As part of the Health Care Trends series, in this course you will learn about both health care industry consolidation and health care coverage trends. Consolidation includes trends on merger and acquisition (M&As) activities among hospitals and health systems, physician practices, and proposed mergers of pharmacies and health insurers. The health care coverage section cites trends among several patient populations: underinsured, uninsured, the ACA, Medicaid and CHIP, and Medicare. The course also posits projected impacts of these trends.

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Knowledge Check

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Additional Resources
Lesson 1 of 5

Introduction

Learning Objectives

After completing this course, you will be able to:

1. Identify current trends in health care consolidation and coverage
2. Describe factors contributing to widespread consolidation in health care
3. Recognize effects of health care coverage on patient access to care
4. Explain predicted impacts of health care consolidation and coverage trends for patients, physicians, payers and policymakers
Health Care Industry Consolidation

Introduction to Consolidation

The shift from volume- to value-based care, exploration of ways to manage population health, and the increasing influence of consumerism have challenged health care stakeholders to improve care delivery by reducing clinical variation while increasing access to capital.

Consolidation activity related to the health care industry has increased steadily since 2009 and is taking on a variety of forms, such as mergers & acquisitions (M&As), joint ventures, and affiliations.

A major question surrounding consolidation is whether this activity will lead to more efficient care delivery, and higher quality and reduced costs of care.
Announced deals among hospitals and health systems reached unprecedented size and scale in 2017. Of 115 transactions, 11 involved sellers with net revenues of $1 billion or greater, 37 involved for-profit targets, and more than 16% involved not-for-profit organizations purchasing a for-profit.

<table>
<thead>
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<th>Year</th>
<th>Transacted Revenue ($ billions)</th>
<th>Number of Transactions</th>
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<td>2017</td>
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<td>115</td>
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Motivating factors for health system consolidation include: improving operational efficiencies, creating clinically integrated care delivery networks, and accessing sufficient populations for population health management.

*Instructions: Click each plus sign below to learn more about trends in consolidation*

**Hospitals and Health Systems**

- Continued hospital and health system consolidation is poised to **remake the delivery system landscape** over the next 10 years.

**Physician Practices**

- Pressure on physician payment from various sources remains likely to **push physicians in smaller settings** to seek employment in either large multispecialty groups or hospital-based clinics.

**Health Insurers**

- The health insurer sector is **more consolidated** than the provider sector.
- Insurers are facing **financial pressures** in the individual, small group, and large group health insurance markets.
Operational, Strategic, and Financial Value

Hospital M&A activity has increased significantly in the past decade, with buyers and sellers looking to create operational, strategic, and financial value.

The main driver is the pursuit of economies of scale, the ability to decrease unit costs or improve productivity and outcomes through increased volumes.

The assumption is that, through M&A, health system investments in technology, quality improvement, ancillary services, or shared services can be spread across a broader base post-transaction.

- Hospital and health system M&As increased 15% in the second quarter of 2017 compared to the previous year’s second quarter, according to an analysis by Kaufman, Hall & Associates, LLC.

- Large health systems have been especially active. Through the first half of 2017, there were six transactions of health systems with nearly $1 billion or more in revenues announced during the first half of the year. There were only four in all of 2016.

Physician Practice Consolidation

The number of physician medical group M&As rose to 48 in the first quarter of 2017, which is a 78% jump from the fourth quarter of 2016.

The trend of consolidation among physician practices includes practices merging with other practices or entering into acquisition deals with other practices, hospitals and health systems or private equity groups.

Strong motivators to consolidate include:

*Instructions: Flip each card to view strong motivators*
Appeal of economies of scale for activities like billing

Greater access to Information Technology and general technology infrastructure
Proposed Health Insurer-Pharmacy Mergers

CVS Health and Aetna

In 2017, CVS Health and Aetna announced the execution of a definitive merger agreement. The merger would provide CVS with guaranteed business from Aetna patients and allow Aetna to expand into new health care territory.


Cigna Corporation and Express Scripts Holding Company

In early 2018, Cigna Corporation announced its $52 billion proposed acquisition of the pharmacy benefits manager (PBM), Express Scripts Holding Company.

The merger will save $600 million annually due to improved administrative efficiencies, better coordination between pharmacy and medical claims and increased leverage in price negotiations with pharmaceutical companies, according to a statement by the companies. Together, Cigna and Express Scripts would boast $141.7 billion in revenue. The sheer bulk of the combined company in theory should allow it to negotiate better prices from drug makers.
to lower costs. However, several experts doubt the merger will drive savings for its customers, including health plans, employers and patients.


Walmart and Humana

In March 2018, the Wall Street Journal announced that Walmart is considering a merger with health insurer Humana. The two companies have not confirmed a merger, but should a deal be announced, it would create a force in the Medicare Advantage industry that some experts say would have the potential to redefine how America's seniors access health care. The combined business would have more than $550 billion in revenue.


Predicted Impacts
Introduction to Coverage

Health insurance is a means for financing a person’s health care expenses.

While the majority of people have private health insurance, primarily through an employer, many others obtain coverage through programs offered by the government. Other individuals do not have health insurance at all.

Encouraged by federal tax subsidies many U.S. employers provide coverage as part of their compensation plans -- employer-sponsored insurance covers more than 150 million workers and their dependents.
The next largest source of coverage, Medicaid, insures less than half as many, 70 million.

Medicare enrolls 50 million.

The Affordable Care Act (ACA) Marketplaces and individual market provide coverage for about 17 million people.

Underinsured Population

A recent Commonwealth Fund report found that in 2016, nearly a quarter of working-age adults with job-based coverage had such high out-of-pocket costs and deductibles relative to their income that they were effectively "underinsured." The uninsured rate is now the highest recorded since the last quarter of 2014.

A major factor in the rising number of underinsured people covered by employer plans are ballooning deductibles. The share of people covered by job-based insurance with deductibles exceeding 5% of household income grew six fold, from 2% to 13%, between 2003 and 2016.

Several factors have led to the rising numbers of underinsured with job-based coverage: health care costs are growing faster than workers’ wages, and although health insurance premiums have grown more slowly over the past five years, many employers are not sharing those cost savings with workers. Additionally, the overwhelming majority of employers lack the staff and expertise to manage the intricacies of health care markets.

People are considered underinsured if they spend more than 10% of their income, excluding premiums, on health care; spend more than 5% if they were low income; or if they have a deductible that exceeds 5% of their income.
Uninsured Population

Uninsured adults are more likely than those insured to delay or go without care due to cost, worry about paying bills for routine medical care, and forgo preventive care.

Individuals are considered uninsured if they do not have health insurance coverage for an entire calendar year. The uninsured rate is now the highest recorded since the last quarter of 2014 when it was 12.9%.
The 1.4-point increase in the percentage of adults without health insurance since the end of 2016 represents nearly **3.5 million** Americans who have entered the ranks of the uninsured in 2017.

Several factors could be contributing to the growth of the uninsured rate since 2016—some insurance companies have **stopped offering insurance** and the lack of competition could be driving up the cost of plans for consumers. As a result, the rising insurance premiums could be compelling some Americans to forgo insurance, especially those who fail to qualify for federal subsidies.

The uninsured rate has increased at least one point among all key demographic subgroups since late 2016, except for those aged 65 and older. The **growth** has been concentrated mostly among middle-aged Americans, racial minorities and lower-income Americans.

By far, the largest decline in the type of health insurance Americans have obtained since the end of 2016 has been among **those who purchase their own plans**.


Health Care Coverage Under the ACA

A sharp uptick in use of preventive care coincided with the...
Prior to passage of the Affordable Care Act (ACA) in 2010, people without job-based health benefits or those who qualified for public insurance programs had few affordable options. When the major ACA coverage provisions went into effect in 2014, the uninsured rate dropped dramatically and continued to fall in subsequent years. In 2016, the nonelderly uninsured rate was the lowest in decades.

The ACA led to gains in health insurance coverage by extending Medicaid coverage to many low-income individuals and providing Marketplace subsidies for individuals below 400% of poverty.

*Instructions: Flip each card to review more results of the ACA*

Under the law, the number of uninsured nonelderly Americans decreased from 44 million in 2013 (the year before the major coverage provisions went into effect) to how many million as of the end of 2016?

28 million
Beginning in 2014, the ACA expanded coverage to millions of previously uninsured people through the expansion of Medicaid and the establishment of Health Insurance Marketplaces. Data show

Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage.

*In 2016, what percentage of uninsured adults said that*

In 2016, uninsured nonelderly adults were over twice as likely than their insured counterparts to

Low-income people

45% of uninsured adults

Medical debt
Health insurance represents a growing share of total health expenditures, particularly among public programs

Spending on public health has increased, particularly by state and local governments. Medicaid is the nation’s public health insurance program for people with low income and covers more than 70 million Americans, or 1 in 5, including many with complex and costly needs for care. The vast majority of Medicaid enrollees lack access to other affordable health insurance. Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. The program is also the principal source of long-term care coverage for Americans. As the nation’s single largest insurer, Medicaid provides significant financing for hospitals, community health centers, physicians, and nursing homes, and jobs in the health care sector. The Medicaid program finances over 16% of all personal health care spending in the United States.
Medicaid is **constantly evolving** as policymakers strive to improve program value and outcomes through:

- Delivery system reforms
- Respond to economic conditions or public health concerns (*such as the opioid epidemic*)
- Implement federal policy changes including those in the ACA or other regulatory changes (*like the Medicaid managed care rule*)

As states began state fiscal year (FY) 2018, Congress was debating major ACA repeal and replace legislation generating **great uncertainty** for states around Medicaid including the **future of the ACA** and **financing for the Medicaid expansion** as well as overall financing for the Medicaid program.

Their needs result from a range of conditions, such as Down syndrome, cerebral palsy, and autism. They may require services such as nursing care to live safely at home, therapies to address developmental delays, and mental health counseling.

Medicaid and the Children's Health Insurance Program (CHIP) covered about half (48%) of children with special health care needs in 2016. Medicaid provides a wide range of medical and long-term care services, many of which are not covered at all or only available in limited amounts through private insurance and makes coverage affordable for many children with special health care needs and their families.

According to the Centers for Medicare & Medicaid Services (CMS) 74,039,021 individuals were enrolled in Medicaid and CHIP in the 51 states reporting January 2018 data.

- 67,683,496 individuals were enrolled in Medicaid and 6,355,525 individuals were enrolled in CHIP.

- Nearly 16.4 million additional individuals were enrolled in Medicaid and CHIP in January 2018 as compared to the period prior to the start of the first Marketplace open enrollment period (July – Sept. 2013), in the 49 states that reported relevant data for both periods, representing over a 29% increase over the baseline period.
Medicare Population

Medicare is the federal health insurance program created in 1965 for people ages 65 and over, regardless of income, medical history, or health status.

The program was expanded in 1972 to cover people under age 65 with permanent disabilities.
Medicare spending accounted for 15% of total federal spending in 2016 and 20% of total national health spending in 2015. In 2017, more than 42 million people on Medicare were enrolled in a prescription drug plan or Medicare Advantage drug plan.
In light of Medicare’s benefit gaps, cost-sharing requirements, and lack of an annual out-of-pocket spending limit, most beneficiaries covered under traditional Medicare have some type of supplementary coverage that helps to cover beneficiaries’ costs and fill the benefit gaps.

In 2017, 30% of all beneficiaries—nearly 21 million enrollees—were enrolled in Medicare Advantage plans rather than traditional Medicare, some of whom also have coverage from an employer plan or Medicaid. Medicare Advantage plans are required to limit beneficiaries’ out-of-pocket spending for services covered under Medicare Parts A and B to no more than $6,700, and may also cover supplemental benefits not covered by Medicare, such as eyeglasses, dental services, and hearing aids.

Predicted Impacts

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Lesson 5 of 5

Additional Resources

**Transcript**

121.8 KB

**Predicted Impacts**

199.5 KB

209.4 KB
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