The Source Roundup: February 2023 Edition

Articles and reports published in the first month of 2023 saw an increased focus on the impact of consolidation as well as private equity investment in health care. Researchers also continued to examine factors impacting health care pricing and explored potential policy options available to the states to address provider prices, including a specific call for legislative intervention in the Western Pennsylvania market.

Healthcare Consolidation

Recent years saw an interesting shift in healthcare consolidation: mergers and acquisitions are becoming increasingly low-volume but high-value and cross-market. In Kaufman Hall's report 2022 M&A in Review: Regaining Momentum, the parties of the 53 announced transactions had a historic-high, combined $45 billion in total transacted revenue for the year, surpassing the previous record of $44 billion from 2017. However, 2022 had less than half of the total transaction volume of 2021. The researchers also noted a shift from market-based scale to capability-based scale. Current regulations of healthcare consolidation are focused on concentration in local hospitals or health systems. Researchers predict that cross-market transactions—those with little or no market overlap—will be a growing trend because it does not change the local competition that regulators focus upon.

A central focus in healthcare consolidation continues to be its impact on prices, which various stakeholders have closely monitored. Published in JAMA, Nancy D. Beaulieu, Michael E.

Chernew and J. Michael McWilliams examined Organization and Performance of US Health Systems to compare the quality and cost of care delivered by independent physicians and hospitals versus those in consolidated health systems. The authors found that consolidated health systems are not delivering better-value care for patients based on evidence from 580 health systems of various sizes. While there may have been marginally better care and slightly better reported experiences from patients whose primary care physicians are part of a health care system, the costs were significantly higher. On average, system-based hospital services were 31% more costly than care from independent hospitals. The authors note that there is potential for health systems to provide better care at equal or lower costs, but that potential is unrealized.

A well-studied and real anticompetitive impact of system consolidation is happening in Pennsylvania. The American Economic Liberties Project (AELP) report Critical Condition: How UPMC's Monopoly Power Harms Workers and Patients has raised alarms amongst Pennsylvania legislators. The report, introduced by two Pennsylvania lawmakers, noted that the University of Pittsburgh Medical Center (UPMC), a $23 billion nonprofit health enterprise that includes hospital, outpatient sites, insurance, commercial and international ventures, has experienced rapid growth in the last decade from owning 12 to 40 hospitals. As a result, it has become not only the state's largest nongovernmental employer, but also owns 71% of all licensed hospital beds within Pittsburgh and 60% of total license hospital beds in Allegheny County. The report considers UPMC a monopsony, where there is only a single buyer in the marketplace, allowing it to directly dictate prices and maintain low wages. AELP and state policymakers are calling for federal, state, and local policy changes that will reintroduce competition to Western P.A, including increased scrutiny of

hospital mergers, prohibition of non-compete agreements, and expansion of FTC power to conduct oversight of nonprofit hospital.

Private Equity

Consolidation in the health sector has seen the entrance of new major player, private equity firms. A new *Health Affairs* study on Workforce Composition in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices by Joseph Dov Brunch et. al., found that private equity-acquired physician practices rely more heavily on advanced practice providers (i.e., nurse practitioners and physician assistants). Comparing provider composition pre- and post-acquisition, researchers saw a higher turnover rate of providers that may be due to the changing organization, management, and financial incentives. For example, junior physicians within the practice may switch to another company where physicians believe there are more future ownership opportunities and fewer chance their job will be replaced by a less costly advanced practice provider. In conclusion, Brunch et. al. highlight the need for increased study of private equity ownership's impact on the clinical workforce because a stable workforce is associated with lower administrative costs, improved quality metrics, and better health outcomes for patients.

Private equity investment is also impacting ground ambulance providers. In a *Health Affairs* study, Loren Adler et. al illustrated how Ground Ambulance Billing and Prices Differ by Ownership Structure. Due to the exclusion of ground ambulance services from the No Surprises Act protection, 28% of commercially insured emergency and 26% of nonemergency transports resulted in a potential surprise bill. The prices of

these bills also varied wildly between the private and public sector due to the high prevalence of out-of-network providers and the lack of national uniformity. The study found that prices and cost-sharing were generally higher for those organizations owned by private equity or publicly traded companies. Adler et. al argue that a surprise billing protection for ground ambulance services like the existing No Surprises Act can be enacted like other health care services without harming public-sector ambulance revenues.

Provider Rates

Health Affairs recently launched a new *Forefront* series "Provider Prices in the Commercial Sector" that will explore physician, hospital and other health care provider prices in the private-sector markets. The series kicked off with Private Sector Health Care Prices – Defining the Terms of the Policy Debate, in which Erin C. Fuse Brown noted that an effective conversation needs a common language rather than highly complex terminology that is currently used to describe the way patients pay for health care. Also, Michael Chernew and Victoria Berquist examined Seven Burning Questions Related to Commercial Prices for Health Care Services that highlight the balancing act needed between spending, access and quality to have better decision-making around policy options.

Consideration of this balancing act requires policymakers to become increasing creative in their policy approaches. The Catalyst for Payment Reform report Combinations of State-Based Health Care Policies to Constrain Commercial Prices and Rebalance Market Power categorizes the various options states can use to address commercial health care prices. Specifically, the four categories are:

1. Ban (punish) bad behavior (e.g. banning anticompetitive contracting practices);
2. Prevent further erosion of competition (e.g. expanding antitrust law to prevent mergers and other acquisitive activity);
3. Regulate costs/prices (e.g. placing caps on provider prices); and
4. Build infrastructure (e.g. creating a repository of claims data)

The report notes that these categories are designed for state legislators to have clear prerequisite policies with an array of alternative next steps to address common sources of market failure. Given the scope of the current problem, the report emphasizes that "no single policy is sufficient to deliver meaningful results," so specificity and flexibility are needed.

That concludes this month's Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please send them our way.