

The great consolidation: The potential for rapid consolidation of health systems

Executive summary

Over the last two decades, financial institutions, retail department stores, and airlines have seen a combination of market, regulatory, and competitive changes drive significant consolidation within their respective industries. In each instance, market drivers prompted industry participants to buy, sell, or merge with other entities to gain scale or enhanced capabilities that could enable them to more effectively compete.

It now appears that the health care industry may be on the verge of a similar transformation. Significant regulatory changes, technological innovations, and market dynamics are setting the stage for what may be a period of rapid consolidation among health systems¹. Looking at historical parallels can provide insight into what may transpire.

While consolidation typically includes traditional mergers and acquisitions (M&A), options such as joint ventures, affiliations, or collaborations could also prove attractive as health systems seek closer working relationships to enable their strategic choices. Note that consolidation can be either vertical (health systems acquiring medical groups) or horizontal (hospitals acquiring other hospitals); this article focuses on horizontal consolidation.

The shift from fee-for-service (FFS), volume-driven health care to outcome-focused, value-based care (VBC) likely requires health systems to make bold strategic decisions: differentiate through innovation, diversify, or manage a population's health risk. Few health systems have the financial and organizational wherewithal to "go it alone" and accomplish these strategies. Thus, conditions similar to those seen previously in other industries may be aligning to support a period of rapid consolidation.

How far might health system consolidation go? Using three approaches, Deloitte modeled an estimate of its potential. One approach modeled health system consolidation after the pattern witnessed in the banking industry from 1990 to

2000. The second approach assumed market share gains consistent with those seen by leaders in other industries during similar periods. The third approach extrapolated historical consolidation and performance trends among health systems. All three estimates independently converged at a similar potential outcome: approximately 50 percent of current health systems will likely remain after consolidation.

Health system consolidation should be pursued cautiously given heightened regulatory scrutiny. Additionally, other industry stakeholders may be wary, particularly health plans and consumers, who have, at times, seen prices rise as a result of consolidation. In fact, regulators did limit earlier periods of consolidation to address such concerns, although activity levels subsequently picked up once regulatory scrutiny eased. Similar starts and stops are expected in this latest wave of health system consolidation.

In the face of potentially rapid consolidation, health systems should consider a number of strategies and potential paths. Staying the course is no longer an option; organizations should prepare by either differentiating to maintain dominance in a clinical or geographic niche, or acquiring or aligning with other health systems. Those that do not act promptly and strategically may face major risks, including loss of significant market share or loss of local control as a result of being acquired.



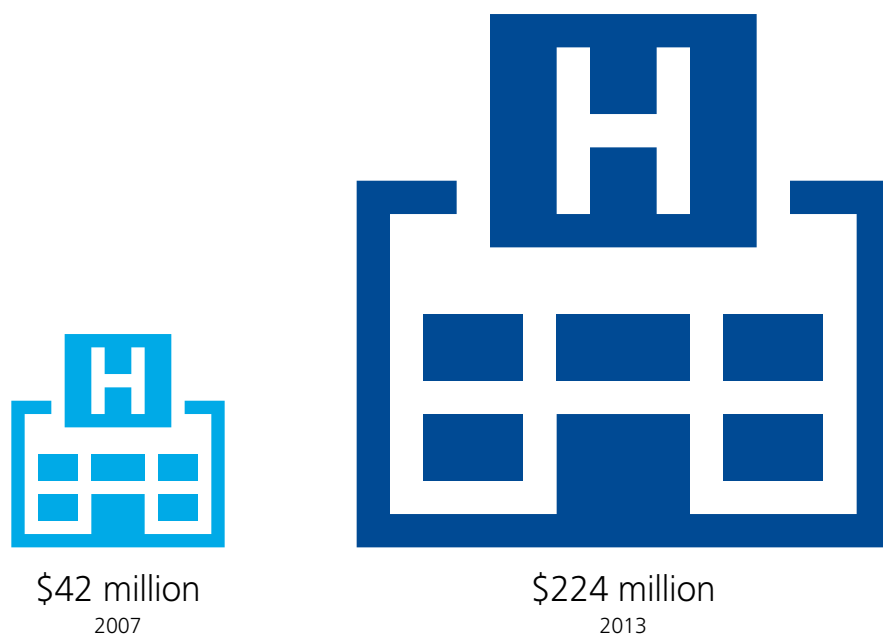
¹ Hospitals are truly becoming "health systems" and the term is used in this report to designate hospitals, except when referring to specific data points on hospital operations or licensure.

The case for consolidation: Why more is likely

Consolidation among health systems has been increasing in recent years, despite heightened regulatory scrutiny. From 2009 through 2013, hospital deal volume increased 14 percent annually.¹ Although the number

of deals decreased in fourth quarter 2013,² deal size is getting bigger (see Figures 1 and 2). In addition to larger acquisitions, there have also been major mergers, most notably the merger of Catholic Health East (CHE) and Trinity Health and their combined 82 hospitals, announced in 2012.

Figure 1. Average deal size for hospital acquisitions³



Source: Irving Levin Associates, The Hospital Acquisition Report 2014

Figure 2. Top three health system acquisitions since the start of 2013

Acquirer	Target	Dollar value of deal	Number of hospitals acquired	Date announced
Community Health Systems	Health Management Associates (HMA)	\$7.6 billion ⁴	71	July 2013
Tenet Healthcare Corporation	Vanguard Health Systems	\$4.3 billion ⁵	28	June 2013
Catholic Health Initiatives	St Luke's Episcopal Health System	\$1 billion ⁶	6	April 2013

Note: Based upon deals with cash consideration.

Market and regulatory forces can make it difficult for health systems to “go it alone.” A number of industry trends suggest that consolidation is likely to continue:

Credit outlook for the sector is poor. Each year since 2008 (including 2014), Moody’s has issued a “negative” credit outlook for not-for-profit health systems. Revenue growth in 2013 fell to a range of 3-3.5 percent, down from 5.2 percent in 2012.⁷ Additionally, expense growth (4.6 percent) has outpaced revenue growth, leading to tighter operating margins.⁸ Trends driving this poor outlook include the shift to outpatient care settings, declining reimbursement, and increasing cost pressures.

Technology and VBC investment needs are significant. Many health systems will require new technologies and capabilities to compete in a VBC environment, which can create considerable financial challenges. For example, Electronic Medical Record (EMR), ICD-10, and Meaningful Use initiatives require continued capital and talent investments for optimization efforts and process overhaul. In addition, VBC models call for closer alignment and coordination among health systems, physicians, and other providers in the care continuum. This may require capital for a supporting infrastructure (e.g., technology platform for data sharing, care coordination, and reporting).

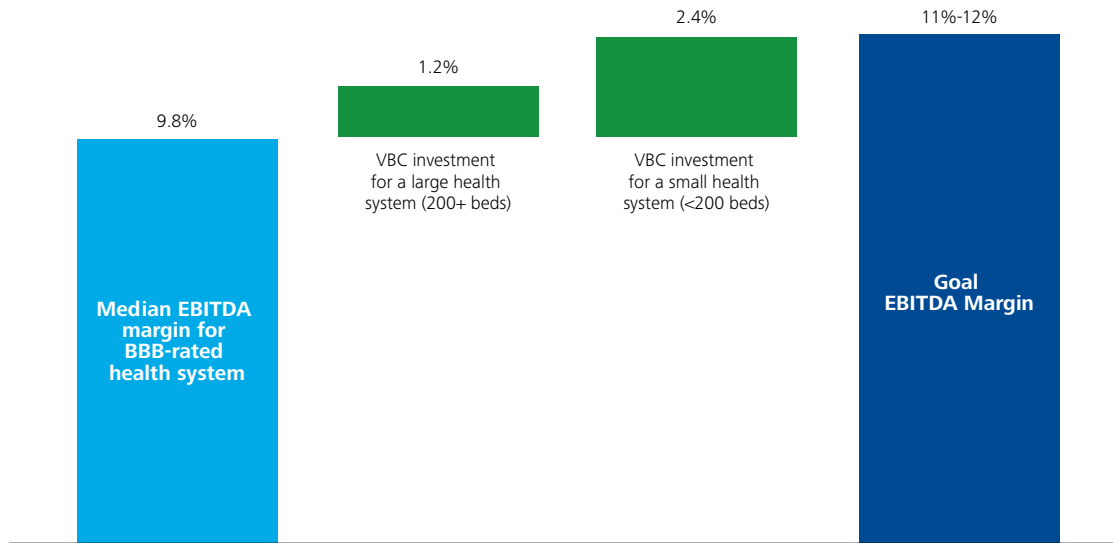
Few health systems have demonstrated themselves “invaluable” to stakeholders. As health care stakeholders – especially consumers, health plans, and employers – seek increased value and lower costs, many health systems may find themselves vulnerable to disrupted

referral patterns and revenue loss. While some health systems dominate local market share or have a unique market offering, many are unable to differentiate themselves enough from competitors – especially in the areas of quality and outcomes – to earn a place in health plan networks or command higher pricing.

Few health systems are aligned with providers along the continuum of primary to post-acute care. This may be another deterrent to growth, as 61 percent of surveyed consumers say they chose their health systems based upon doctor recommendation (51 percent based their choice on convenience/distance from home), rather than on quality.⁹ Having all the provider components in place might enable a health system to control the entire care for future VBC models (e.g., bundled payments). However, many health systems lack either the full continuum of components or the capability to integrate those components. Even as health systems increasingly acquired physician groups these past couple years, some failed to clinically integrate or financially align them in their organization.

Health systems often lack access to much-needed capital. Access to capital is important to address investment needs and to mitigate financial performance degradation. However, few health systems have the required steady, predictable cash flow to access the debt capital market at manageable rates; for a not-for-profit, this typically requires strong credit ratings and a minimum EBITDA in the 11-12 percent range (see Figure 3). Currently, 55 percent of health systems are below this target EBITDA.¹⁰

Figure 3. Projected minimum EBITDA needed to access debt at manageable rates¹¹



Note: Based upon U.S. not-for-profit health systems

In addition, some health systems have under-invested in building their VBC capabilities because some payers (health plans, Medicare and Medicaid, and employers) have not yet fully transitioned from volume- to value-based payment models. As the market shifts, these lagging health systems may require even more capital, thereby accelerating consolidation.

Potential paths to consolidation

This paper looks at four health system groups in the U.S. health system sector with the potential for horizontal consolidation (see Figure 4): large chains, mid-tier systems, Academic Medical Centers (AMCs), and small community health systems. Each of these groups has undergone consolidation in the past; generally to grow market share, add new service lines, or broaden

geographic reach. Many deals were intended to improve financial performance by reducing costs or gaining scale.

In the future, health system consolidation is likely to occur in three phases (see Figure 5), with organizations adopting four possible positioning approaches: The Innovator, The Aggregator, The Diversifier, and The Health Manager (see Figure 6). Each health system grouping will likely follow different paths; in addition, the landscape for each group is expected to change during each phase of consolidation.

Consolidation may consist of traditional acquisitions or alignment arrangements – joint ventures, affiliations, collaborations – as providers seek to enable the strategic choices they make as the market shifts to value-based care.

Figure 4. The health system landscape

Group	Description	Number of health systems ¹²
Large health systems/national chains	<ul style="list-style-type: none"> • 10+ hospitals • Multi-region or multi-state footprint 	80
Mid-tier health systems	<ul style="list-style-type: none"> • 2-9 hospitals • Local regional/metropolitan area footprint 	273
Academic Medical Centers (AMCs)	<ul style="list-style-type: none"> • Academically affiliated • Independent and multi-hospital systems • Local regional/metropolitan area footprint 	134
Small community health systems	<ul style="list-style-type: none"> • Independent • Located in urban, suburban, and rural markets 	1,346
Total: Non-government health systems		1,833

Figure 5. Phases of consolidation

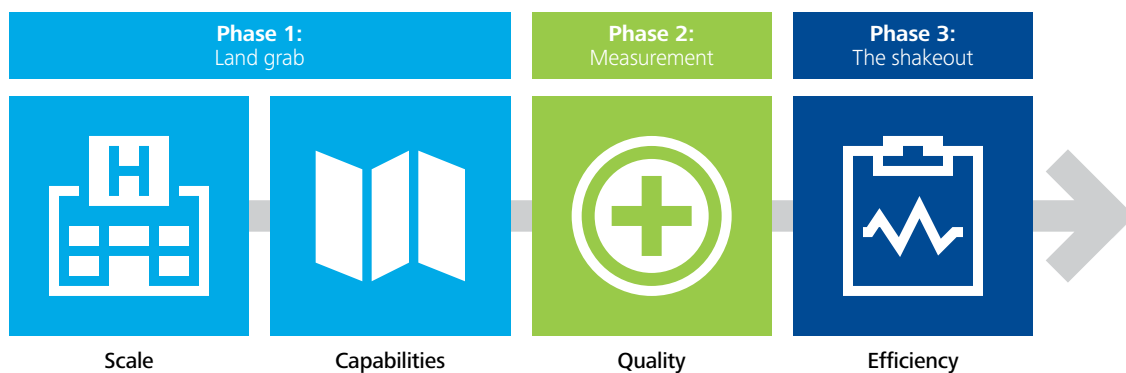
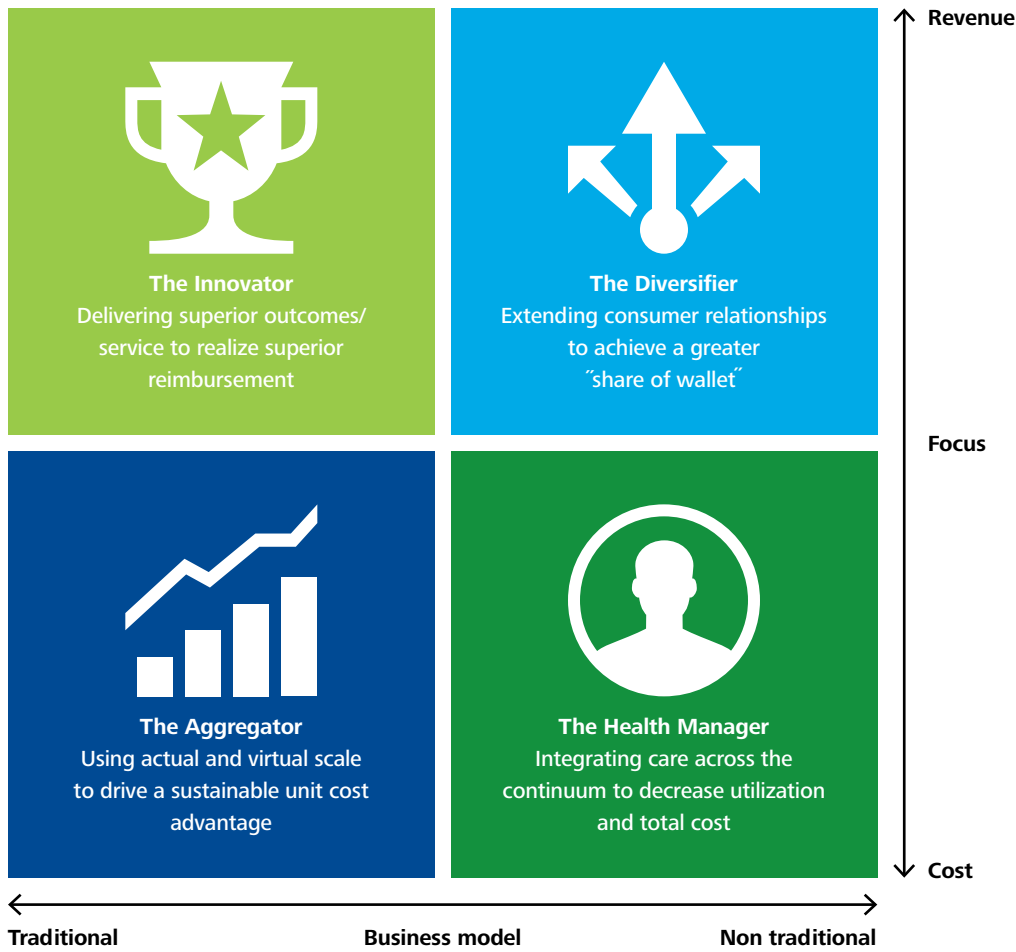


Figure 6. Possible positioning for consolidation



Phase 1: Land grab for scale and capabilities

Health systems already may be in the first phase of rapid consolidation, as evidenced by major deals like the 2013 merger (announced in 2012) of Catholic Health East and Trinity Health (now called CHE Trinity Health) and the more recent acquisition of Health Management Associates (HMA) by Community Health Systems. Larger systems and national chains have been getting bigger in order to improve financial performance, position themselves for

new health plan networks, and collaborate on quality and outcomes. Market share (measured in terms of net revenue) of the top 20 health systems grew from 21 percent in 2007 to 25 percent in 2012.¹³ Mid-tier health systems and AMCs have been acquiring independent health systems in their local markets to gain scale or enhance capabilities, such as expanding into geographies with an attractive payer mix or building VBC components.

Analysts expect the positive 2013 M&A trends to accelerate in 2014.¹⁴ Corporate and private equity leaders surveyed in 2014 also predict increased consolidation among health systems (20.4 percent named health care providers as the likely “most active sector for M&A” in the coming 12 to 18 months, second to 28.1 percent for the technology sector).¹⁵

Deloitte projects that health system M&A is likely to increase sharply during the next two years as the sector progresses through Phase 1 of rapid consolidation. Some mid-tier health systems may seek to use consolidation to demonstrate their value to payers or differentiate their offerings via dramatic cost efficiencies, high quality, or niche service offerings (Innovator or Aggregator approaches). Others may seek to control the whole care continuum (Diversifier or Health Manager approaches). Specifically:

- Large health systems and national chains may continue to expand their geographic footprint, gain scale, and gain efficiencies.
- AMCs and mid-tier health systems may be part of the land grab – acquiring other health systems in the region to gain scale and market share.

Small community health systems may be acquired by both large and mid-tier health systems.

Phase 2: Quality and outcomes measurement

During the second phase of rapid consolidation, all four marketplace approaches may be evident. As stakeholders continue to push for value, improved care quality and outcomes become more critical. Payment models that promote these attributes are likely to gain in adoption, including ones that offer financial bonuses for achieving certain goals. Conversely, financial penalties for poor quality or outcomes may become larger and more common. These penalties may significantly erode health system financial performance and contribute to consolidation.

Health systems with proven superior quality or outcomes, such as fewer re-admissions or lower utilization rates, might use value-based care bonuses to build financial strength (Innovator and Aggregator approaches), or invest in new or expanded capabilities (Diversifier and Health Manager approaches).

AMCs may be well-positioned in a quality- and outcomes-focused marketplace, given their strong reputation among consumers for their research and physician training programs, especially when compared to community health systems. AMCs with a strong market position and proven high quality and outcomes may seek consolidation with other top performers to gain additional capabilities and market share.

In contrast, health systems with inferior quality and outcomes, including AMCs, may experience more competition, financial stress, and heightened performance expectations from health plans and employers. For example, mid-tier health systems or AMCs that previously had strong financials despite inferior quality and outcomes could miss out on VBC bonuses, become squeezed financially, and find they are a stronger system’s acquisition target.

Phase 3: Price and quality shakeout

During health system consolidation's third phase, winners and losers may be evidenced by a price and quality shakeout in the market. Health systems may look to position themselves to deliver value to purchasers and coordinate population health activities, thereby gaining market share. Health systems that are able to produce superior outcomes, control costs, differentiate their offerings, or control the whole care continuum are most likely to gain market share. Those who cannot prove themselves invaluable to stakeholders may struggle, losing revenue and market share to their competitors. These sub-performing health systems may become a target for consolidation. In some markets, this phase is already occurring.

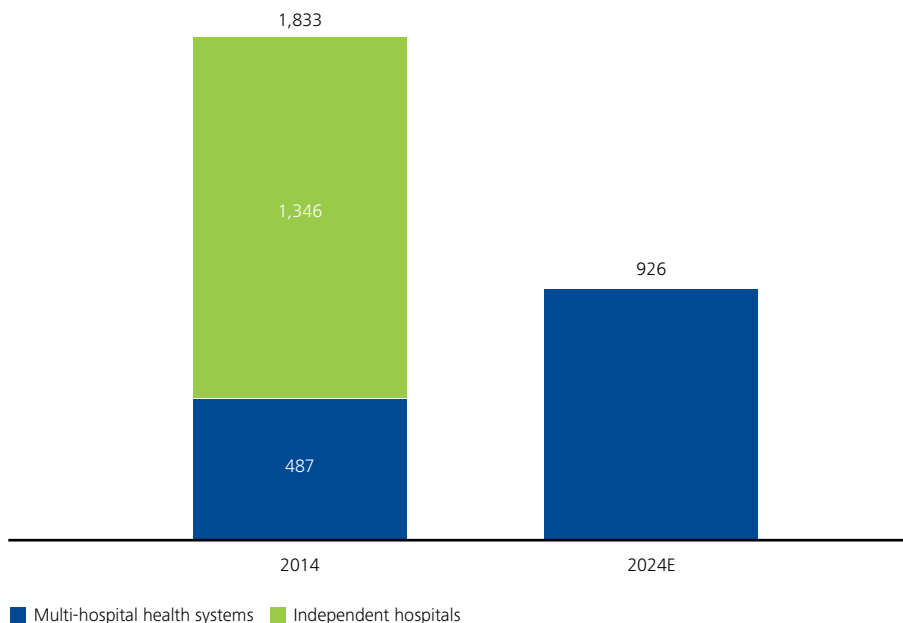
Some AMCs may be immune to value pressures if they are the only dominant health system in their regional market; however, this may not prove true for all. AMC costs are typically higher than community hospitals, so they risk being excluded from narrow networks or other health plan programs that align with higher-quality, lower-cost providers. Depending on payer-

provider market dynamics, some AMCs may have to play by the same rules as other health systems and compete on cost, triggering consolidation. In fact, consolidation is already occurring among AMCs, as seen in Northwestern Memorial Healthcare's recent purchase of Cadence Health¹⁶, a small system in its region, and the announcement of Banner Health's intent to purchase the University of Arizona Health Network¹⁷.

Consolidation projections

If horizontal consolidation continues during the coming decade, Deloitte's analysis – using three independent approaches where results converged – estimates that likely only 50 percent of today's unique health systems are expected to remain (see Figure 7). Additionally, there likely will be a larger number of hospitals per system. Consolidation may include traditional acquisitions, joint ventures, affiliations, and other collaborations, as providers seek closer working relationships to implement new financial and VBC models.

Figure 7. Projected consolidation: Number of health systems



Same story, different industries

Numerous industries have seen rapid consolidation in recent decades:



Retail department stores:

95 percent fewer U.S. department store chains are in operation today than in the 1960s.¹⁹



Airlines: 75 percent fewer U.S.

passenger airlines exist today compared to the 1970s.²⁰



Banking: 52 percent fewer

banks exist today in the U.S. than in 1990.²¹

Among these industries, banking offers useful comparisons to health systems. Both share the need for access to capital to fuel innovation, implement current technology, expand capabilities, address regulatory compliance, and stave off competition.

Historically, banking was highly localized, as is health care today. Twenty years ago, consumers primarily did their banking at local community or regional banks. Today, consumers often choose national banks because they offer more products and convenience (e.g., more local branches and online services). Banking has been highly regulated by both federal and state agencies, as are today's health systems. Finally, the banking industry's financial performance has been highly influenced by market forces, such as the economy and inflation, similar to many health systems today.

Of course, the two industries also are very different. For one, banks are primarily for-profit public companies and many health systems are not-for-profit.²² For another, the nature of the provided services and clients (payers) differ. However, banking provides an interesting case study of an industry that has gone through multiple waves of consolidation. Today, banking's top four companies own 63 percent of the market – in 2000, they only owned 41 percent²³ – and there are a third fewer banking institutions.²⁴

Two primary drivers sparked considerable banking industry consolidation from 1990-2000:

- **Market driver: savings and loan crisis.** In 1979, the Federal Reserve began increasing interest rates to address rising inflation. Savings and loan institutions – banks that specialize in collecting savings deposits and making long-term loans – were pinched by rising rates. Over the following years, margin compression, a lack of capital and – in some cases, fraud – led to the failure of more than 1,000 of the 3,000 savings and loan firms.²⁵
- **Regulatory driver: repeal of interstate banking regulation.** Until the Riegle-Neal Interstate Banking and Branching Efficiency Act of 1994, regulation limited the geographic expansion of banks and barred banks from moving across state lines. Riegle-Neal removed these constraints, enabling banks to grow their footprint and build geographic diversification.

These drivers led banks to consolidate to gain scale, access capital, reach new markets, and improve stability. During 1990-2000, in total, nearly 5,432 banks consolidated through failure, merger, or acquisition.²⁶ By 2000, there were 35 percent fewer banks than in 1990.²⁷

Figure 8 shows industry parallels that support the use of banking to underlie one of the three health system consolidation models.

Figure 8: Comparison of banking and health system industries

Feature	Banking in 1990	Banking in 2012*	Health systems in 2012*
Largest organizations' market share	<ul style="list-style-type: none"> • Number of organizations²⁸: 4 • Market share²⁹: 19% 	<ul style="list-style-type: none"> • Number of organizations³⁰: 4 • Market share³¹: 59% 	<ul style="list-style-type: none"> • Number of organizations³²: 20 • Market share³³: 25%
Player landscape	<ul style="list-style-type: none"> • Large national banks • Regional banks • Small community banks 	<ul style="list-style-type: none"> • Large national banks • Fewer regional banks • Fewer small community banks 	<ul style="list-style-type: none"> • Large national systems • Mid-tier regional health systems • Academic Medical Centers • Small community health systems
Significant market forces	<ul style="list-style-type: none"> • Economic downturn • Inflation rates • Technology (brick-and-mortar banks to ATMs) 	<ul style="list-style-type: none"> • Technology (ATMs, online and mobile banking) • Security and privacy • Inflation rates 	<ul style="list-style-type: none"> • Economic downturn • Increasing push for value by purchasers (employers and payers) • Enabling technology needs (e.g., care coordination systems)
Regulatory forces	Repeal of Interstate Banking Act	Financial reform	Affordable Care Act (reducing and changing payment model), HITECH Act (offering incentives to invest in health information technology)

* Note: Market share for health systems and banking reflects most-recent-year-available data, 2012.

As is the case for health systems, consolidation for banks has been cyclical. For example, during the 1990s and early 2000s, banks responded to increasing regulations and market pressures by consolidating: the largest banks got larger; regional banks were bought out; small savings and loans firms went under. Later, many banks which acquired others found they needed substantial capital infusions to build-out their technology infrastructure and product/service capabilities; this fueled further consolidation throughout the 2000s. Another round of consolidation occurred as many banks struggled financially during the 2007-2009 recession. Today, banks face numerous financial and regulatory pressures under Financial Reform, likely prompting some to again eye consolidation.

The new, consolidated world for health systems

Assuming the journey of health systems to horizontal consolidation is similar to that of banks, the future health care delivery system would look dramatically different than today's. Most independent health systems would no longer exist; instead, health systems would likely fall into the following three groups:

- 1. Diversifiers: National mega-health system operators/holding companies.** Post consolidation, these national systems may have holdings in even more parts of the country than they do today. Also, their independent financial and operational strategies at a regional level might roll up into those of the national holding company. Mega systems' main competitive advantage in a consolidated landscape may be scale – pushing out leading practices to each of their regions and dominating markets so they cannot be excluded by health plans. These systems also may excel if they have lower costs than competitors. Examples of national systems that may grow even larger through consolidation include:
 - National chains of standalone health systems (e.g., Community Health System, Tenet)
 - Multi-state Catholic systems (e.g., Catholic Health Initiatives, CHE Trinity Health)

- 2. Innovators/Aggregators/Health Managers: Regional health systems.** These mid-tier health systems may consolidate further in their region and more broadly in nearby markets. Differing from today's mid-tier health systems, these organizations may be more clinically integrated and encompass the whole continuum of providers from primary to post-acute care. Their main strategy in a consolidated landscape may be to position themselves to deliver value to purchasers and coordinate population health activities, thereby gaining market share in their regional market.
- 3. Specialists.** This group includes AMCs, single-service-line health systems (e.g., cancer, pediatrics, orthopedic, heart), Critical Access Hospitals, and non-hospital-affiliated, post-acute providers. Specialist health systems may be valuable to payers (health plans and VBC organizations like ACOs) because they offer unique offerings that produce leading outcomes for certain types of patients or conditions, or their brand evokes physician and consumer loyalty.

Implications

Consolidation is under way. Health systems should consider their course of action now if they hope to compete in a dramatically different future.

Consolidation may help health systems address a number of emerging challenges. For example, regulators' push for greater price and quality transparency from health systems may lead to a payment differential for higher quality. This, in turn, could generate new payment and delivery models that require more sophisticated supporting technology. Some health systems may seek consolidation to access capital for these needed technologies. In addition, employers and government payers continue to look for ways to reduce health care spending. Their efforts may put further pressure on health systems to cut costs and manage risk; those systems with more scale and leverage in their marketplaces – gained through consolidation – may be better able to react to this pressure.

However, there are some significant concerns with rapid consolidation. State and federal agencies have increased regulatory scrutiny of recent health system M&A – over 30 percent of cases across all industries the Federal Trade Commission (FTC) investigated from 2009 to 2013 were health-system related.³⁴ Regulators are concerned about consolidation’s effect on rising prices, despite efforts by health systems to mitigate the risk of insolvency. Also, health plans are critical of health system consolidation because of the increased bargaining power it can give health systems in contract negotiations – which, plans assert, may increase consumer prices. Health systems should consider regulatory scrutiny and perspectives from other industry stakeholders as they develop strategies to position themselves for the next wave of consolidation.

Finally, the success of previous health system consolidations has been mixed, with numerous organizations experiencing post-merger integration challenges arising from different cultures, technologies, and processes. Health systems should develop post-integration strategies that extend to infrastructure, processes, and talent to increase the probability of their long-term viability.

The bottom line

Facing the possibility of significant industry consolidation, health systems should consider preparing now for their future in a value-based world. Potential strategies include differentiating to maintain dominance in a clinical or geographic niche; or acquiring/aligning with other health systems. Those organizations that fail to act promptly and strategically may face major risks, such as loss of significant market share or loss of local control as a result of being acquired.

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Appendix

Deloitte's health system consolidation analysis included three approaches to project what horizontal consolidation might look like if it occurred in the U.S. health care market. The analysis included all for-profit and non-for-profit health systems and independent hospitals, except for federally owned facilities. There were 1,833 unique health system entities at the analysis's starting point. The three approaches independently converged on similar projections – a range of 45 to 52 percent – in the number of health systems remaining after consolidation.

Approach One: Application of other industry trends

Deloitte applied banking industry consolidation trends from 1990 to 2000 to the health care market. The result of this analysis was a 49 percent reduction in total health systems.

Approach Two: Top-down analysis

Deloitte assumed that market share gains by the top four health systems would be consistent with market share gains seen by leaders in other industries during similar periods. Using consolidation and subsequent market share trends of the top four banks from 1990 and 2010, market share trends for top players in other industries (such as airlines), and market share trends among health systems, assumptions were made to project consolidation by the large health systems. The result of the analysis was a 52 percent reduction in total health systems.

Approach Three: Bottom-up analysis

Deloitte extrapolated historical consolidation and performance trends among health systems. This included projections for what would happen if independent hospitals and mid-tier health systems either merged with each other or were acquired by larger health systems. Based upon the independent and mid-tier health systems' operating margin, assumptions were made using financial performance and past consolidation trends. For example, historical trends in the number of independent hospitals were extrapolated forward, and trends in the number of hospitals with negative operating margins were included in projections of those likely to be acquired. The result of the analysis was a 45 percent reduction in total health systems.

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