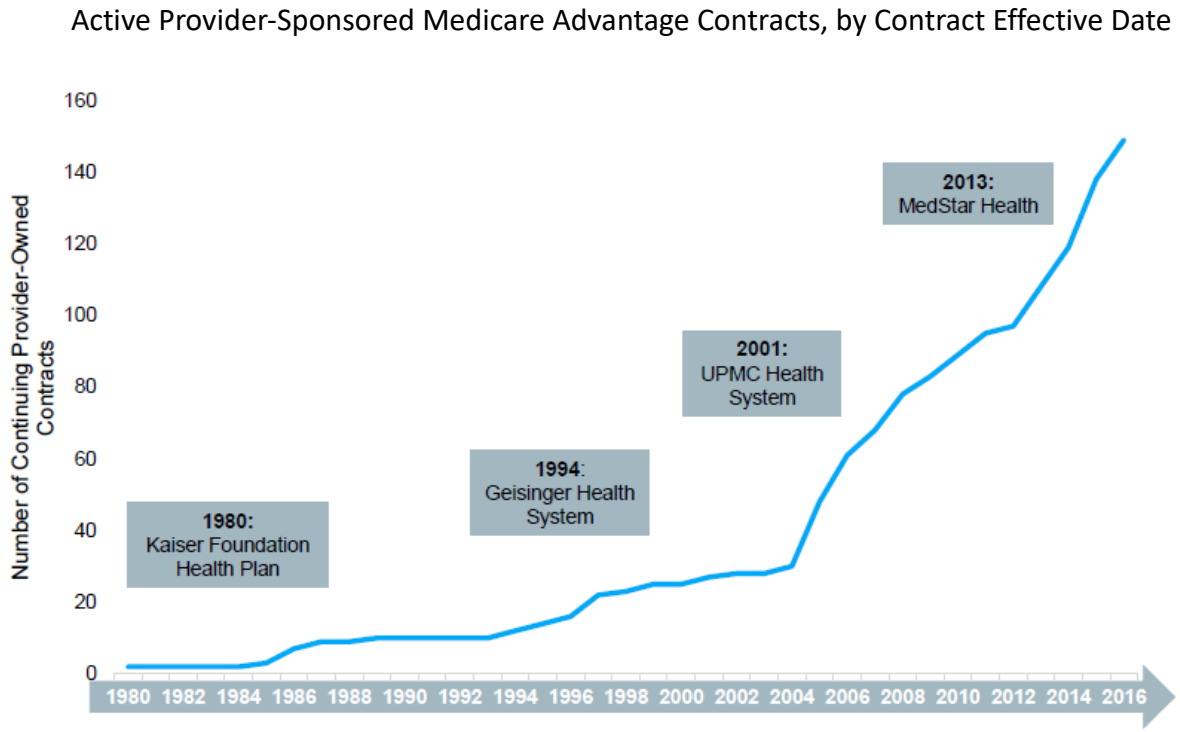
The original vertically integrated carrier models that first took hold were driven by hospitals and physicians who pushed to take on the risk and rewards of managed care by cutting out the third-party insurer. Providers first lobbied to be allowed to contract directly with Medicare as provider-sponsored organizations, and then by forming provider-owned commercial Health Maintenance Organizations (HMO). The latter provider-owned HMO model was expected by many to become the dominant managed care structure, but most lost millions of dollars within a few years and failed. In addition, the HMO model and managed care generally lost traction by the early 2000s for a multitude of reasons, including consumer backlash about restricted choices and poor management of capitated payments.

However, following the passage of the ACA, the vertically integrated carrier model saw a revival as health care began moving towards value-based payment. The ACA provided incentives for health care providers and health insurance carriers to improve quality and reduce costs for Medicare beneficiaries. In order to do so, many provider groups formed Accountable Care Organizations and vertically integrated with Medicare Advantage carriers. These carriers then began expanding to provide products in the commercial market, as well.

In addition, the ACA's introduction of medical loss ratio (MLR) regulations for carriers created an unintended incentive for carriers to vertically integrate with providers. Specifically, MLRs only allow carriers to keep a certain percentage of their profits – any additional profits must be returned to their enrolled members. However, vertically integrated carriers have the opportunity to take additional profits that would have counted towards their MLR and relabel those funds as business costs by transfering payments to their related health care entities. Those funds would then be absorbed by the vertically integrated provider without counting against the vertically integrated carrier's profit cap.

Between 2012 and 2015, more than half of new Medicare Advantage plans were offered by providers (FIGURE 4). By 2016, just over half (52%) of all entities on the public health insurance exchange market were vertically integrated plans. A 2018 survey of health systems found one-third of U.S. health systems offered a health plan. And in 2021, almost 60% of health system chief financial officers and finance and managed care executives health care executives surveyed indicated interest in establishing a Medicare Advantage program as a way to manage risk.

FIGURE 4: Health systems are increasingly interested in launching their own Medicare Advantage products



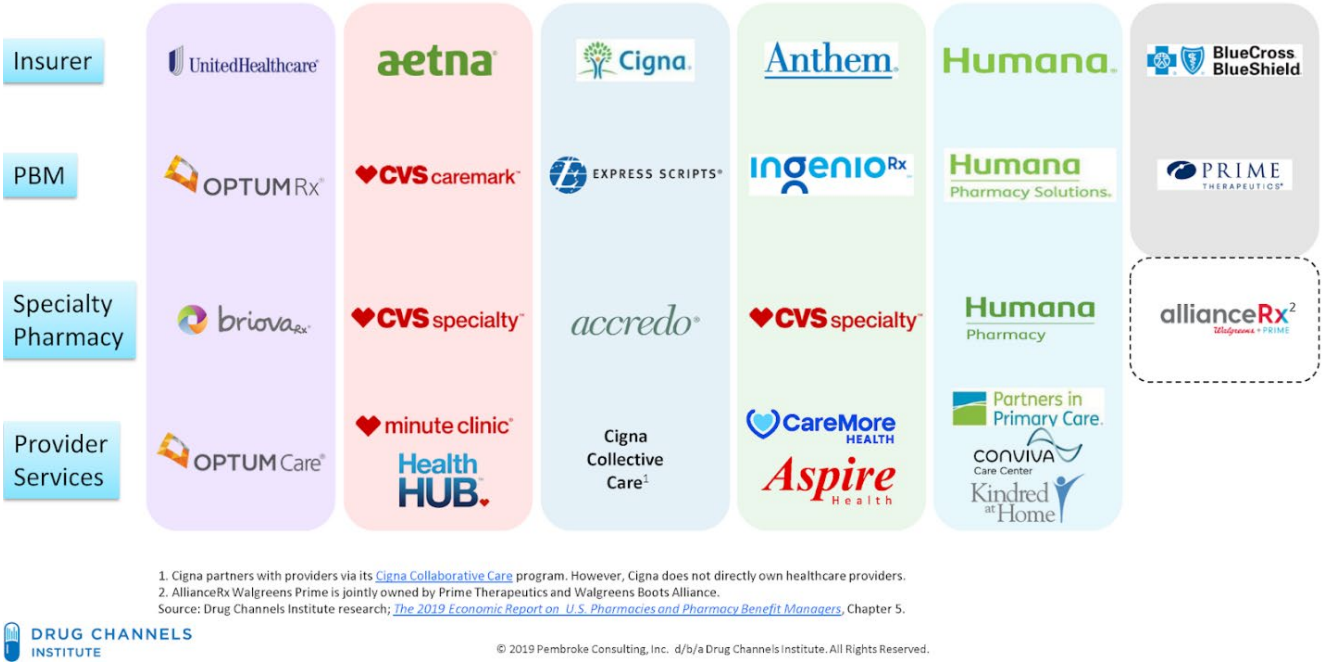
SOURCE: Avalere Health, 2016. "Provider-Sponsored Health Plans: Enrollment, Quality, and Future Impact."

In recent years, there has been increasing integration across traditionally separate health care players that control different pieces of the U.S. health care landscape. This can be seen in hospital acquisitions of provider groups, insurer acquisitions of pharmacy benefit managers (PBMs), and various other partnerships that further consolidate health care businesses (FIGURE 5). Some of the more prominent national examples include:

- Optum, a subsidiary of UnitedHealth Group, which is the nation's largest health insurer, is considered an industry leader in vertical integration. Since 2011, Optum has expanded to acquire more than a dozen different health care organizations providing a range of services including data, pharmacy, and direct care.
- Anthem, the nation's second largest health insurer, acquired Aspire Health, the nation's largest non-hospice, community-based palliative care provider, in 2018, and Beacon Health Options, a behavioral services provider, in 2020.
- CVS Health, one of the largest national retail pharmacies, acquired Aetna, the nation's third largest health insurer, in 2018. In recent years, it has also purchased Signify Health, a medical services provider which provides in-home care to patients, and Oak Street Health, which owns primary care medical centers in 21 states.

- Cigna, the nation's fourth largest insurer, purchased Express Scripts, one of the largest pharmacy benefit managers, in 2018, and Verity Solutions, which provides drug pricing software, in 2019.

FIGURE 5: Vertically integrated parent companies increasingly own multiple different health care entities



SOURCE: Fein, 2019. "Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?" Drug Channels.

NOTE: PBM = Pharmacy Benefit Managers

Appendix 3. Organization of vertically integrated systems in Virginia

There are many ways vertically integrated systems can be organized

There are three dominant organizational models in which payers and hospitals may share ownership interests:

- The hospital system owns an insurance carrier – this model is commonly referred to as a "provider-sponsored health plan" (FIGURE 6a)
- The insurance carrier owns a hospital system (FIGURE 6b) – e.g., Kaiser Permanente
- Joint ventures – there is shared ownership between an insurance carrier and a hospital system (FIGURE 6c)

FIGURE 6a. Hospital-owned insurance carriers are commonly referred to as "provider-sponsored health plans"

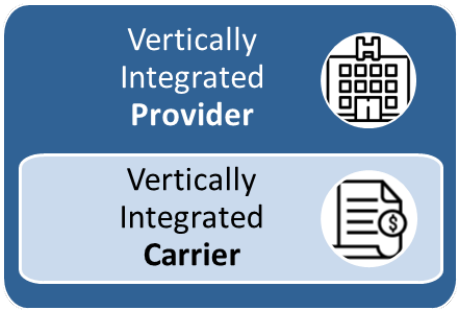
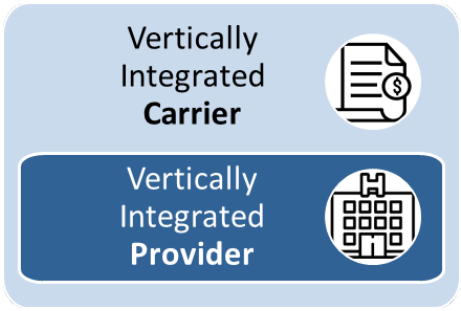


FIGURE 6b. Insurance carriers can own a hospital system, such as in the case of Kaiser Permanente



The third model – joint ventures – is becoming more common, as insurance carriers want to partner with established hospital systems for name recognition when they enter new markets, and hospital systems look for the support of an established insurance carrier as they take on the risk of managing patient care and costs.

FIGURE 6c. Joint ventures between insurance carriers and hospital systems are becoming increasingly common

All vertically integrated systems in Virginia are provider-owned

Currently, all vertically integrated systems in Virginia consist of a vertically integrated provider(s) with ownership of a carrier (FIGURE 6a).

Centra Health & Piedmont Community Health Plan

Centra Health launched **Piedmont Community Health Plan** as a joint venture with Individual Network Physicians in 1997, before taking full ownership in 2015 (See FIGURE 7 for organizational chart). Piedmont Community Health Plan has two subsidiary carriers, through which it offers commercial individual and group health insurance products (TABLE 12).

TABLE 12. Piedmont Community Health Plan offers commercial individual and group health insurance.

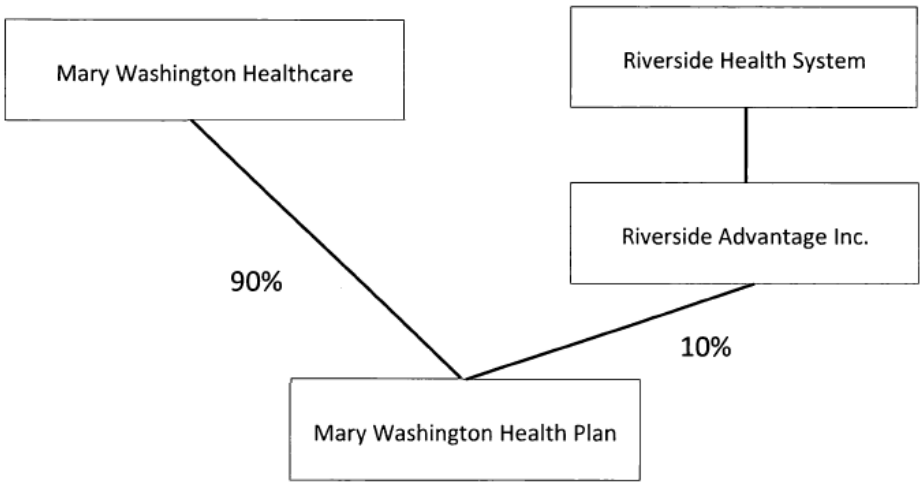
Subsidiary	Products Offered
Piedmont Community HealthCare	• Commercial – Group
Piedmont Community Healthcare HMO	• Commercial – Individual • Commercial – Group

SOURCE: State Corporation Commission, Virginia Bureau of Insurance, 2021. Annual Statements for Piedmont Community Healthcare, Inc. and Piedmont Community Healthcare HMO, Inc.

Mary Washington Health Care/Riverside Health System & Mary Washington Health Plan

Mary Washington Health Care launched **Mary Washington Health Plan** in 2019 to offer Medicare Advantage plans. In 2022, **Riverside Health System** acquired a 10% ownership stake in Mary Washington Health Plan, facilitating the carrier's expansion to the Riverside market and administration of Riverside Advantage, a Riverside Health System Medicare Advantage product (FIGURE 8).

FIGURE 8. Mary Washington Healthcare and Riverside Health System have joint ownership of Mary Washington Health Plan.



SOURCE: State Corporation Commission, Virginia Bureau of Insurance, November 2021. Form A Statement Regarding the Acquisition of 10% Membership Interest of Mary Washington Health Plan, Inc. (The "Domestic Insurer") by Riverside Advantage, Inc., Exhibit A-2 Post-Closing Organization Structure.

In 2023, Riverside Health System acquired an additional 10% ownership for a total of 20% equity in Mary Washington Health Plan.

Sentara Healthcare & Optima Health/Virginia Premier

Sentara Healthcare owns **Optima Health**, which was established in 1984 as a joint partnership with Bon Secours. In 2003, Sentara Healthcare purchased Bon Secours' minority share and took full ownership. **Virginia Commonwealth University Health System** established **Virginia Premier** in 1995. Sentara acquired 80% ownership of Virginia Premier in 2020, and 100% ownership in 2022. Sentara has combined the Optima Health and Virginia Premier plans under Optima Health Plan as of July 1 of this year, and will rebrand its insurance business as Sentara Health Plans beginning in 2024 (See FIGURE 9 for organizational chart).

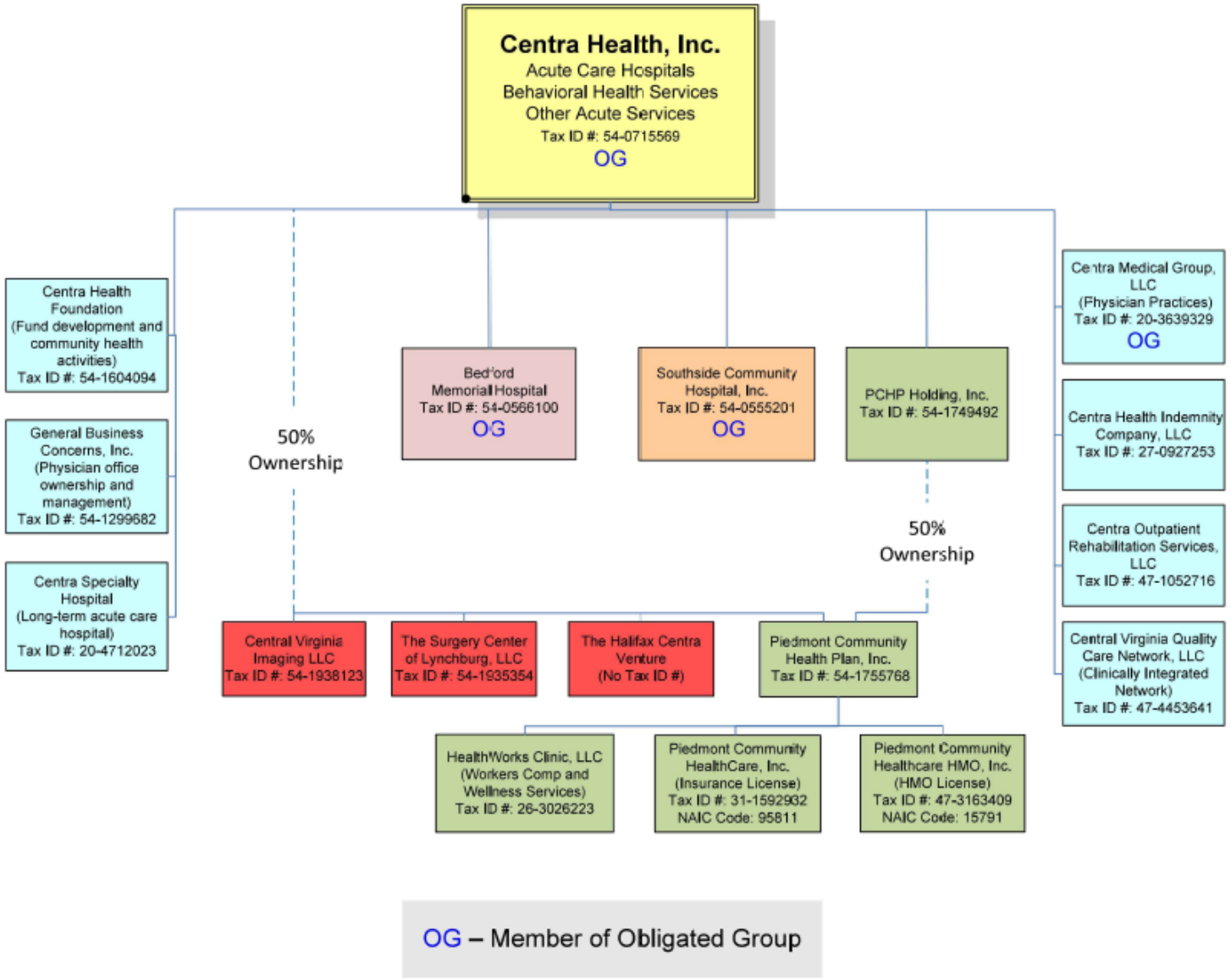
Sentara Healthcare offers commercial, Medicaid, and Medicare health insurance products through several subsidiaries – Optima Health Insurance Company, Optima Health Plan, and Virginia Premier Health Plan (TABLE 13).

TABLE 13. Sentara Healthcare offers a wide range of insurance products through its subsidiaries.

Subsidiary	Products Offered
Optima Health Insurance Company	• Commercial – Group
Optima Health Plan	• Commercial – Individual • Commercial – Group • Federal Employees Health Benefits Plan • Medicaid • Medicare
Virginia Premier Health Plan	• Medicaid • Medicare

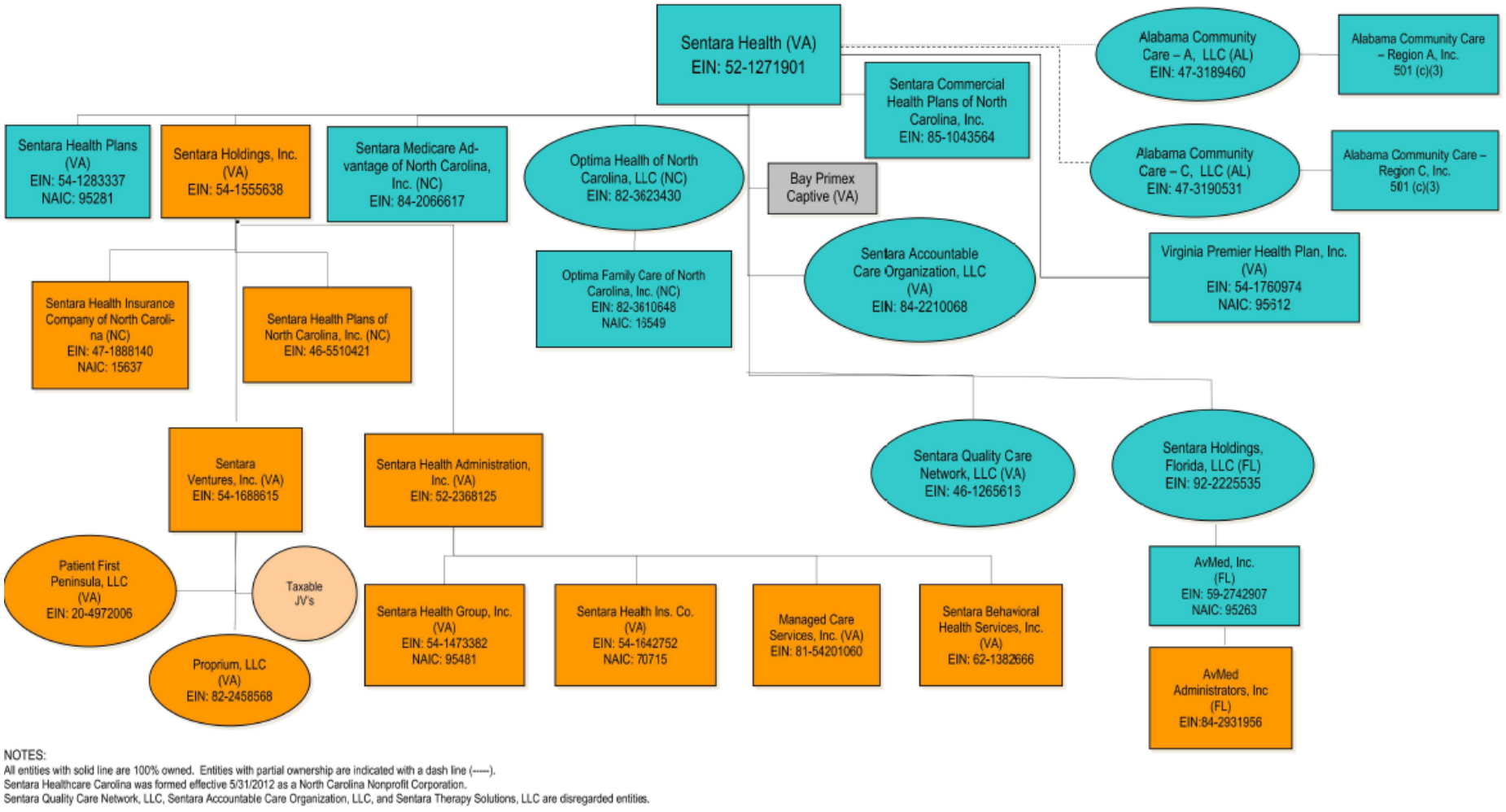
SOURCE: State Corporation Commission, Virginia Bureau of Insurance, 2021 and 2022. Annual statements for Optima Health Insurance Company, Optima Health Plan, and Virginia Premier Health Plan, Inc.

FIGURE 7. Centra Health has full ownership of Piedmont Community Health Plan.



SOURCE: State Corporation Commission, Virginia Bureau of Insurance, September 2022. Statement of the Piedmont Community HealthCare HMO, Inc.

FIGURE 9. Optima Health Plan renamed to Sentara Health Plans on July 1, 2023.



SOURCE: State Corporation Commission, Virginia Bureau of Insurance, June 2023. Statement of the Sentara Health Plans.

Appendix 4. Dominant carriers in Medicare Advantage

Virginia's Medicare Advantage landscape is dominated by Humana and UnitedHealth Group across all MSAs except Washington-Arlington-Alexandria (TABLE 14).

TABLE 14: Vertically integrated carriers are not competitive at the MSA-level for Medicare Advantage products

Metropolitan Statistical Area	1st Largest Insurer	Share	2nd Largest Insurer	Share
Blacksburg-Christiansburg	Humana	41%	UnitedHealth Group	32%
Charlottesville	Humana	50%	CVS Health	18%
Harrisonburg	Humana	46%	UnitedHealth Group	21%
Lynchburg	UnitedHealth Group	43%	Humana	36%
Richmond	Humana	45%	UnitedHealth Group	26%
Roanoke	UnitedHealth Group	39%	Humana	36%
Staunton	Humana	35%	UnitedHealth Group	34%
Virginia Beach-Norfolk-Newport News (VA-NC)	Humana	51%	UnitedHealth Group	18%
Winchester (VA-WV)	Humana	56%	UnitedHealth Group	24%
Washington-Arlington-Alexandria (DC-VA-MD-WV)	Kaiser	41%	UnitedHealth Group	25%

SOURCE: American Medical Association, 2022. "Competition in Health Insurance: A comprehensive study of U.S. markets."

Appendix 5. Price transparency data and cost analyses

Data Source

JCHC staff analyzed publicly available hospital and carrier price data to assess whether vertically integrated providers in Virginia receive reimbursement amounts from their vertically integrated carriers that significantly differ from other carriers' reimbursements. The hospital and payer price transparency files are uploaded by each hospital system and carrier on their respective websites. Although they are required to be machine-readable files, they are inconsistently formatted and can be difficult to locate. JCHC staff chose to contract with Tuquoise Health, a health data company that pulls and aggregates price transparency files posted online by hospitals and payers.

Data Analysis

JCHC staff examined both prices posted by hospitals and prices posted by payers. Hospital data used for the study analysis were retrieved from Turquoise Health in February 2023, and payer data were extracted in June 2023. Staff focused on analyzing potentially "shoppable" services, where consumers would see the biggest differences in price for procedures. Contract rates between hospitals and payers are most variable for commercial plans, in contrast with Medicaid and Medicare plans where rates are set by a government entity. Virginia Premier and Mary Washington Health Plan are Medicaid and Medicare products, respectively, and therefore were not included in the analyses.

Regional Selection

Given the limited geographic reach of vertically integrated systems in Virginia, as well as limitations in the available data, JCHC staff focused on analyzing commercial rates within three specific CBSAs:

- CBSA 47260 (Virginia Beach-Norfolk-Newport News) – to capture Sentara Healthcare hospital rates and payments from payers within the area, including Optima Health
- CBSA 47894 (Washington-Arlington-Alexandria-DC-VA-MD-WV) – to capture Inova Health System hospital rates and payments from payers within the area, including Innovation Health Plan
- CBSA 31340 (Lynchburg) – to capture Centra Health hospital rates and payments from payers within the area, including Piedmont Community Health Plan

Hospital Data

Hospital data included reported rates for standard items and services, identified by Current Procedural Terminology (CPT) code. The data could include multiple rates for the same CPT code depending on the specific facility, procedure setting (inpatient or outpatient), and

payment type (hospital chargemaster price, negotiated prices with payers, or discounted self-pay/cash rate).

For each CBSA of interest, JCHC staff examined all available hospital rates to identify the five most frequently reported CPT codes. Rates marked as applying to inpatient items and services were excluded in order to focus specifically on potentially "shoppable" rates in hospital outpatient settings. For each of the top five identified CPT codes, JCHC staff examined rates reported by the vertically integrated provider and by other hospital systems in the area.

For example, staff identified 131 different rates for CPT code 99283 (Level 3 Emergency Department visits) in CBSA 47260 (Virginia Beach-Norfolk-Newport News):

- 21 rates reported by a Sentara Healthcare hospital for payment by Optima Health insurance
- 3 rates reported by other hospitals for payment by Optima Health insurance
- 86 rates reported by a Sentara Healthcare hospital for payment by other carrier insurance
- 21 rates reported by other hospitals for payment by other carrier insurance

Staff assessed descriptive statistics (e.g., mean, median, range) of prices for each CPT code and calculated z-scores to identify trends in price distributions across multiple CPT codes. Staff conducted means testing to identify significant cost differences between hospitals for the same procedures.

Payer Data

Payer data included reported in-network negotiated rates for covered items and services, and historic out-of-network allowed amounts and payments. Similar to the hospital data analysis, for each CBSA of interest, JCHC staff examined all fee schedule or negotiated rates without a billing code modifier to identify the five most frequently reported CPT codes. For each of the five identified CPT codes, JCHC staff examined both the institutional and professional portion of the fee, and examined rates reported by the vertically integrated carrier and by other carriers in the area.

For example, staff identified 300 different rates for CPT code 49505 (hernia repair) institutional fees in CBSA 47894 (Washington-Arlington-Alexandria-DC-VA-MD-WV):

- 8 rates reported by Aetna insurance for a Sentara Healthcare provider
- 25 rates reported by Aetna insurance for an Inova Health System provider
- 78 rates reported by Aetna insurance for all other providers
- 6 rates reported by Innovation Health insurance for a Sentara Healthcare provider

- 40 rates reported by Innovation Health insurance for an Inova Health System provider
- 66 rates reported by Innovation Health insurance for all other providers
- 39 rates reported by Anthem insurance for all other providers
- 2 rates reported by Optima Health insurance for a Sentara Healthcare provider
- 16 rates reported by Optima Health insurance for an Inova Health System provider
- 20 rates reported by Optima Health insurance for all other providers

Staff assessed descriptive statistics (e.g., mean, median, range) of prices for each CPT code and calculated z-scores to identify trends in price distributions across multiple CPT codes. Staff conducted means testing to identify significant differences between carriers for the same procedures.

Limitations

There are a number of limitations with the current hospital and payer price transparency data files. Most hospitals (84%) and more than 200 payers had posted pricing data as of April 2023. However, even as the number of reporting hospitals and payers improves, the data quality and completeness within their posted files requires additional refinement. Researchers have reported duplications in the data, with files with different source names containing identical pricing information or multiple negotiated rates reported for an identical procedure with the same billing code, billing modifiers, and providers. JCHC staff were able to receive deduplicated data from Turquoise Health. Even so, the amount of data reported and available for inclusion in staff analyses varied significantly for both payers and providers, and these differences were not explained by payer network size or the numbers of services providers offered. The price data also do not specify if price variations are due to contractual details (e.g., to explain a $0 negotiated rate), and often contain referential prices (e.g., 70% of the list price) without any inclusion of the list price.

As a result, JCHC staff used a limited set of CPT codes for each provider and carrier of interest to identify cost trends. CMS have continued to update their cost data submission guidelines and penalties to increase compliance and data usability. JCHC staff analyses were based on data for the five most commonly reported CPT codes, so the identified cost patterns may change if additional data are made available for further analyses.

Appendix 6. Health system and carrier ratings data

Hospital Quality Ratings

The Centers for Medicare & Medicaid Services (CMS) provides an overall star rating for hospitals based on quality measures across five categories:

- Mortality
- Safety of care
- Readmissions
- Patient experience
- Timely and effective care

The overall rating shows hospital performance compared to other U.S. hospitals. New or small hospitals may not report all data and do not receive an overall hospital rating. 2023 CMS overall star ratings were based on data collected between 2018 and 2022.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a CMS survey of hospital patients asking about their experience, including comfort, communication, and satisfaction. The most recent scores were based on data collected between 2016 and 2022.

Health Plan Ratings

The National Committee for Quality Assurance (NCQA) provides a rating for each health plan that reports measures publicly based on multiple metrics of clinical quality and patient experience:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcomes Survey (HOS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

NCQA also examines each health plan's health quality processes through NCQA Accreditation. Health plans may receive NCQA Health Plan Accreditation if they meet specific standards related to quality improvement such as population health management, utilization management, and consumer protection. This is a voluntary process that many, but not all health plans, undertake. Accredited health plans receive additional points for their overall rating. The overall rating score is the weighted average of all measures. 2022 health plan ratings are based on 2021 HEDIS, 2020 HOS, and 2020 CAHPS reports.

CMS also provides a rating for each Medicare Advantage plan based on various metrics of quality (measured by HEDIS), outcomes (measured by HOS), patient experience (measured by CAHPS survey), and other federal reporting requirements data from 2019 through 2021.

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