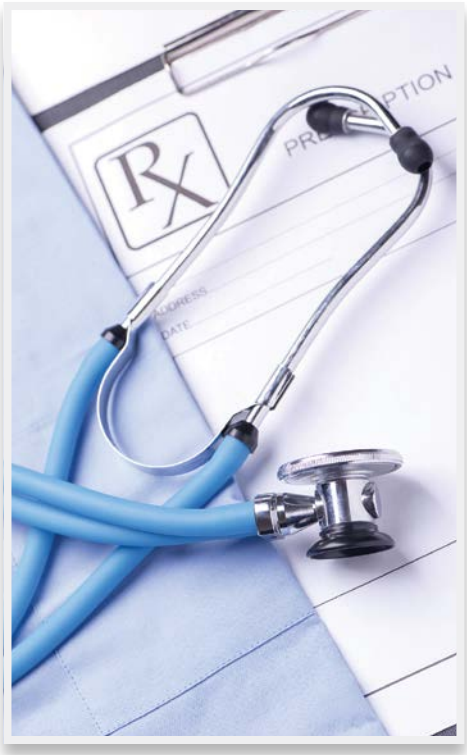
Hospital Industry Structure: Considering the Impact of the Affordable Care Act

BY JAMES BURGDORFER, JUNIPER ADVISORY

In its 2010 Governance Institute white paper, Juniper Advisory described the ownership structure of the hospital industry in anticipation of the impact of healthcare reform and the Affordable Care Act (ACA) on hospital consolidation.[1] Leading up to enactment of the ACA, health policy experts had concluded that the U.S. healthcare delivery system was consuming too great a share of the economy. Essentially, the industry was viewed to be too expensive for the country and patients, and providing mediocre health outcomes. These factors were the economic rationale for healthcare reform and, eventually, implementation of the ACA.

In 2010, the ACA was viewed to have two primary objectives: control the cost of healthcare and provide improvements to the healthcare system including expanding the number of people with insurance coverage and adding safeguards for patients. The hospital industry believed that the ACA would impact the economics of the industry in two fundamental ways. First, the cost of doing business would increase as the industry moved from fee-for-service to a value-based structure. Second, reimbursement would decline as Medicare rates were reduced.

As a result, it was believed that the ACA might significantly increase consolidation between hospitals and result in the creation of larger systems of care so as to achieve economies of scale. Juniper felt this could result in more transactions, larger transactions, interstate transactions, and more transactions involving non-profit buyers. Further supporting the notion of creating larger companies, evidence suggested that better health outcomes were achieved by larger organizations that were able to devote greater resources to standardizing protocols. Now, more than six years into the ACA, and at the beginning of likely change to it, it is useful to consider the impact of the ACA on the ownership of the industry and its level of concentration.



1 James Burgdorfer et al., *Hospital Consolidation Trends in Today's Healthcare Environment* (white paper), The Governance Institute, Summer 2010.

Key Board Takeaways

As boards think about the impact of the ACA on the ownership and structural concentration of the hospital industry, the following points are important to consider:

- There has been only a moderate level of business combination activity since 2010. However, there have been two significant changes to structure: the proportion of hospitals that are part of a multi-hospital system has increased to 65 percent, and there are now fewer companies (1,890) in the hospital industry.
- Multi-hospital systems remain small, less than six hospitals per system. There continue to be dramatically more companies than in similar-sized major industries.
- There has been significantly more business concentration in the non-hospital sectors of healthcare services: insurance, pharmaceutical, and devices.
- The proportion of hospital boards that are considering independence has grown from 15 percent to 80 percent. Only investor-owned and Catholic-sponsored hospital companies have combined into large companies. Both of these ownership forms have boards that are appointed by, and accountable to, owners.

Impact of the ACA on Hospital Industry Structure

This section updates the hospital industry's structure since our 2010 analysis and considers changes since implementation of the ACA. In 2010, we reviewed the various ownership forms, the trends in horizontal consolidation, and the size of companies that comprised the hospital industry. In this article, we update that information through 2016 and provide a first look at the impact of the ACA on industry ownership and concentration.

The information on hospitals in the American Hospital Association (AHA) database is focused on facilities. As a result, an understanding of the commercial structure of the industry is accomplished through considering, in sequence, the number and type of hospital facilities, the development of hospital systems and companies, and the size and nature of these companies.

The data on hospital *facilities* provides basic information on the number of individual hospitals and their ownership forms. The information concerning the development of hospital *systems* provides further insight into the overall ownership and control of the industry. The data on hospital *companies*, describes the formation of business entities in the industry and their access to capital and relative size.

Hospital Facilities

As noted in 2010, several features of the AHA database necessitated adjustment to fit these goals:

- Certain facilities included in the AHA data categorized as "other" have business characteristics that differ from general acute care hospitals. These include long-term acute care, psychiatric, and Veterans Affairs hospitals. We eliminated these from the data in the charts below so as to focus on the general acute care hospital industry only. We believe this provides a more accurate picture of the hospital business.
- Similarly, the AHA data concerning investor-owned facilities includes long-term acute care, psychiatric,

behavioral health, and specialty hospitals. For the same reason, we excluded these from the data.

- The AHA groups academic, local government, and 501(c)(3) systems into one "non-profit" category. We believe the majority of these are 501(c)(3) community hospitals. The majority of local government-owned systems are single hospitals, and most academic systems, at least at present, are freestanding facilities.
- Religious-sponsored facilities tend to be part of systems. We believe the number of stand-alone religious-sponsored facilities is insignificant.

Table 1 reflects changes in the number of general acute care and critical access hospitals, as reflected by provider numbers, over time and by ownership type. It also indicates the proportion of all hospitals held by each ownership group.

Overall, there was no meaningful change in the ownership structure of the hospitals during the 2008–2016 period. The gradual decline in the total number of hospitals over the past 20 years continued through 2016. The largest declines have occurred during periods of externally stimulated consolidation (i.e., in the mid-1990s and during the ACA years). Community 501(c)(3) non-profit hospitals had the largest proportionate decrease between 2008 and 2016 (11 percent) due to consolidation and closures of very small hospitals.

The number of investor-owned general acute care hospitals increased slightly during the 2008–2016 period, after declining slightly during the 1995–2008 period. However, there are fewer well-capitalized and investor-owned companies in 2016. Also, this sector's participation in M&A transactions is declining.

Table 1: Hospital Facilities

Ownership	1995	2000	2005	2008	2013	2016
501(c)(3) non-profit hospitals[1]	2,507	2,341	2,295	2,265	2,079	2,015
Proportion of total hospitals	50%	50%	50%	50%	47%	47%
Governmental hospitals	1,350	1,163	1,110	1,105	1,068	971
Proportion of total hospitals	27%	25%	24%	24%	24%	22%
Faith-based hospitals	585	662	663	658	667	726
Proportion of total hospitals	12%	14%	15%	15%	15%	17%
Total non-profit hospitals	**4,442**	**4,166**	**4,068**	**4,028**	**3,814**	**3,712**
Proportion of total hospitals	88%	89%	89%	89%	87%	86%
Total investor-owned hospitals	**589**	**514**	**514**	**513**	**574**	**618**
Proportion of total hospitals	12%	11%	11%	11%	13%	14%
Total hospitals[2]	5,031	4,680	4,582	4,541	4,388	4,330

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.
Notes:
1. Includes community 501(c)(3) and academic hospitals.
2. General acute care and critical access hospitals only. Long-term acute care, Veteran Affairs, and other specialty hospitals excluded.

Table 2: Change in Hospital Facilities

	1995	2000	2005	2008	2013	2016
Total hospitals	5,031	4,680	4,582	4,541	4,388	4,340
M&A market						
Announced transactions	128	86	50	60	100	90
Avg. number of hospitals per transaction	NA	1.5	1.8	1.3	2.5	1.2
Total hospitals involved	**NA**	**132**	**88**	**78**	**247**	**111**

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 2 describes the source of change in the number of hospital facilities.

The majority of change resulted from M&A transactions. Net hospital closures have not played a significant role in consolidation. However, it is possible that closures could increase somewhat in the foreseeable

Table 3: Hospital System Development

	1995	2000	2005	2008	2013	2016
Total hospitals	5,031	4,680	4,582	4,541	4,388	4,330
Total hospital systems	253	266	314	330	362	386
Hospitals in systems	2,040	2,291	2,387	2,488	2,482	2,825
Hospitals per system	8.1	8.6	7.6	7.5	6.9	7.3
Proportion of hospitals in systems	41%	49%	52%	55%	57%	65%
Independent hospitals—*not* in a system	2,991	2,389	2,195	2,053	1,906	1,505
Proportion of hospitals not in systems	59%	51%	48%	45%	43%	35%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 4: Ownership of Hospital Systems

	1995	2000	2005	2008	2013	2016
Non-profit systems						
Community 501(c)(3) and governmental	162	195	244	264	297	324
Faith-based	71	56	55	51	50	47
Catholic	57	45	42	39	35	33
Other	14	11	13	12	15	14
Total non-profit systems	**233**	**251**	**299**	**315**	**347**	**371**
Total investor-owned companies	**20**	**15**	**15**	**15**	**15**	**15**
Total non-profit and investor-owned systems	**253**	**266**	**314**	**330**	**362**	**386**

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

future as struggling hospitals might have difficulty finding partners. Despite much commentary to the contrary, the number of announced M&A transactions increased only slightly during the 2008–2016 period. The size of transactions, measured by the number of hospitals involved, has also been consistently small over this period, averaging approximately one-and-one-half hospitals per transaction. The only exceptions were during years when the data were impacted by large transactions amongst investor-owned companies.

Hospital Systems

Table 3 reviews the development of multi-hospital systems. These include non-profit and investor-owned general acute care systems.

This is the first data that can be used to assess the overall level of *business concentration* in the industry. The proportion of hospitals that are part of systems is one measure of such concentration. During the 2008–2016 period there was gradual concentration of the hospital industry. The proportion of hospitals that are part of systems increased from 55 percent in 2008 to 65 percent in 2016. This increase in concentration has been occurring at a relatively consistent pace over the past 20 years. The business entities, themselves, have not become larger. In fact, as measured by the number of hospital systems, they have become slightly smaller.

Table 4 describes the development of multi-hospital systems by ownership type.

In continuing to assess the development of multi-hospital systems between 2008 and 2016, we consider which types of non-profit hospitals have been most inclined to consolidate (i.e., by either forming or becoming part of multi-hospital systems). Over this period, the number of community 501(c)(3) systems grew by 15 percent. The number of Catholic-sponsored systems shrank by 15 percent, primarily as a result of intra-Catholic mergers. These resulted in fewer, but larger Catholic systems. The number of investor-owned companies remained constant. However, there has been considerable

consolidation amongst large publically held investor-owned companies.

Tables 5–9 describe the development of multi-hospital systems by *ownership type.*

Table 5 describes the development of community 501(c)(3) systems.

During the 2008–2016 period, the number of multi-hospital systems increased by 23 percent and the proportion of all acute care hospitals in systems increased to 35 percent. However, the size of these systems, as measured by number of hospitals, shrank slightly.

Next we consider the development of Catholic-sponsored systems since 1995 (see **Table 6**). Non-Catholic faith-based systems are not a significant group from a national point of view.

During the 2008–2016 period, smaller Catholic systems continued to merge into large Catholic systems. The proportion of total systems that are Catholic declined in the 2000s. The proportion of total hospitals that are sponsored by the Catholic Church increased slightly. The size of Catholic systems, as measured by numbers of hospitals, continued to increase. We suspect that this is attributable to a strong sense of ownership and commonality of purpose that is present in Catholic systems.

We summarize the development of *all non-profit systems* in **Table 7**.

Between 2008 and 2016, the number of all non-profit systems increased by 18 percent, although the number of hospitals that were part of these systems grew by only 2 percent. The proportion of all hospitals that are part of a non-profit system increased from 43 percent to 51 percent. However, the number of hospitals per system shrank from 6.3 to 5.9.

Table 8 reviews the development of *investor-owned systems.*

The investor-owned sector has not been growing. Investor-owned companies are, however, much larger, measured by number of hospitals, than any of the non-profit system groupings. The investor-owned companies average 40.3 hospitals per system versus 5.9 hospitals per system for all non-profits. Again, one would attribute this to board decisions that reflect the fact that ownership nominates board members of investor-owned companies.

Table 9 (on the next page) reviews the development of *all systems*, both non-profit and investor-owned.

Table 5: Community Systems

	1995	2000	2005	2008	2013	2016
Community 501(c)(3) and governmental systems	162	195	244	264	297	324
Hospitals in community systems	866	1,115	1,210	1,317	1,270	1,506
Hospitals per community system	5.3	5.7	5.0	5.0	4.3	4.6
Proportion of all systems that are community systems	64%	73%	78%	80%	82%	84%
Proportion of all hospitals in community systems	17%	24%	26%	29%	29%	35%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 6: Catholic Systems

	1995	2000	2005	2008	2013	2016
Catholic systems	57	45	42	39	35	33
Hospitals in Catholic systems	488	560	555	556	521	588
Hospitals per Catholic system	8.6	12.4	13.2	14.3	14.9	17.8
Proportion of all systems that are Catholic systems	23%	17%	13%	12%	10%	9%
Proportion of all hospitals in Catholic systems	10%	12%	12%	12%	12%	14%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 7: All Non-Profit Systems

	1995	2000	2005	2008	2013	2016
Non-profit systems	233	251	299	315	347	371
Hospitals in non-profit systems	1,451	1,777	1,873	1,975	1,908	2,207
Hospitals per non-profit system	6.2	7.1	6.3	6.3	5.5	5.9
Proportion of all systems that are non-profit	92%	94%	95%	95%	96%	96%
Proportion of all hospitals in non-profit systems	29%	38%	41%	43%	43%	51%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 8: Investor-Owned Companies

	1995	2000	2005	2008	2013	2016
Investor-owned companies	20	15	15	15	15	15
Hospitals in investor-owned companies	589	514	514	513	574	605
Hospitals per investor-owned company	29.5	34.3	34.3	34.2	38.3	40.3
Proportion of all systems that are investor-owned companies	8%	6%	5%	5%	4%	4%
Proportion of hospitals in investor-owned companies	12%	11%	11%	11%	13%	14%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 9: All Systems Combined

	1995	2000	2005	2008	2013	2016
Hospital systems	253	266	314	330	362	386
Hospitals in systems	2,040	2,291	2,387	2,488	2,482	2,825
Hospitals per system	8.1	8.6	7.6	7.5	6.9	7.3
Proportion of all hospitals in systems	41%	49%	52%	55%	57%	65%

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 10: Hospital Companies

	1995	2000	2005	2008	2013	2016
Hospital systems	253	266	314	330	362	386
Independent hospitals	2,991	2,389	2,195	2,053	1,906	1,505
Total hospital *companies*	3,244	2,655	2,509	2,383	2,268	1,891

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 11: Largest Hospital Systems—2015

10 Largest Hospital Systems	Total Revenues in Billions	Market Share	Tax Status	Debt Rating
HCA	$39.7	4.0%	IO	Ba2
Ascension Health	$20.5	2.1%	NP	Aa2
Community Health Systems	$19.4	2.0%	IO	B2
Tenet Healthcare	$18.6	1.9%	IO	B2
Catholic Health Initiatives	$15.0	1.5%	NP	Baa1
Trinity Health	$14.7	1.5%	NP	Aa2
Providence Health	$14.4	1.4%	NP	Aa3
UPMC	$12.8	1.3%	NP	Aa3
Dignity Health	$12.6	1.3%	NP	A2
Sutter Health	$11.0	1.1%	NP	Aa3
Total, 10 Largest Hospital Systems	**$178.7**	**18.0%**	-	-
Hospital industry, aggregate	$994.0			

Sources: Company Web sites, audited financial statements, credit rating agencies, Juniper estimates.
IO = investor-owned, NP = non-profit

The total number of hospital systems and their proportion of all hospitals has increased since the late 1995. However, the number of hospitals per system is stagnant, indicating that hospital systems, on average, remain relatively small businesses.

Hospital Companies

In order to better understand the extent to which control has become more centralized, we next consider changes to the number of business entities or *companies* in the hospital industry (see **Table 10**). By combining the number of independent hospitals with the total number of systems, we approximate the number of businesses (i.e., entities under discrete ownership and governance control). Between 2008 and 2016, the number of companies continued to decline through consolidation; however, there are still nearly 1,900 companies with distinct boards of directors and managements making up the general acute care industry.

Table 11 lists the 10 largest hospital companies by size, as measured by revenues, and market share. Consolidation has caused the share of market occupied by the 10 largest companies to increase from 15 percent in 2008 to 18 percent in 2015.

The hospital industry has one market leader, in terms of size, which commands only 4 percent of industry revenue. By comparison, the leaders in the airline and banking industries occupy 22 percent and 23 percent of their industries, respectively. Frequently, more than half of the top 10 competitors in any given industry are of relatively comparable size. However, Ascension, HCA's largest competitor, is only one-half the size of HCA in terms of revenues. Historically, such comparisons have been viewed to be less important in the hospital industry due to local and regional, rather than national market characteristics, and lack of international markets.

Market leaders of most major industries have access to capital, which is significantly better than that experienced by even the leading hospital companies. In every mature major industry except the hospital industry, the leading companies have access to both equity and debt markets. Access to debt is characterized by strong investment grade ratings and the ability to issue debt in most of the major global markets and, also, be able to issue commercial paper and medium-term notes.

There are no hospital companies, non-profit or investor-owned, with this sort of access to capital. Approximately 40 percent of non-profits have strong credit ratings and good access to debt, although limited to municipal bond, private institutional, and bank markets. None, of course, have access to equity. Currently, *no* investor-owned companies have investment-grade ratings, and only five are publically held.

Observations

As noted in our 2010 review, there was only modest change in the ownership and concentration of the hospital industry from 1995 to 2008. This article describes the impact of the first six years of the ACA, through 2016, on consolidation. Some notable findings include:

- Despite references to enormous levels of merger activity among hospitals, the pace of announced combinations was only moderate during the entire period, and well below levels experienced in the mid-1990s.
- However, there has been an increase in the systemization of hospitals. More hospitals are now part of multi-hospital systems (65 percent in 2016, versus 55 percent in 2008). The size of these systems has not increased since 2008 and, on average, they remain small businesses.
- An increasing proportion of hospital M&A transactions feature non-profit buyers. As a result, there have been more

mergers and fewer asset acquisitions during the first years of the ACA.
- Only Catholic-sponsored and investor-owned hospital systems have combined into significantly larger companies. We believe this is due to the presence of, and accountability to, "owners" for these two groups.
- There have been no large interstate combinations between non-profit systems.
- Academic hospitals are beginning to expand by acquiring non-profit hospitals in their region.
- Despite some consolidation, there remain nearly 1,900 separate business entities, and the largest companies are small compared to their peers in other industries.

Despite references to enormous levels of merger activity among hospitals, the pace of announced combinations was only moderate during 2008–2016, and well below levels experienced in the mid-1990s. However, there has been an increase in the systemization of hospitals.

The nature and tone of the merger market has been impacted as hospital companies struggle with the implications of healthcare reform and the ACA:
- Increasingly, boards of hospitals are considering independence. Approximately 80 percent of independent hospitals and small systems were doing this in 2016, up from 15 percent in 2008. As a result, it has become much more acceptable for boards to acknowledge, often publically, that they are considering the topic.
- There has been a very significant increase in the number of affiliations and alliances. These are contractual arrangements in which no ownership or control is exchanged. They have been occurring at the rate of several hundred per year recently.
- The significant growth in acquisitiveness by larger non-profits has resulted in many new participants in merger transactions.
- Transactions are taking considerably more time to complete and are more fragile.
- Mergers involving government-owned hospitals have been burdened with political disputes. As a result, this sector of the industry is changing very slowly.
- We sense that there is a bias towards combining through pre-packaged bankruptcies as hospitals approach the "zone of insolvency."
- The health insurance industry has continued to consolidate. Fewer than 10 companies comprise the majority of the health insurance market.

The ACA had two primary objectives: lowering the cost of healthcare and improving coverage and protection. Little progress has been made on the first objective; the cost of healthcare continues to consume more than 16 percent of GDP.

The ACA has made significant progress on the second objective as 20 million additional people have health insurance coverage and improved protections are in place. Regardless of what happens to the ACA itself, the industry continues to move towards value-based care and reimbursement. As a result, new ways and structures will need to be found that will enable it to deliver care more efficiently.

The negative impact of the industry's fragmented structure on efficiency and effectiveness has been well-documented. Other major industries with characteristics similar to the hospital industry (i.e., commercial complexity, capital intensity, and heavy regulation) have fewer and larger companies. Only a few urban markets (e.g., Cleveland, Denver, and Dallas) benefit from strong larger companies. Many continue to ask why the industry remains so fragmented.

The hospital industry, uniquely, has evolved from a complex and interrelated set of mission and commercial objectives, but the determinants of success have changed enormously. In the past, the hospital industry's local approach and fragmented structure fitted the needs of the market and were consistent with its transportation, commercial, and reimbursement characteristics. This evolution along with the governance structure of the community non-profit hospital industry plays a large role in its resistance to structural change. **In our view, the conflict between the exigencies of reform versus the governance preference for independence is the largest factor facing the industry today.**

In addition, the lack of structural change in the past six years was partially the result of strict antitrust enforcement by the FTC, and strong demand from the municipal bond market. In 2010, many observers thought that the municipal bond market would be less willing to buy small issues of small hospital companies. Surprisingly, this was not the case. Also, historically low interest rates during the period enabled many hospital companies to remain independent.

Given all of the factors described above, it is hard to predicate the future pace of consolidation. We believe it is likely that business combinations will continue at a moderate level and that they will likely continue to be hard to complete. Should any of several things happen, however, the potential for *disruption* of the industry exists. First, significant change in the capital markets could cause an increase in consolidation. This would most likely be in the form of dramatically higher interest rates or a substantial decrease in demand from the municipal market due to changes in income tax policy. Also, potential repeal-and-postpone scenarios could cause significant economic stress on hospital financial performance with the same result. Should insurance companies be granted the ability to sell policies across state lines, large community non-profits might actively consider interstate business combinations. This sort of growth might be less likely to meet with FTC resistance than has been the case with mergers in contiguous markets.

We are optimistic that the industry will encourage innovative thinking and pave the way for the strong organizations that can provide healthcare in new and unique ways, regardless of ownership, location, size, or other factors addressed in this article. We hope this updated review is of help to industry participants as they consider industry trends, strategic responses, and market positions in order to reach the best conclusions for their communities and patients.

The Governance Institute thanks James Burgdorfer, Principal with Juniper Advisory, for contributing this article. He can be reached at jburgdorfer@juniperadvisory.com.