HEALTH CAPITAL Topics
Volume 17
Issue 8
August 2024
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Valuation of Hospitals: Competitive Environment

Demand for a variety of healthcare services – including those provided by hospitals – is likely to increase significantly in the near future, primarily as a result of the changing demographics of the U.S. population, most notably the growth in the number of Americans over the age of 65.[1] Indeed, a *Health Affairs* study found that population aging alone will create approximately 0.74% annual growth in the demand for inpatient hospital services.[2] While hospital consolidation is leading to operational efficiency for hospitals in providing services to an increasing number of patients, the federal government's intensifying focus on anticompetitive behaviors in healthcare may hinder traditional consolidation efforts going forward. This second installment in a five-part series on the valuation of hospitals reviews the competitive environment in which hospitals operate.

Demand for hospital services is driven by the number of people with health insurance, per capita disposable income, federal funding for Medicare and Medicaid, and the aging population.[3] The number of Americans who are employed and/or have private health insurance typically drives demand for increased healthcare services, including those provided by hospitals. Individuals with higher incomes typically have higher healthcare utilization, and simultaneously reduces the likelihood of bad debt for hospitals since patients can afford to pay hospital bills.[4] The elderly population also utilizes a greater proportion of (and expenditures related to) medical services relative to the rest of the general population, and as such will comprise a growing part of the patient population in future years. In addition to those with the means to purchase healthcare services (through insurance or out-of-pocket spending), hospital services are also typically utilized by those who are less healthy. The prevalence of chronic diseases has been on the rise nationwide, with 60% of adults having one chronic disease and 40% having two or more chronic diseases.[5] In fact, 90% of U.S. annual healthcare expenditures (totaling nearly $4.5 trillion), are for patients with chronic diseases.[6] Healthcare utilization is almost twice as high for chronic disease patients than those without any chronic diseases, with hospital inpatient utilization being as much as four-fold higher.[7]

The total number of non-federal, short-term hospitals in the U.S. is 6,120.[8] The number of beds in these hospitals (and, consequently, the number of available beds per capita) has been falling since the 1980s.[9] The national reduction of available hospital beds likely represents a shift in the type of services rendered in these hospitals, rather than a shortage of available hospital services. Over the past couple decades, the utilization of outpatient visits in hospitals has risen steadily, from 1,848 per 1,000 persons in 2000 to 2,399 per 1,000 persons in 2022.[10]

Although the total number of hospitals in the U.S. has remained relatively stable since the late 1990s, these organizations have not been idle. Since the 2010 passage of the *Patient Protection & Affordable Care Act* (ACA), the number of hospital mergers and acquisitions (M&A) has increased dramatically.[11] Between 2005 and 2009, there were approximately 50-60 hospital transactions in the U.S. each year;[12] in 2019 alone, there were 92 hospital deals.[13] Likely due to the COVID-19 pandemic, this activity has slowed back down – in 2021, only 49 hospital transactions were announced (although several of those transactions were "mega mergers").[14] In 2023, 65 deals were announced, representing the highest M&A activity since 2020.[15] This uptick in transactional activity may be due to the fact that hospitals are battling financial issues that were exacerbated by the pandemic; to combat such issues, hospitals are looking for partnerships to stay afloat and diversify.[16]

Industry stakeholders are divided on the potential effects of this consolidation trend, with some claiming that integration will bring operational efficiency, as well as improved coordination and quality of care, while others warn that concentration of market share among fewer providers may result in rising prices for healthcare services.[17] While consolidation allows providers to operate efficiently, and could potentially help providers keep their doors open in underserved areas, it often has the effect of reducing competition.[18] Evidence has found that consolidation has led to higher prices (without any increase in the quality of care).[19]

Perhaps as a result of recent studies highlighting the potential ill effects of hospital concentration, the federal government has turned its regulatory focus in recent years toward competition in healthcare, which may serve to further cool hospital M&A. In 2018, the U.S. Department of Health & Human Services (HHS), the Department of the Treasury, and the Department of Labor issued a report comprising over 50 recommendations to increase quality, decrease cost, and promote competition in healthcare.[20] Three years later,

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President Biden issued an executive order to promote competition in the American economy.[21] The executive order was designed to address issues the administration identified as contributing to harmful trends associated with decreased competition and corporate consolidation, which are ultimately harming American consumers.[22] While the executive order did not immediately establish requirements, it directed federal agencies to review issues and implement policies to reflect the administration's goals.[23] Pursuant to the executive order, federal agencies have subsequently taken action to increase competition in hospitals, among other priorities.[24] Specifically, the Federal Trade Commission (FTC) has filed a number of lawsuits over the past couple years to halt hospital transactions, including suing to block:

(1) A merger of two New Jersey-based health systems, RWJ Barnabas Health and Saint Peter's Healthcare System, which caused the systems to scrap their merger plans;[25]

(2) HCA Healthcare's acquisition of five Utah hospitals from Steward Health, which caused HCA to abandon the acquisition;[26]

(3) A merger of two Rhode Island health systems, Lifespan and Care New England, which caused the systems to abandon their merger plans;[27]

(4) New Jersey's biggest hospital system, Hackensack Meridian Health, from acquiring competitor Englewood Healthcare, which caused Hackensack to scrap the acquisition;[28] and

(5) Novant Health, a non-profit health system, from acquiring two North Carolina hospitals from Community Health Systems, a publicly-traded mega-system. Ultimately, Novant Health decided to call off the acquisition.[29]

As a result of increased regulatory scrutiny, hospitals are changing integration strategies, and merging across markets. Cross-market mergers can involve health systems and hospitals thousands of miles apart, or simply those in neighboring markets.[30] These mergers are more attractive to hospitals, as they have received little resistance from government agencies compared to mergers occurring within the same market.[31] For example, BJC Healthcare in Saint Louis, Missouri, merged with St. Luke's Health System in Kansas City, Missouri, to create a combined state-wide system with a revenue of nearly $8.7 billion.[32] Similarly, Risant Health, a nonprofit established by California-based integrated health system Kaiser Permanente, announced acquisitions of Geisinger, a Pennsylvania-based integrated health system, and Cone Health, a nonprofit integrated health system in North Carolina, in the past year.[33] Together, the three systems have combined revenues of over $105 billion.[34]

In addition to the overall number of hospitals and hospital beds, the supply of hospital services is also dictated by the number of physicians and non-physician practitioners (NPPs) who can provide those services.[35] Over 945,000 physicians actively practiced in the U.S. in 2021,[36] approximately 52% of which were employed by hospitals and health systems.[37] Over 46% of these physicians are over the age of 55,[38] which indicates that over the next 10 to 15 years, nearly half of all physicians will either retire or significantly reduce the number of hours worked per week, resulting in a shortage of physician services.

Although the U.S. may face a shortage of physicians in the near future, the supply of NPPs may actually double over the fifteen years.[39] The Association of American Medical Colleges (AAMC) has projected that by 2034, the supply of advance practice registered nurses, including nurse practitioners, in the U.S. will grow by 309,000 full-time equivalents (FTEs); and the supply of physician assistants in the U.S. will grow by nearly 129,000 FTEs.[40] This growth exceeds the growth in patient demand for healthcare services, which may serve to ameliorate the physician manpower shortage.

Hospitals are increasingly operating in a highly competitive environment with other, freestanding facilities, such as urgent care centers, free standing emergency departments (FSEDs), and ambulatory surgery centers (ASCs).[41] While hospitals typically have competitive advantages over ASCs, such as established managed care contracts and community position, ASCs have been able to treat a more profitable pool of patients (relative to hospitals) by: (1) concentrating only on specific diagnosis-related groups (DRGs); (2) treating far fewer Medicaid patients, which often involves reduced reimbursement rates; and, (3) opting out of emergency room facilities and services so as to forego the related regulatory requirements under laws such as the Emergency Medical Treatment and Active Labor Act (EMTALA) related to the provision of care regardless of a patient's ability to pay.[42] With fluctuations in reimbursement and other operating pressures, hospitals are attempting to combat this competition by similarly shifting procedures from the inpatient setting to lower-cost outpatient settings.[43]

Over the next few years, hospitals may benefit from: (1) the number of individuals with private health insurance; (2) disposable income per capita; (3) funding for Medicare and Medicaid; and (4) the number of adults aged 65+.[44] However, hospitals are still hampered by the increasingly intense, complex, and overlapping regulatory scrutiny from federal, state, and local regulators. The next installment in this five-part series will review the regulatory environment in which hospitals operate.

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