



The Governance Institute's E-Briefings



Volume 10, No. 5, September 2013

Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

News, Articles, and Updates

Multi-State Non-Profit Health Systems: Why There Are Not More, but Soon Will Be

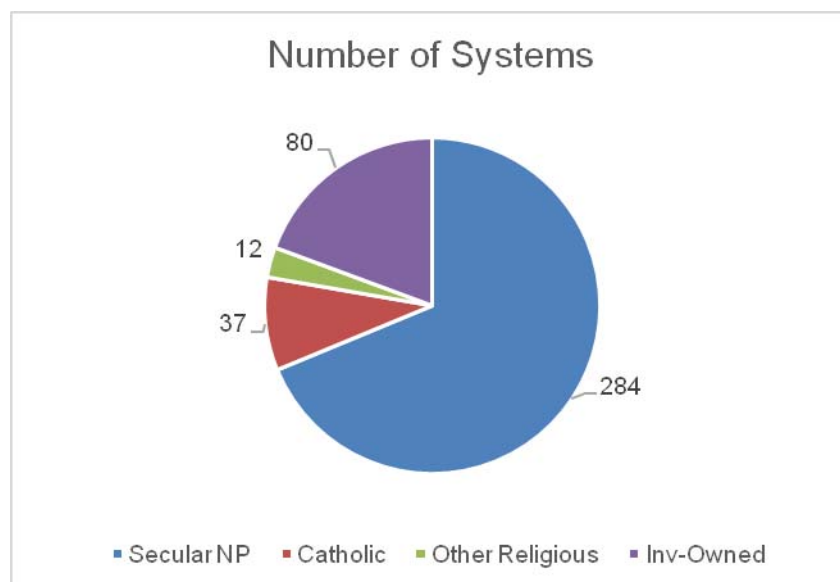
By Barry Sagraves, Juniper Advisory, LLC

After several years of enthusiastic merging and acquiring, multi-hospital systems now own approximately 70 percent of all U.S. hospitals not owned by a government entity. There are more than 400 systems, of which over two-thirds are secular non-profit systems (see **Exhibit 1**). However, unlike their religious and investor-owned counterparts, almost all of these systems have remained small and local. In an era where scale seems to be more important than ever, these 284 secular non-profit systems average only five hospitals per system, and boast only five systems

that can be argued to be significantly active in more than one state.

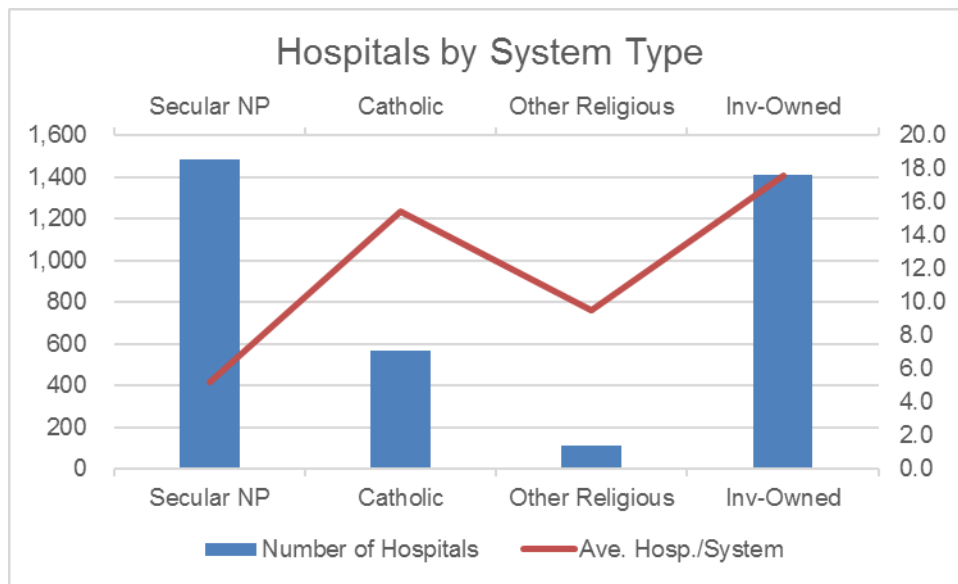
Are these small, local non-profit systems anomalous dinosaurs, destined to be swallowed up by larger systems, or simply to wither away? Or are they financially and (maybe more importantly) culturally able to change their focus and join the game everyone else is playing? Will they be able to form larger, financially strong systems to rival those already extant, and which are themselves increasingly merging into ever-larger competitors?

Exhibit 1: Number of Systems



Source: American Hospital Association.

Exhibit 2: Hospitals by System Type



Source: American Hospital Association.

The hospital industry is uniquely structured among U.S. industries, particularly in its complete lack of dominant players.¹ HCA, the largest system, has less than a 4 percent market share by number of hospitals. Typically, large industries have three or so dominant players and several niche ones; the hospital industry has nothing but niche players.

A big reason for this is that a large segment of the industry is made up of individual community non-profit hospitals that have not historically wanted or needed to either form or join a system. The historical roots of these organizations largely explain why they have not banded together into large, efficient multi-state systems, and those who have combined have typically done so locally.

Whether these small, local systems will aggressively seek to combine into larger, multi-state systems has major implications for the future shape of the hospital industry, the viability of population health as envisioned by the Affordable Care Act (ACA), the \$3.7 trillion municipal bond industry, and, of course, the strategies and ultimate success or failure of the individual systems themselves.

¹ Juniper Advisory, LLC, discussed this in more detail in a past white paper; James Burgdorfer et al., *Hospital Consolidation Trends in Today's Healthcare Environment*, The Governance Institute, Summer 2010.

Past Obstacles to Multi-State Non-Profit Systems

It is relatively straightforward to explain the lack of multi-state non-profit systems, yet worth recounting in order to assess the likelihood of them becoming a significant feature of the industry in the future. The main reasons for the local nature of these systems include:

- **Local mission.** The vast majority of independent non-profit hospitals were founded by members of the local community, often with a bequest from a prominent family. The purpose of such hospitals—often required by the founding gifts—was local care. Even when some such hospitals evolved into multi-hospital systems, their focuses have remained on their local region rather than expanding into other states—this just hasn't been seen as part of their mission.
- **Municipal finance.** Municipal bonds have been by far the dominant means of financing non-profit hospitals' capital needs. Traditionally, bonds were issued by conduit agencies in each state, and bought largely by local individuals. Financing capital projects through a number of different issuers in different states was relatively costly and inefficient.
- **Complexity.** Each state has its own programs (notably Medicaid), legal regime, payer landscape, and politics; it is simply more complicated to operate in multiple states.

Lacking size and influence, many organizations have found it better to remain in their own home area.

- **Charitable trust law.** States' charitable trust laws governing non-profit assets have inhibited some interstate transactions and movement of assets, even among non-profit partners.

Out of these obstacles, the most significant one has probably been the organizations' sense of their own missions; some of the other obstacles have diminished significantly over recent years.

Both religious and investor-owned systems, by contrast, have had compelling reasons to spread across wide geographies. Many religious systems were laid out, literally, along wagon train and railroad routes, often as congregations of religious sisters were asked to provide care in newly settled parts of the West. These institutions often predated the founding of secular non-profit hospitals as described above, resulting in many of today's remaining two-hospital towns.

The growth of investor-owned systems has been no less intentional. All investor-owned companies have an imperative to grow, and many have sought geographic diversification in order to mitigate risks of Medicaid funding and structure, economic base, and political attitudes toward for-profit healthcare.

Current Multi-State Non-profit Health Systems

In our survey of non-profit systems, we identified only five secular non-profit systems in the country that could be considered truly multi-state systems (and even these five could be debated). These comprise 119, or 7.5 percent, of all secular non-profit system hospitals (see **Table 1**). In an industry that, as described above, already has a highly unusual structure, this lack of aggregation by even successful secular non-profit systems is perhaps the most extraordinary aspect of that structure.

Table 1: Five Multi-State Health Systems

<u>System</u>	<u>Location</u>	<u>Revenue</u>	<u>Hospitals (Owned)</u>	<u>States</u>	<u>Formation</u>
Banner Health	Phoenix, AZ	\$4.7b	23(22)	AK=1, AZ=12, CA=1, CO=4, NE=1, NV=1, WY=3	1999 merger, Samaritan Health Services and Lutheran Health System
Carolinas HealthCare System	Charlotte, NC	\$4.4b	23(12)	NC=19, SC=4	Organic, founded 1940
Essentia Health	Duluth, MN	\$1.6b	15(15)	MN=10, WI=1, ND=1, ID=3	2004 Benedictine HS and SMDC HS; 2008 Innovis; 2010 Brainerd Lakes HS
Mayo Clinic Health System	Rochester, MN	\$8.8b	25(23)	AZ=1, FL=1, GA=1, IA=2, MN=13, WI=7	Organic, clinic founded 1892. System formed 1992
Sanford Health	Sioux Falls, SD	\$2.5b	33(23)	IA=3, MN=16, ND=5, SD=9	2009 merger, MeritCare Health System and Sanford Health

Source: American Hospital Association.

There are a number of other systems that have made incursions across state lines, such as UnityPoint Health and ProMedica, but such systems so far are not major players in their secondary state markets.

So, what features do these five systems possess that have provided the basis for their unique geographic presence? And what lessons can other systems learn from them that may lead to further combinations of secular non-profit systems?

First, and most obviously, all but Carolinas (which serves primarily Charlotte and its referral catchment area) serve rural areas to a significant degree rather than major metro markets. Indeed, Essentia, Mayo, and Sanford all serve the same region, the Dakotas and Minnesota. While Banner is tilted heavily toward the Phoenix market, the legacy Lutheran markets are rural and widely scattered.

Second, Banner, Essentia, and Sanford were the result of mergers between existing systems in different states. Two of the three systems forming Essentia are Catholic, but the inclusion of the secular Innovis Health in 2008 makes it worthy of consideration as a multi-state system.

Carolinas and Mayo appear to have taken similar paths to their present configurations. Each has absorbed smaller, stand-alone rural hospitals to create referral networks to their tertiary hubs. Indeed, Carolinas has “absorbed” its four South Carolina hospitals by contract-managing, rather than acquiring, them.

So, the common attributes of current multi-state secular non-profit systems would appear to be:

- Result from mergers of relatively similar-sized systems
- Serve a largely rural population
- Employ a range of transaction structures (purchase, lease, manage)
- Are relatively static once formed (i.e., don't then spin off markets that don't “fit”)

But are these systems models or outliers? Most systems do not have the brand name of Mayo. Many do not serve primarily rural populations. Almost none have received major gifts from a wealthy benefactor, as Sanford has.

Why More Are Coming

The dynamics set in motion by the ACA will likely result in a dramatic increase in the number and

size of secular multi-state non-profit systems over the next 10 years. Like most trends, this will begin slowly, then accelerate until a number of these organizations rival in scale those in the investor-owned and Catholic sectors.

Chief among these drivers are the desire for scale and the need to serve ever-larger populations. As investor-owned companies accelerate their consolidation (CHS and HMA, Tenet and Vanguard), mergers such as Catholic Health East with Trinity Health are also dramatically reshaping the landscape and increasing the minimum size considered necessary for long-term success. While most population health efforts to date are within individual states, these will broaden out, and direct-contracted, narrow network products with large employers will require coverage wherever the employer is.

Growth across state lines is also being facilitated by changes in the financing of capital projects. Not only are more municipal bond conduits able to issue bonds across state lines, the ever-increasing presence of institutional investors has created a preference for larger, more-diverse issues. The days of the local, stand-alone \$50 million muni issue are not gone, but they are surely numbered. Additionally, increasing use of taxable and non-asset-based financing will further lessen the ties to locality.

While the ACA is changing many aspects of healthcare funding, there remain benefits to diversification across multiple states. The range of exchanges and insurance markets across states will achieve varying degrees of success, and for many states Medicaid funding remains a challenge. Many systems in Illinois, for example, gaze fondly and rather jealously at their neighbors in Indiana and Wisconsin, whose Medicaid systems are much more generous to providers.

New organizational and transaction structures are enabling non-profit systems to expand across state lines more effectively than they have previously. Chief among these is the recent penchant of non-profit systems to joint venture with investor-owned companies to facilitate expansion as well as add management or clinical expertise.² Duke LifePoint, Aurora IASIS, and the Cleveland Clinic's affiliation with Community Health Systems are examples of non-profits partnering to expand beyond their

² James E. Burgdorfer, “Hospital Joint Ventures between Non-Profit and Investor-Owned Companies: Uses and Future Applications,” E-Briefings, The Governance Institute, November 2012.

traditional local bases. While these have so far resulted in one-off acquisitions, it would be a small step to expand the structure to facilitate system-to-system mergers.

Finally, there are increasing numbers of systems banding together for specific purposes, which may foretell a future merger. For example, there are a number of instances of non-profit systems in adjoining states collaborating on a unified managed care/population health strategy. If they partner effectively on the payer side, logic would suggest that a merger among the providers might be in the cards at some point.

Will this happen? The imperatives of growth and diversification are compelling in favor of a significant increase in large non-profit systems. Previous barriers, particularly relating to financing, are rapidly declining in importance. Attorneys general continue to play a key, and varied, role in transactions of all types (witness the opposition to Sanford's merger with Fairview in Minnesota this

past spring), but law and policy are likely to evolve over time.

Probably the largest remaining obstacle is the continuing sense of local mission. Having been founded locally, and usually still with local leaders on the boards, expansion within the home region is typically as much as seems appropriate for these systems. This is not a lack of vision, just a vision that has evolved in a sensible, linear path over time. Yet the discontinuities and challenges of the current environment may render this linear path ineffective, if not dangerous.

The trajectory of the hospital industry will encourage further consolidation. As independent community hospitals are joining systems in the current phase of this process, systems themselves will amalgamate in the next. Catholic and investor-owned systems are well attuned to this and are actively engaged in the process. Forward-thinking secular non-profit systems would be well advised to take out their atlases and see if there isn't an appealing partner in an adjoining state.

The Governance Institute thanks Barry Sagraves, managing director at Juniper Advisory, LLC, for contributing this article. He can be reached at bsagraves@juniperadvisory.com.