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COVID-19's Continuing Effects On Health Care Economics

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The COVID-19 pandemic continues to significantly stress the U.S. health care system, by simultaneously overloading the system's capacity to treat the sick and depriving it of revenue from both nonurgent patient care and elective procedures over an extended period.

While doctors have returned to providing some elective procedures, the delta variant complicates the sector's recovery. Despite how any recovery may continue, however, the pandemic has altered the U.S. health care landscape by accelerating several important pre-pandemic trends in provider economics.

Understanding this aspect of the pandemic's legacy will help general counsel and legal teams at providers successfully steer their organizations through the highly dynamic period ahead.

Continued Consolidation

The most notable and immediate economic impact of the pandemic for providers will be an acceleration of the consolidation that has been taking place in the U.S health care sector for the past two decades. The pandemic made strong providers weaker, and pushed the precarious ones toward—or into—bankruptcy.

Vertical mergers and acquisitions, and supermergers of national players at multiple levels of the health care delivery chain, will continue. At the other end of the spectrum, one study has shown that one in four rural providers is in financial jeopardy; many of them will seek to consolidate with urban systems to bolster their stability.

That there have been fewer restructurings and bankruptcies of both larger and smaller institutions in the wake of the pandemic than was originally forecast might seem to suggest that many institutions have successfully weathered the storm. But fewer such restructurings and bankruptcies are due less to the resiliency of provider organizations than to the success of the Coronavirus Aid, Relief and Economic Security Act, Paycheck Protection Program loans, and the continued availability of cheap money from capital markets and lenders—all resulting in staggering fiscal deficits for the U.S. government.

It's also helped that lenders have chosen to be generous with forbearance, for three reasons. First, no one wants to be the bank that forecloses on a hospital in the wake of a pandemic. Second, lenders have made calculated decisions that the financial positions of providers will strengthen over time. Finally, banks have a strong desire to avoid becoming owners of highly regulated businesses whose primary assets walk out the door every evening.

Loan forbearance is not forgiveness, however, and eventually the bill will come due for health care providers in the form of increased debt service. And to service that greater debt, nonurgent patient care, and elective procedures will have to return to levels above pre-pandemic numbers.

It is likely that many providers will struggle to clear this higher bar, leading to new rounds of consolidation as institutions seek stronger balance sheets, economies of scale and the ability to offer a greater number of services. Continued consolidation will, in turn, trigger a rise in the number of interstate providers.

This will occur partially out of necessity, as the pool of local merger candidates shrinks, and partially because the lifting of jurisdictional restrictions on telehealth during the pandemic further eroded the psychological barrier presented by those geographic boundaries—a trend that will likely continue regardless of whether those restrictions are eventually restored.

More Private Equity Investment

The health care provider landscape is also likely to see increased investment by private equity funds in physician practices. (Hospitals, being more highly regulated, make for less attractive investment opportunities.)

While consolidation offers one path to increased financial stability, it isn't always possible for a physician practice to find a strategic transaction partner where a combination makes sense for both sides. Private equity can fill that gap.

For this to happen, however, practices need to recover enough that banks can sell the debt to private equity investors at an attractive price—but not such a high price that it makes sense for the bank to hang on until full recovery is reached. But this scenario—partial recovery in the near term, followed by a protracted climb to full recovery—is quite likely for many practices.

Transactions between physician practices and private equity firms bring their own set of legal complexities. Many states prohibit what they call the "corporate practice of medicine"—that is, an entity without a medical license employing physicians to practice medicine.

Because of this prohibition, providers looking to be acquired by a private equity firm need to use a transaction structure known as the "friendly physician" or "friendly PC" model. While this maneuver has several permutations, the general strategy calls for the private equity firm to form a management services organization, or MSO, which acquires the nonclinical assets of the provider.

The provider then enters into a management services agreement with the MSO, which then effectively controls the practice. Provider physicians receive equity in the MSO, in exchange for relinquishing their economic rights in the practice.

One area of health care that is particularly ripe for either consolidation or outside ownership is senior care—particularly facilities outside the realm of skilled nursing. Senior care was already facing competition from home health care before a pandemic that fundamentally challenged the viability of providing long-term care to a medically vulnerable community in close quarters. That competition has only increased, presenting senior care facilities with a particularly tough climb back.

Value-Based Reimbursement and Shifting Regulations

Larger provider organizations and increased private equity involvement in physician practices will be encouraged by

another prepandemic trend: the continued move to value-based reimbursement, in which hospitals and physicians are reimbursed through outcomes-based and capitation-based arrangements, rather than the number of patients seen and tests ordered.

Larger organizations have the critical mass that value-based reimbursement calls for. The investment theses of private equity firms often require the sorts of efficiencies that value-based compensation supports.

Ultimately, however, value-based reimbursement rewards hospitals and physicians for fewer visits and procedures. While this may be desirable from a public policy perspective, it means permanent pressure on the bottom lines of even large provider systems—leading to further consolidation.

However, the considerable economic forces encouraging consolidation and outside investment are not occurring in a vacuum, but rather at exactly the same time that the Biden administration is taking a tougher stance on antitrust enforcement in health care and elsewhere. And the involvement of private equity in health care is receiving greater public scrutiny.

General counsel and legal teams at providers are in the middle, having to guide their organizations through more complex and urgent deals and a less hospitable regulatory environment. Further, that regulatory environment is likely to experience significant flux, as the economic and operating realities of the evolving health care ecosystem continue to bump up against regulations created during the professionalization of medicine a century ago.

Indeed, we may find that delivery of health care is entering what will come to be seen as a second professionalization. The imperative to put the health of the patient first will remain, but both state and federal regulations will be reconfigured to reflect changing technologies and business models.

In the face of these changes, general counsel and legal teams at health care providers will continue to play a critical role in providing both strategic leadership and tactical execution.

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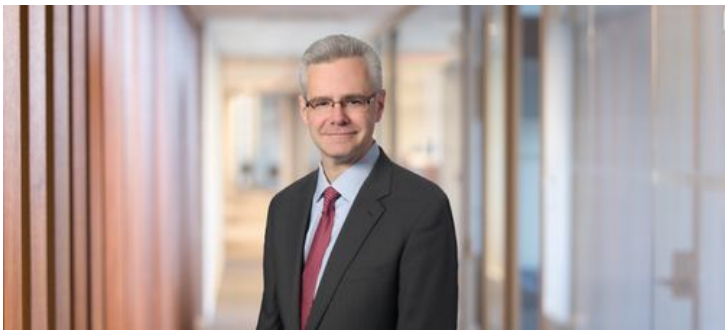

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