

The Source Roundup: May 2023 Edition

As we prepare to transition to the summer, this month is an opportune time to examine the impacts of potentially a new season in the health care market. Researchers noted that not only is there a rise of geographically distant mergers even as rural hospitals struggle to maintain profitability, but also that private equity is a new major financier of the health care market. On the other hand, California hopes to increase competition with Golden Choice, a state-run public option. Federally, price transparency efforts could be a step towards creating a system where consumers can better achieve cost savings in their health care services. However, researchers remain cautious on whether these efforts will reach their full potential with continuous compliance problems such as inconsistent health insurance directories.

Competition and Consolidation

Healthcare consolidation is not a new phenomenon. However, Amol S. Navathe and John E. Connolly warn antitrust enforcers and regulators to watch [Hospital Consolidation: The Rise of Geographically Distant Mergers](#) in an article recently published in the Journal of the American Medical Association (JAMA). While traditional consolidation involved either similar-sized hospitals merging or a bigger system acquiring a small system in the same local region, cross-market mergers, which involve mergers with systems in different geographic areas, are becoming increasingly frequent. Unlike traditional mergers, the impacts of cross-market mergers that extend beyond state lines are not well studied. The article notes that research by The Source's

Jamie S. King, Alexandra Montague, and Thomas L. Greaney in partnership with UC Berkeley's Petris Center found that regardless of the type of merger, hospital consolidation leads to better negotiating power, which results in higher prices. Navathe and Connolly argue that more research into cross-market mergers is imperative as states are starting to address anticompetitive practices in health care. Until there is investigation into cross-market mergers' impact on quality of care and pricing, the authors predict that targeted policy responses will be limited.

At the same time, states are also becoming alarmed by the decline in rural hospitals' financial stability and its resulting impact. An article published in *Health Affairs* by Caitlin Carrol, Rhiannon Euhus, Nancy Beaulieu, and Michael E. Chernew considered [Hospital Survival In Rural Markets: Closures, Mergers, and Profitability](#). Although most of the United States' population is located within urban areas, there is a sizeable minority living in rural areas that often have only a few or single health care provider in their local geographic market. The researchers focused on rural health care competition from 2010 to 2018 and found that at the base-line, rural hospitals were not profitable. While 77% of the unprofitable hospitals were able to continue operating, 7% of the unprofitable hospitals were forced to completely shut down, and 17% merged with another provider, usually with an organization from outside their region. The article argues that despite some unprofitable hospitals that have continued to operate, a meaningful amount of hospital closures and mergers are happening in rural areas. Regulators must craft targeted legislation to ensure access to care is continued as competition decreases with hospital closure and mergers.

Another phenomenon regulators should be aware of is the deepening presence of private equity in the health care market.

As economists predict a global recession with mass layoffs in multiple industries, private equity is turning more to the health care market for its recession-proof reputation. Bain & Company published its annual Global Healthcare Private Equity and M&A Report with surprising results given the pandemic driven uncertainty. Overall, 2022 saw transactions totaling nearly \$90 billion and was the second-best recorded year for healthcare dealmaking. While this is a significant slowdown from the \$151 billion in 2021, it is still substantially more than previous years. The report found that the second-half of 2022 saw a slowdown in dealmaking because of geopolitical forces but believe that transactions will continue in 2023. Investors are being cautious of the rising interest rates and labor costs but are exploring new carve-outs and public-to-private deals that will lead to private equity becoming an increasingly dominant force in the health care market.

System Reform

In a report published by The Commonwealth Fund, Richard M. Scheffler and Stephen M. Shortell examine [A Proposed Public Option Plan to Increase Competition and Lower Health Insurance Premiums in California](#). A public option is a government-run health insurance coverage program that simultaneously exists alongside private health insurance plans. While implementation varies, generally the government will set the parameters and reimbursement rates to ensure health care affordability and increase competition in the market. Scheffler and Shortell argue that not only is there widespread support for a public option in California, the increasing gap between insurance premiums and weekly pay is also increasing the need for it. The authors found that in 14 of the 19 Covered California regions, Golden Choice would be the lowest-cost plan. The proposed Golden Choice plan

would lower premiums by creating a low-cost, high-quality integrated provider network that would not be focused on turning a profit. Furthermore, the researchers argue that Golden Choice is completely feasible because implementation does not require additional price regulation or market intervention. To implement this, California would have to apply for a Section 1332 waiver and determine how to administer the Golden Choice plan.

Price Transparency

In the second year of implementation of the federal price transparency rule, Turquoise Health published the second [Price Transparency Impact Report](#) based upon the reported, machine-readable files of almost 5,400 hospitals from Q1 of 2023. Unlike the previous report, the Report estimates about 84% of hospitals produced the required files with pricing data. The authors attribute this high compliance rate with continued enforcement of new hospital price transparency rules required by the Centers for Medicare & Medicaid Services. Looking into the future, the Report anticipates even more startups and innovators entering the price transparency movement. Ultimately, Turquoise Health is hopeful that increasing hospital compliance is the next step to patients knowing the price of treatment when booking health care services.

The No Surprises Act (NSA) is another federal price transparency effort for which implementation is being evaluated. The Act targets surprise balance bills when insured consumers inadvertently or unknowingly receive care from an out-of-network provider and limits the consumer bill to the amount they would have paid if the service had been in-network. In [No Surprises Act: Perspectives on the Statutes of the Consumer Protections Against Balance Billing](#), Jack Hoadley et. al. from the Urban

Institute surveyed 32 health care industry stakeholders on the new federal mandate. These experts largely agree that the NSA is showing early positive signs that consumers are being protected. Regulators and payors are seeing fewer consumer complaints that are violations of the NSA while consumer advocates are receiving fewer consumer surprise billing complaints. Even with these positive trends, the experts remain cautious on whether the NSA can truly be considered a success. They recommend close monitoring of consumer awareness, insurance literacy, and billing lags.

Much of the healthcare cost savings rely on being able to accurately determine which providers are in-network or out-of-network. In an article published in the *Journal of the American Medical Association*, Neel M. Butala, Kuldeep Jiwani, and Emily M. Bucholz evaluated the [Consistency of Physician Data Across Health Insurer Directories](#). By comparing the entries of five major payors, researchers found that a staggering 81 percent of entries were inconsistent amongst multiple directories. In accordance with previous research, most of the inconsistencies were due to the physicians being reported as practicing at all of the physician group's locations, rather than listing only the individual physician's actual location. The article noted that inconsistency increased as physicians became part of more insurer directories. Although CMS proposed creating a national physician directory, health insurers are wary of the difficulty of maintaining directories due to frequent information changes and the overall administrative cost. Regardless, the authors emphasize that the NSAs protections require accurate physician directories so decreasing inconsistencies must be prioritized.

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.