

# The Source Roundup: November 2021 Edition

As hospital consolidation continue to rise amidst the pandemic, there has been contentious debate over the impacts of provider consolidation. This month's roundup begins with articles that discuss some of these issues, including studies that found both benefits and potential harms of certain hospital mergers, acquisitions, and partnerships. Also highlighted in this month's roundup are studies on the implications of proposed payment reforms across specialties, increasing health care costs for individuals with employer-sponsored insurance, and the continuing lack of plan comparison among Medicare beneficiaries during open enrollment season.

## Market Consolidation/Competition

Although there were fewer merger and acquisition deals announced in the third quarter of 2021, the total transacted revenue and average seller size by revenue was higher, according to Kaufman Hall's analysis in "[M&A Quarterly Activity Report: Q3 2021](#)." The report reveals that in the third quarter, seven transactions involving 20 hospitals were announced. The decline in transaction volume has not resulted in much lower total transacted revenue. For the seven transactions announced in the third quarter, the total transacted revenue was \$5.2 billion. This included two megamergers, in which the smaller partner has annual revenues of more than \$1 billion. Kaufman Hall reports that the fewer hospital mergers and acquisitions is being offset by a high percentage of these megamerger transactions. The report shows a continuing trend of hospitals and health systems looking for strategic partnerships that have more of a "transformative

impact,” rather than an outright expansion. The report adds that this trend is likely to continue in the coming years, especially as organizations recover from the pandemic.

The nation’s shift toward building large hospital systems may cause concern from an antitrust perspective, but a report prepared by Kaufman Hall for the American Hospital Association (AHA) argues that “[Partnerships, Mergers, and Acquisitions Can Provide Benefits to Certain Hospitals and Communities](#).” An analysis of 463 hospital acquisition deals closed between 2015 and 2019 shows that a significant percentage of hospitals involved in merger, acquisition, and partnership transactions faced financial distress or challenges prior to the deal. According to Kaufman Hall, mergers and acquisitions have saved some health systems and hospitals from closure, easing financial pressure and allowing them to scale up to provide resources and engage in partnerships. The report additionally states that recently acquired hospitals often can expand their offerings and benefit from capital investment to develop new enhancements. The AHA suggests that partnerships, mergers, and acquisitions have been an essential tool for some hospitals and health systems as they adapt to a rapidly changing environment, not only for financial stabilization, but also to preserve and improve access to care in local communities.

However, another study found that while mergers and acquisitions may provide more financial stability to hospitals, they also often cut less profitable service lines like maternal, neonatal, and surgical care, potentially harming rural residents. In a research article published by *Health Affairs*, Rachel Mosher Henke et al. examine the influence of rural hospital mergers on changes to inpatient service lines at hospitals and within their catch areas. The study, “[Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Mergers in Rural Areas](#),” identified 172 rural hospitals that merged between 2009 and 2016 across 32 states and matched those with 549 comparison hospitals that

had remained independent. The study found that recently acquired rural hospitals were more likely than those that remained independent to shut down maternal, neonatal care, and surgical care services. The study also found that merged hospitals in rural areas showed reductions in volume of mental or substance use disorder stays, whereas hospitals that remained unaffiliated showed increased volumes, indicating a potential unmet need in the communities of rural hospitals post-merger. The researchers suggest that although rural hospitals can improve financially when they join larger health systems, the merger may also reduce access to some service lines that are essential to the community.

## **Healthcare Costs**

Policy proposals that use Medicare rates as a benchmark for commercial payments to curb health care spending could significantly affect physician payments, but the effects will likely vary considerably by specialty, according to a study released by the Urban Institute. In "[Commercial Health Insurance Markups Over Medicare Prices for Physician Services Vary Widely by Specialty](#)," Stacey McMorrow, Robert A. Berenson, and John Holahan explore the markups specialties get from commercial plans compared to traditional Medicare Rates. The researchers looked at data from FAIR Health's private insurance claims database from March 2019 to February 2020. It included 17 physician specialties and approximately 20 services per specialty that represent 40% of total professional spending. The study found that ten specialties, including cardiology and anesthesiology, received between 120% to 330% more in commercial plan payments than Medicare rates, but other specialties such as dermatology and obstetrics got less. The analysis found that a small number of physician specialties received commercial markups over Medicare payment rates above 150%, and these specialties would face the largest income losses if forced to accept Medicare rates from private

payers. As policymakers seek various strategies to rein in healthcare spending, these findings have important implications for debates over physician payment reforms, public option and single-payer policies, and Medicare payment reforms.

The Health Care Cost Institute (HCCI) released the [2019 Health Care Cost and Utilization Report](#), their annual look at health care spending among people with employer-sponsored insurance. HCCI analyzed medical and prescription drug claims from 55 million individuals who were under age 65 and on an employer-sponsored health plan between 2015 and 2019. The report shows that despite a decline in healthcare utilization, patient healthcare costs and out-of-pocket spending has increased for individuals on employer-sponsored health plans due to high prices. According to the report, per-person spending increased to an all-time high of \$6,001, amounting to an increase of 21.8% from 2015 to 2019. Other key findings show that (1) average per person out-of-pocket spending totaled \$829 in 2019, (2) average prices grew 3.6% in 2019, (3) utilization declined 0.7% between 2018 and 2019, and (4) prices accounted for the largest part (nearly two-thirds) of per-person spending growth during the five-year period. Drawing on data from the years immediately before the COVID-19 pandemic, the 2019 report provides an important resource to those seeking to understand how the health care system changed during and after the pandemic, as well as the drivers of health care spending.

With Medicare open enrollment running from October 15 to December 7, it is now the time of year for Medicare patients to review their coverage and health care needs for 2022. However, a new report by Wyatt Koma et al. shows that [“Seven in Ten Medicare Beneficiaries Did Not Compare Plans During Past Open Enrollment Period.”](#) The Kaiser Family Foundation analysis examined the share of Medicare beneficiaries who compared plans during the 2018 open enrollment period for coverage in 2019, the share who compared drug coverage in

Medicare Advantage (MA) and stand-alone drug plans, and variation by demographic characteristics. The data reveals that 71% of all beneficiaries didn't compare their plan to other plans available for the 2019 coverage year. A greater number of beneficiaries in MA's drug plans (81%) didn't compare drug coverage. Among stand-alone drug plan enrollees, more than 7 in 10 said they did not compare coverage offered by their current prescription drug plan to other prescription drug plans. The analysis also found that beneficiaries who are Black and Hispanic, with low incomes and fewer years of education were less likely to compare plans. The number of plans on MA and Part D is expected to increase again for the 2022 coverage year, and the ramifications of the report's findings could be significant for a large share of Medicare beneficiaries, given the potential consequences of year-to-year plan changes for their coverage, access to care, and out-of-pocket costs.

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. Stay safe and healthy!