Ownership Form and Hospital Industry Consolidation

During the current decade, CEOs of many large non-profit systems have reported that the hospital industry is confronted with major systemic issues that can best be addressed by industry consolidation.

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These issues center on business complexity and capital demands. They argue that the structure (the number of business entities and their ownership form) of the hospital industry will likely change. At the same time, the meltdown of the U.S. financial system in the fall of 2008 ("Meltdown") is likely to profoundly affect business combination transactions, in terms of both transaction types and the ownership form of participants, for years to come. Because meaningful change in the structure of the hospital industry can only result from business combinations, the impact of the Meltdown on transaction options is an important topic for non-profit health systems to consider. This article describes two factors that will affect the extent to which industry concentration will occur in the future: the differing approaches taken to industry consolidation by various non-profit hospital groups, and the types of transactions that are likely to be available subsequent to the Meltdown.

Results of Business Combinations

In considering any impact ownership form may have on future levels of concentration in the hospital industry, it is helpful to consider the results of merger activity over the past twenty years.

Community sponsored 501(c) (3) hospitals entered into a large number of transactions during the 1990s in response to the advent of managed care. These were primarily cashless mergers and contractual arrangements between non-profits that resulted in the creation of regional networks. During the 2000s, community hospitals entered into a significant number of outright sales for cash, generally as a result of difficulty they experienced in accessing capital. These were often "conversions" (i.e., sales to for-profits, in which foundations were created by sellers). However, with only one exception, large interstate networks were not developed. A comparison of the 10 largest community hospitals in 1995 and 2007 reflects this lack of concentration. In 1995, the top 10 community hospitals listing (the 10 largest health systems in the community hospital category) had a total of 168 hospitals; in 2007, the total was 153 hospitals despite the fact that this sector's share of the total hospital business had remained unchanged over this period.

Faith-based hospitals, particularly those sponsored by the Catholic Church, created a number of large interstate systems in the 1990s through business combination transactions. Cashless transactions and contractual agreements were used to combine smaller Catholic and Adventist systems. These were the result of congregation issues (notably, the declining number of Sisters) and national strategies. Twelve large interstate systems were formed during this period, and only one of the 10 largest Catholic systems in 2007, Catholic Healthcare West, existed in its present form in 1995. The 10 largest Catholic systems controlled 227 hospitals in 1995; by 2007 this number had grown to 349. The proportion of *total* hospitals controlled by Catholic organizations, however, remained relatively unchanged, reflecting meaningful consolidation within this group.

For-profit hospitals focused on transactions with other for-profits during the 1990s via cash acquisitions and stock purchases. In the process, fifteen large interstate systems were built. Their attention shifted to cash acquisitions of non-profits in the 2000s, resulting in a slight shift in industry ownership. This interest in acquiring non-profit hospitals was driven by significant private-equity investment and the aggressive use of financial leverage. During both decades, financial engineering transactions (e.g., initial public offerings [IPOs] and leveraged buyouts) were popular. Over the past two decades, for-profit companies have changed from predominately public ownership in the mid-1990s to predominately private ownership in 2009, through the significant investment of private-equity companies that occurred in the late 1990s and early 2000s.

Today, the hospital industry has two extraordinary structural anomalies: tremendous fragmentation of business entities, and a highly concentrated price setting "mechanism." Juniper estimates the hospital industry has over 3,300 separate business entities, each of which is attempting to manage and finance an inherently complex business. Other industries of comparable size (5 percent of GDP) typically have 50 to 100 business entities. Meanwhile, the managed care industry has experienced significant concentration during the past two decades. We estimate that the federal government and 10 largest insurance companies, taken together, account for approximately 80 percent of payments for hospital care today.

The Meltdown's Impact

The Meltdown is affecting the hospital merger market in three ways: 1) the overall level of business combination activity has slowed and purchase prices for hospitals have declined, 2) certain announced transactions have failed to close due to failures of transaction financing, and 3) most *unusually*, stresses have been placed on agreed-upon transactions due to shrinking investment portfolios and escalating costs of terminating pension plans encountered by sellers.

We believe poor capital market conditions resulting from the Meltdown will affect the hospital merger market for many years. It is going to be difficult for potential buyers (both non-profit and for-profit) of hospitals to access the fixed income markets due to projected default rates on corporate debt that have not been seen since the Great Depression. Also, private equity appears to be wavering in its commitment to the hospital industry; in fact, several private equity firms have recently "pulled the plug" on their portfolio hospital companies. As a result, the ability of for-profits, in particular, to grow and foster consolidation could be significantly hampered.

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Future Use of the Merger Market

Non-profit hospital industry leaders concur that business complexity and capital intensity are driving the need for larger business entities and a more conventionally structured industry. However, given the experience of recent merger markets, as described above, two significant issues could stand in the way of such consolidation: governance factors associated with community hospitals, and the Meltdown's impact on the capital markets.

Community hospitals represent the largest number of business entities in the industry and some of its more successful companies. Community hospitals share much in common with other non-profit hospitals: they are confronted with the same fundamental business issues, both choose not to have an organizational focus on corporate development activities, and both have large volunteer boards. As a group, community hospitals are confronted with the need to both de-leverage and consolidate. However, they have been significantly less active than Catholic hospitals and for-profits in forming large interstate systems. Unlike community hospitals, Catholic systems have "shareholders" (the congregation) and a broader business and board perspective. This shareholder "discipline" and broader business perspective have served both Catholic and for-profit systems well.

In light of these competing objectives and the likely slow-down in for-profit activity, non-profits should focus their attention on certain transaction alternatives. The capital markets are altered as a result of the Meltdown and are likely to be very discerning regarding debt offerings by hospital companies. However, certain transaction forms can be used to implement business combination transactions without the use of financial leverage. For example, cashless mergers and member substitutions can result in effective business combination structures without the burden of financial leverage. Similarly, contractual means (such as joint operating agreements) are available to consolidate control, although they need to be very carefully structured to avoid the problems currently being experienced by the Health Alliance in Cincinnati, which is currently dealing with the departure of two of its participating entity hospitals.

Given the likelihood of a more conventionally structured industry in the future, we encourage community hospitals to consider expanding the local and regional focus of their boards. Long-term success could hinge on recognizing and acting upon the need for business scale and the means by which it can be achieved without significant financial leverage. In order accomplish this, significant change to board focus, mission, and overall thinking should be considered.

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