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Assessing Independence

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Several recent surveys indicate that nearly 80 percent of non-profit hospital boards are assessing their independence. This means they are determining whether to affiliate, combine, or remain independent. Only 15 percent of boards were considering this a few years ago. This is the Affordable Care Act's (ACA) greatest impact on non-profit hospital boardrooms today, and much more so than the "flood" of mergers widely described in periodicals.

In September 2014, a *New York Times* article described the FTC's wariness of mergers amongst hospitals.[1] In this, an economist suggested that the ACA has "unleashed a merger frenzy" and that she saw antitrust enforcement as a tool to slow the "march toward conglomeration." Perhaps these assertions were intended to be forecasts. In any event, they are very common misstatements. In fact, mergers are being completed at a tepid rate of 70 to 80 small transactions per year, far below the annual rate of nearly 150 in the early and mid-1990s. The hospital industry remains the most fragmented major industry in the U.S.

This article focuses on the disconnection between the much-discussed and presumed impact of the ACA, or the "merger frenzy," and actual market developments. The significance of the large proportion of hospitals that are considering their independence has been largely ignored, along with most of the issues associated with this. As a starting point, we will review the reasons boards are studying their independence, the approaches they are taking, the role of governance, and common missteps that are occurring.

Why Assess Independence?

The reasons for considering independence have changed significantly over the past 25 years. In general, pursuit of this topic has gone from a sign of weakness by a relatively few financially challenged hospitals, to a widely accepted and prudent approach being conducted by the majority of hospitals.

During the early and mid-1990s, the emergence of managed care produced a perceived need to create larger regional systems. Many boards considered independence as a result of this objective and it drove most of the combinations during this period. It resulted in the most active hospital merger market of the past 25 years, reaching a peak of nearly 200 transactions in 1997. Despite this, far fewer hospitals were considering independence during this time period than today.

In contrast, during the early and mid-2000s, financial challenges made it difficult for many mid-sized hospital companies to raise capital. This was the motivation for considering independence and entering into business combinations. Combinations occurred at a greatly reduced rate, approximately 30 to 50 per year.

Over the last few years, the primary motivation for considering independence and combinations has been the ACA, specifically the need for economies and efficiencies associated with scale. The external and pervasive nature of the ACA accounts

[1] Robert Pear, "FTC Wary of Mergers by Hospitals," *The New York Times*, September 17, 2014.

for the dramatic increase in the proportion of hospitals considering independence. However, as mentioned earlier, this has not resulted in a significant increase in the number of completed combinations or any change in the fragmented structure of the industry.

In addition to the business attributes of scale, there are new and added factors causing some to consider independence. These center on the growing evidence that quality and safety can be improved via the replication and standardization associated with larger companies. Also, dynamics in certain markets (e.g., narrow network formation, physician recruitment and behavior, and existential risks in states without Certificate of Need laws) are stimulating certain hospitals to consider independence.

Responses of Participants

The current merger market began three to four years ago as passage of the ACA became likely. It features mid-sized hospital companies considering whether to become part of larger companies by affiliating or combining, and larger multi-hospital systems seeking growth through acquisitions. Beyond these generalizations, the ACA's impact on independence varies significantly by type and size of hospital, as follows:

- **Mid-sized hospitals**, those with approximately $100 million to $700 million in net patient revenue (NPR), are actively considering independence, as described herein, but not yet entering into large numbers of combinations. As a group, these hospitals are more strategically motivated and their boards are less interested in the creation of foundations than in the past.
- **Large systems**, those with more than $2 billion in NPR, have become very acquisitive in an effort to achieve scale. Correspondingly, they are developing much greater skill in business combination transactions. Their response to acquisition opportunities has improved noticeably and they are more often commercially reasonable in the transaction terms that they propose.
- **Intermediate-sized systems**, those with approximately $1 billion in NPR, are the most enigmatic group. It is difficult for them to decide how to respond to the ACA. Often, they are too large to, at least so far, consider joining a larger company, but too small to be a successful consolidator. As a result, this group is experiencing the least structural change.
- **Small hospitals**, those with $50 million in NPR and less, are experiencing dramatic decline in acquisition interest from larger hospital companies. Many might not be able to find a partner at all. With exceptions, this group faces a very difficult future.
- **Investor-owned hospital companies** appear to be losing their advantage in growing through the acquisition of non-profit hospitals. This is due to intra-sector consolidation that has left only nine investor-owned companies, greater competition from non-profits for acquisitions, and the non-financial demands of strategically motivated sellers. The best success for this group is coming through their participation in buyer joint ventures.

Approaches to Assessing Independence

Secondary research involves a review of one's financial circumstance and market position. It does not seek input from market participants (i.e., primary sources). Non-profit hospital boards have historically relied exclusively on secondary research as they considered their independence. Generally, it is the first inclination of managements, boards, consultants, and attorneys. It is a very worthwhile approach and almost a necessity. However, if conducted in a vacuum or in the wrong hands, it can be used in harmful ways.

Recently this form of analysis has been misused by boards to make curious decisions. Particularly troubling are those that are based upon forecasts of sharply improved operating results, notwithstanding very obvious operating and financial challenges. Also, this approach is sometimes used merely to substantiate the original inclination of boards rather than openly explore alternatives (more on this as we discuss "missteps" later in this article).

Primary research is a developing alternative that centers on receiving market input as a component of a board's diligence in considering independence. It has only recently become an alternative, perhaps because of the greater social acceptance of considering independence. By seeking real input from market participants, more ideas and a greater understanding of reality can be achieved. It can also be a very useful tool for boards to gauge the market's relative willingness to provide sought-after objectives under affiliations, where no ownership or control is exchanged, *versus* business combinations, where some or all of ownership and control is exchanged.

Governance

There are important differences in the approaches that non-profit boards and corporate boards take to the topic of independence that should be noted. Non-profit boards are typically made up of volunteers who are local, and the composition of the board is self-perpetuating. Most notably, board members are *not elected by owners*. As a result, while there is no lack of sincerity and purposefulness, there is no direct accountability in non-profit boardrooms. Additionally, attorneys general focus primarily on conversions (i.e., combinations between for-profits). Taken together, these factors create circumstances under which well-intended and earnest board members participate in major decisions in an environment influenced by group decision-making dynamics, ideological thinking, and an absence of accountability.

In considering independence, the relationship between management and the board differs dramatically from the corporate setting. Boards of many publicly held corporations exclude CEOs from discussions and decisions regarding change-in-ownership due to the potential for conflict. In non-profit hospital boards, just the opposite occurs; management usually initiates and leads consideration of this topic. This seems appropriate given the makeup of boards and the complexity of business. It is, however, a point that boards should be aware of.

Non-profit boards functioned well in the past when hospitals were local missions and even as they became local businesses. They are particularly adept at philanthropy and local matters. However, they are often not functioning as well in responding to the structural challenges inherent in the ACA. Understandably, their focus often centers on avoiding change. As a result, management must initiate discussion of this topic in most cases.

Missteps and Transaction Mistakes

Missteps

Missteps are increasing as more hospital boards consider independence. These occur both publically and privately. In either case, they usually lead to a decline in outcomes, value, and missed opportunity.

Public missteps often involve entering into exclusivity arrangements either prematurely or inappropriately relative to the public announcement related to it. These are occurring frequently. For example, recently a mid-sized Midwestern hospital announced that it was going to return to the merger market to seek a partner after spending a full year in exclusive discussions with a major academic system regarding a business combination. This type of delay under public scrutiny need *never* happen; it is harmful to the hospital and the community. Sadly, we doubt that management, the board, or the community have any awareness of the harm of this sequence or its repercussions.

Private missteps are more difficult to detect, but we hear of them frequently in our work. They are often an outcome of managements and boards relying on forecasted dramatic improvements. This, too, can lead to poor decisions and decline in value. In other cases, illogical transaction structures are attempted. These usually reflect well-intended but fruitless efforts by boards to retain governance independence or significant participation in future governance of the combined enterprise.

These missteps generally result from the complexity and external nature of the merger market. Managements, boards, and consultants with little experience in this market often engage in time-consuming, expensive, and meandering reviews. Group decision-making dynamics and ideology only act to compound the challenges.

Transaction Mistakes

These have also been occurring at a surprising rate, perhaps as high as 20 percent of announced agreed-to combinations. These are harmful events in which hospital companies, after considering independence, select a partner of choice, and enter into a letter of intent and make a public announcement describing the potential combination. However, the transaction does not close. These are enormous mistakes that lead to loss of value, opportunity, and a whole host of operating challenges. They are usually preceded by faulty assessments of independence and result directly from poorly designed processes regarding partner selection.

From a broader view, these missteps and mistakes are reflective of early stages of change in a fragmented and tradition-bound industry. They rarely occur in the corporate world where there is greater familiarity with the merger market and accountability to ownership.

Final Thought

A significant amount of data has been developed that suggests larger hospital companies can be more efficient and effective under the ACA. However, there has been little discussion of why it is so difficult for non-profit boards and managements to move forward, notwithstanding this evidence. This topic deserves more attention and discussion, and this article serves as a starting point.

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