Parallels between Consolidation of the Commercial Banking and Hospital Industries

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Abstract

We believe that the consolidation experience in the U.S. banking system might hold meaningful lessons relative to future changes in the hospital industry. Both industries are historically fragmented industries, both are service providers, both are capital intensive and highly regulated, firms in both industries were historically independent locally owned/controlled, and both have strong ties to their community. Likewise, the patterns of consolidation seen in banking reveal insights about potential hospital consolidation. Lastly, we present implications from this comparison that may assist decision-makers as they navigate healthcare industry consolidation.

Keywords: Healthcare Consolidation, Banking Consolidation, Healthcare Reform, Mergers, Acquisitions

Introduction

Over the past 25 years, commercial banking has experienced significant consolidation. The Patient Protection and Affordable Care Act ("Healthcare Reform") has generated widespread expectation that significant consolidation will occur in the hospital industry. This article attempts to consider those factors that led to concentration in the banking industry over recent decades as a guide to what might occur in the hospital industry.

The authors believe that a comparative review of the commercial, social, regulatory, and ownership factors impacting these two industries reveals much concerning the potential future change to the structure of the hospital industry. This article explores certain parallels and contradictions between these two industries. Also, we review many of the issues that the banking industry experienced as it consolidated with an eye towards identifying lessons that can be applied towards change in the hospital industry.

Note, we focus here on the nonprofit segment of the hospital business. This sector represents approximately 85% of the industry and consists largely of 501(c) (3) community-sponsored hospitals (48% of the industry), religious-sponsored hospitals, mostly Catholic (15% of the industry), and local government-owned hospitals (22% of the industry). The 501(c) (3) segment is where real structural change is expected to occur as Catholic hospitals concentrate to a handful of companies and local government-owned operators gradually exit the business (Burgdorfer2010).

Parallels and Divergences

Industry turbulence is the catalyst for industry restructuring. Economists dating back to Adam Smith and Joseph Schumpeter explain that such turbulence often "weeds out" weaker competitors that fail or are forced to merge with stronger players (Schumpeter 1942). Stronger players get larger and stronger and, oftentimes, turbulence creates opportunities for new entrants. Clearly, the healthcare industry is in a period of turbulence. Likewise the banking industry has experienced several cycles of turbulence, most recently with the 2008-2009 Financial Crisis, that have been the catalysts for consolidation.

Banking shares many similarities with the hospital business and has, perhaps, a 20 year head-start in the consolidation process. Many observers believe that the consolidation that has been experienced in the U.S. banking system might hold meaningful lessons relative to future changes in the hospital industry. Both industries were historical fragmented industries with many local providers, both are service providers, both are capital intensive and highly regulated, firms in both industries were historically independent locally owned/controlled, and both have strong ties to their community. As a result, we describe several observations from industry consolidation in banking that could be informative for hospital executives and trustees.

Fragmented: Prior to the earliest waves of industry consolidation, banking was a fragmented industry, with over 30,000 independent banks in the United States in 1930's (Wharton 2013). Today, while the number of banking branches/locations has tripled to over 94,000, the number of institutions has declined by 75% to less than 7,000 banks with the 10 largest banks controlling 50% of the market and the top 50 bank holding companies controlling over 70% of the industry (US Census 2013; Wharton 2013). Even with this massive consolidation, many commentators believe banking will continue to consolidate.

The U.S. hospital industry remains extraordinarily fragmented and consists of over 2,700 very small to moderate-sized companies in a dizzying array of ownership types. The 50 largest hospital systems generate only about 25% of all hospital industry revenue, and the very largest hospital companies have market shares of only 2% to 4% each (Burgdorfer2010).

Local Control: Like thousands of independent community banks that were acquired over the last few decades, most hospitals are locally controlled institutions. In fact, many of the community leaders that populate local bank boards can also be found on the board of the local hospital. Furthermore, it is typical for the local bank president to be on the hospital board and the hospital president to sit on the local bank board.

While local banks and community hospitals may share the characteristic of local control, they have very different ownership structures – most community hospitals are non-profit, 501(c)(3) entities. The nature of ownership and the manner with which boards of directors consider governance deliberations is often less focused in non-profit contexts. For banks, ownership is a straight-forward and commercially conventional issue. Whether publicly-held or privately-held, there is generally clarity regarding the identity and objectives of owners, especially for community banks where the largest shareholders typically comprise the board of directors. For larger banks, boards often contain representatives of larger stockholders and frequently "hear" from them. Additionally, for commercial firms like banks, the best practices and case law related to discharging the board's fiduciary responsibility are well documented and reasonably well understood by directors.

In contrast, hospitals have a complicated and confusing array of non-profit ownership forms, often with strong historical origins and traditions. Effectively, governance stops at board level and there are no "owners" to hold the board accountable. For-profit directors are very mindful of their fiduciary responsibilities of duty of care and duty of loyalty; in contrast, many non-profit directors and trustees have significant protections by state laws indemnifying volunteer trustees.

Unfortunately, both the absence of "owners" and very different standards for fiduciary responsibility can often result in a lack of discipline and clarity in board decision-making, especially around difficult decisions such as merging into a large hospital system. In contrast, Catholic hospital systems have sponsors (religious orders) that are akin to owners. It is noteworthy that Catholic hospital companies have consolidated considerably in the past two decades perhaps because they have an "owner."

Community Ties: Both banks and hospitals tend to be heavily intertwined with their communities. As noted above, there are often significant relationships at the board level. Many community organizations receive funding, volunteer support and leadership from the banks and hospital in their community. Both tend to be visible and influential institutions in the community. These community ties are also strong because both banks and hospitals tend to be very large employers of local residents.

Politically Sensitive: For a variety of reasons, banks and hospitals receive significant attention from local governing bodies. As noted above, they tend to be significant corporate citizens. And, more pragmatically, they tend to be large employers in the community. Many a city councilman has bemoaned the loss of jobs when a local bank is acquired. Also, given that banks and hospitals are such large, visible and involved corporate citizens, the perceived loss of a these local institutions is often a blow to their civic pride.

Communities that once housed the home office of several important banks and hospitals suddenly find themselves served by branches of some large, distant, conglomerate – a perception not welcomed by most community leaders.

Customer Emotions: There is also an emotional parallel at the customer level. Both healthcare and banking elicit more emotional response compared to industries like groceries or gasoline. Customers are very sensitive to their health and their money. As such, a bank or hospital acquisition is often met with a more emotional response than when the local tire repair shop joins a national chain.

Services: Obviously, both hospitals and banks are service industries. Much, but not all, of this service must be provided locally, in the presence of the customer. As we will discuss below, we see an important distinction here that will impact integration scenarios: while historically most banking service was provided in the presence of the customer, a higher percentage of banking activities can now be performed remote from the customer, often with the aid of technology, and/or can be centralized. Many banking customers have opted for mostly electronic based bank services such as direct deposit and online banking. Healthcare Reform is likely to force similar change in the hospital industry. Technology is allowing some remote service such as using video links whereby some primary care services can be provided remotely; however, in contrast to banking, most hospital-based services must be provided locally in the presence of the customer.

Capital Intensive: Both industries are capital intensive. Hospitals require significant and recurring investment in capital for plant and equipment. Increasingly, and partially as a result of Healthcare Reform, hospitals are finding it necessary to invest more heavily in information technology and the employment of physicians. Banks require tremendous access to capital to support lending and provide liquidity.

Both community banks and community hospitals have more limited access to capital than their larger competitors. Indeed, non-profit hospitals have even fewer capital sources because, unlike banks, they cannot bring-in additional equity by issuing stock. Their non-profit status leaves them with only retained earnings and debt as capital sources. Given their capital intensity and the increased capital demands associated with Healthcare Reform, these concerns present a serious challenge for non-profit hospitals.

Heavily Regulated: Certainly banking and healthcare are among the most heavily regulated industries in the United States. Both are subject to many dozens of regulations and a plethora of regulatory agencies at the state and federal level. Also, both have a "gorilla" regulator that can effectively put them out of business: banks cannot function without Federal Deposit Insurance Corporation ("FDIC") insurance; hospitals cannot function without Centers for Medicare & Medicaid Services ("CMS") approval. Most notably, both have regulators that control pricing. In banking, the Federal Reserve Bank heavily influences (some would say "controls") interest rates as well as numerous regulations that control interest rates and service fees such as recent limits on debit card fees. For hospitals, the government literally sets the price paid by a large percentage of their customers via Medicare and Medicaid.

While the regulators have a significant impact on pricing for both banks and hospitals, there are important distinctions in the pricing mechanism in the two industries. Hospitals' payers are highly concentrated; when added together, the ten largest managed care companies and the U.S. Government represent payment for over 85% of all hospital revenues (Burgdorfer2010). Bank costumers, on the other hand, especially retail customers, number in the millions. Certainly, the largest payer to the hospital industry, the US Government *via* Medicare and Medicaid, is changing the rules of the business. In healthcare, government is not just a regulator, it is the largest customer. Private payers, are also forcing changes, *e.g.*, pay-for-performance and bundled-payment contracts.

Having considered similar characteristics between the banking and healthcare industries, we now turn to how consolidation has evolved in banking and consider implications for the healthcare industry.

Forces of Consolidation

Having considered shared characteristics in both industries such as historical industry fragmentation, community ties, social/political issues, role of regulation, and governance/ownership structure, we will now consider business combinations in these industries. There are many similarities and differences between the role that business combinations and the structural consolidation that results play in the banking and the hospital industries. Change in the number and size of companies in a given industry (*i.e.*, its structure) often results from the relative importance and interplay of three forces: economies-of-scale, regulation, and customer preferences/behavior.

These forces can act as catalysts that reward scale and efficiency and penalize poorly positioned industry participants. Classically, organizations that are impacted, but cannot adapt to these forces, fail to remain independent. One path through this sort of disruptive change involves growth through mergers and acquisitions. The banking industry has experienced several cycles of change (most recently with the 2008-2009 financial crisis) that have been the catalyst for consolidation. The hospital industry is undergoing the greatest level of turbulence in its history due to the impact of Healthcare Reform.

In banking, all of these classic forces have had roles in stimulating consolidation. There is some debate, however, as to the leading cause. A common view suggests that most mergers were the result of economies of scale objectives, *e.g.*, in the data processing area; however, much research, including a very recent report by the FDIC, suggests economies of scale are not a key driver (FDIC 2012; Morrissette 2005). Others, including the recently retired chairperson of the FDIC, have considered whether regulations favored large banks and, thus, drove small banks to consolidate (Bair 2012). This issue was again brought to the forefront during the financial crisis of 2008-2009 when banking regulators seemed to favor larger banks – regulators seemingly labeled some banks "too-big-to-fail" (officially named "systemically important banks") while allowing dozens of community banks to fail during the recession. Perhaps a more fundamental and natural force was the preference of customers. Increasingly, customers appear to be switching preferences away from small, local banks to larger banks with countless branches and ATM locations as well as cutting-edge technology. It also appears that "national branding" has now become an advantage in banking, similar to other consumer product industries. Surely, all three forces (economies of scale, regulation, and customer preferences) played a role in banking industry consolidation.

We see these three forces at work in healthcare. Many of the classic forces causing industry consolidation are now appearing in the hospital industry.

Economies of scale issues for hospitals are most pronounced in the use of technology. Hospitals are facing significant investments in new and complex information technology systems such as electronic medical records. Access to capital is another economy of scale issue. Most hospitals must raise large sums to invest in IT systems, new equipment and facilities and to acquire physician practices. Most industry observers believe that the regulations embedded in Healthcare Reform will force consolidation. While a detailed review of Healthcare Reform is outside the scope of this discussion, a few key elements drive consolidation. According to the American Hospital Association and Moody's, post-Healthcare Reform consolidation is being driven by improved efficiency through scale, increased quality, coordination of patient care, and access to physician and management resources (AHA 2013; Moody's 2013). Emerging bundled-payment systems and capitation models shift risk to providers. This, in turn, leads to consolidation as hospitals seek scale to better manage risk in large pools.

Increased capital needs are occurring at the same time as hospitals are experiencing greater difficulty in accessing capital. This is forcing smaller hospitals to combine with larger hospital companies that have greater access to capital. Buyers of tax exempt debt are becoming more institutionally-oriented and hence demanding of the liquidity associated with larger debt issues.

As in banking, customer behavior is changing in the hospital business, both at the patient and payer levels. Patients will increasingly be comparison shopping for healthcare providers, particularly hospitals, which provide the best quality care at the lowest price. Healthcare Reform makes it necessary for hospitals to provide this information to consumers *via* "scorecards." Payers, too, are increasingly demanding that hospitals provide this sort of information to consumers. In the past, few would have expected that hospitals would receive ratings and awards similar to automobiles and appliances. We will soon have the equivalent of "JD Power" ratings and "Consumer Reports" information for hospital companies.

More profoundly, payers are changing. Certainly the largest payer, the US Government via Medicare/Medicaid, is changing the rules of the healthcare game. However, private payers, are also forcing changes such as pay-for-performance and bundled-payment contracts upon hospitals. These payer-forced changes bring us back to the issue of economies of scale. Bundled-payment systems and capitation payment models shift risk to the providers – there are very strong economies of scale in bearing risk. Risk is best borne by large pools.

While there may be additional forces of industry turbulence driving hospital consolidation, it clearly shares at least three factors with banking consolidation: economies of scale, regulatory issues, and changing customer behavior.

Patterns of Consolidation

In many consolidating industries, one can observe some patterns. The patterns in hospital consolidation seem similar to banking industry consolidation.

Distressed Phase: The early stages of consolidation often center on distressed firms that find they cannot compete in a changing industry. This is an opportunistic phase where stronger participants can acquire and repair weak firms and create substantial value. Distress in banking typically has two root causes: poor financial performance stemming from inefficient operation and poor loan portfolio quality. Economic recessions are a major factor in poor loan portfolios. Consequently, the recent recession created a new wave of distressed bank transactions.

Similarly, underperforming hospitals exhibiting poor cost-per-case or revenue mix characteristics are often forced to merge with stronger participants. Worse yet, some hospitals fail to meet bond covenant tests and are, effectively, forced to merge. The capital markets are another indicator of hospital distress. Hospitals without the financial performance and, increasingly, size necessary to issue debt fall farther behind in the facilities and technology "arms race."

Scale Phase: This is a merger phase in which mid-size firms scramble for partners as a result of increased importance placed on economies of scale. Many bank mergers of the 1990's fit this description. In this stage, firms look to acquire others in order to improve scale and leverage their expense bases so as to lower costs per unit. They also often look to acquire firms in other geographies and sometimes even seek to establish national brands and footprints. This is the manner in which banking behemoths like Bank of America were built.

Similar patterns are currently emerging in the hospital business. The loudest chorus driving hospital mergers today is the need for scale due to Healthcare Reform. To compete in this changing industry, hospitals are making very large investments in IT systems, *e.g.*, electronic medical records. Physician integration and employment is another capital intensive requirement facing hospitals. Hospitals, which are beginning to bear actuarial risk as bundled-payment systems and capitation payment models emerge, are also looking for ways to access larger risk pools through consolidation.

Scope & Capabilities Phase: While "distressed" and "scale" transactions were most common in the early phases of banking consolidation, consolidators eventually turned to "scope" transactions to acquire additional products and services. Announcements of these transactions were often accompanied by phrases such as "cross-selling", "penetration" and "full service." Readers may recall Citicorp's desire to build a "financial supermarket" offering the broadest scope and range of financial services. As with "scope" transactions, firms sometimes enter into acquisitions in order to acquire specific capabilities, *e.g.*, the ability to serve a certain customer type or to acquire unique technology faster than they could build it. Over several decades of bank mergers and acquisitions, many transactions sought a combination of both scale and scope of capabilities.

Hospitals are now entering into acquisitions in order to expand their capabilities by selecting partners that can assist them in integrating with physicians, improving quality, and developing population management tools. Also, vertical integration, which increases the scope of an organization by adding additional steps in the value chain, may be an even more important objective for hospitals than for banks. Vertical integration was not a significant factor in banking consolidation; however, we are seeing it in healthcare transactions in several ways, notably, as hospitals are buying primary care practices and are offering insurance-like products to employers. Likewise, some insurers are vertically integrating forward by acquiring healthcare service providers including primary care practices.

Implications

The hospital industry remains fragmented while the banking industry has consolidated significantly. In light of its excessive cost to the economy and poor effectiveness, the hospital industry needs structural change. Banking experience holds several possible insights into future hospital consolidation transactions and subsequent integration.

Integration, Standardization & Centralization: Generally, economies of scale are more easily realized through standardization and centralization of activities. The industrial revolution was based on these principles; however, banking and healthcare are both service industries. The banking industry has wrestled with the proper degree of standardization and centralization.

Excessive standardization can increase quality but can lead to challenges in meeting unique needs of various communities served. Similarly, centralization can reduce costs and make standardization easier to accomplish, but it often eliminates local jobs and can strain community relations. Many banking analysts believe the perceived need for local variation (rather than standardization) was a result of resistance to change by bank employees and customers, rather than a true need for significant local variation and tailoring of products and services.

In the hospital industry, numerous industry experts and research studies emphasize the significant benefits that result from evidence-based medicine and the increased use of standardized methods and protocols. The Institute of Medicine found that Medicare alone spends over $50 million per year on unnecessary care that could be eliminated through standardization (Yong 2011). We believe healthcare merger integration strategy should be focused on standardization of care to increase clinical quality and reduce costs.

Room for Variety: While the dominant theme in the banking industry has been consolidation, the industry structure still includes a significant number of both independent and specialized banks. Research by the Federal Reserve Bank predicts a barbell industry structure consisting of mega-national banks at one extreme and numerous small and specialized banks at the other extreme (DeYoung 2003). We see similar patterns in other industries such as restaurants and even barber shops.

While "get big, get scale" is the headline story in healthcare today, it is likely that the structure of the industry will include a role for independent and specialized hospitals that provide unique value propositions which cannot be provided by large systems. A word of caution relates to lessons learned by many small banks, *i.e.*, simply being "local" will likely not be sufficient in providing a unique value to combat large, well-run systems. Early in banking consolidation, the large banking companies struggled with integration; execution was poor. Eventually, large banks significantly improved execution and service quality, making it much more difficult for small, local banks to differentiate themselves. Hospital trustees should be wary of a strategy that relies solely on being "more local."

Ally or Acquire: It is important to note that acquisitions and full asset mergers are not the only possible response to industry consolidation. The benefits of coordination and combination can be accomplished through a variety of arrangements besides full acquisition including joint ventures, purchasing organizations, clinical affiliations, etc. Generally, banking regulations make joint ventures and other alliances a difficult format for cooperation; as such, banks mostly use full acquisitions. There are some examples of joint ventures in banking such as jointly owning a company providing shared back-office support functions or sharing technology programs such as ATM networks. Also, some banks attempt alliance style structures by uniting independent banks under the umbrella of a shared holding company structure; BankOne (predecessor of today's Chase Bank) described its family of banks as the "Uncommon Partnership." We believe joint ventures and other alliance type relationships are much more relevant in healthcare industry consolidation. Applying a model created by Dyer (2004), the nature of the healthcare delivery suggests a more prevalent use of alliances; however, we note that most executives prefer the clarity of a full acquisition. Also, the numerous non-profit institutions provide a "wrinkle" compared to the banking industry. Non-profit institutions are already implementing creative alliance structures linking non-profits and for-profits even including participation by private equity funds.

Roles: The most obvious roles in merger and acquisition transactions are "buyer" and "seller." However, experience from the banking industry shows that there are many ways to play the "buyer" role. In both industries, some buyers view themselves as a "partner" putting together a "string of pearls"; they seek to work together with their sister institutions. Other buyers are "aggregators," building scale and geographic scope in order to have sufficient market power. A few strive to be "national aggregators," building national brands. It is important that buyers center on their own identity. Similarly, sellers need to have a clear and candid understanding of how their merger partner sees their role.

Timing Matters: The discussion of merger phases or cycles begs the question of best timing for a seller and for a buyer. For a distressed seller, one lesson from the banking industry is to sell early rather than late. While all executive teams are trained to be optimistic and seem to be genetically pre-disposed to exert herculean efforts to turn-around faltering institutions, the risk of continued deterioration is high. For both hospitals and banks, it is better to sell a slightly-stressed operation than to wait too long and sell after reaching full financial distress. This is a very difficult judgment call, particularly for non-profit hospital boards.

Merging early, and before becoming severely distressed, requires a difficult and candid discussion of the probability of success. The standard is not "can we limp-along and survive" but "even if we survive, can we be strong enough to fulfill our mission and thrive." Of note, concerning the value of hospitals, the quality of a market and a hospital's market share are the most important factors. Once market share loses begin, whether the hospital is financially distressed or not, value is declining.

In the "get big, get scale" phase, CEOs of buying banks often felt rushed to complete transactions before competitors could snatch-up key targets. There were pressures to complete transactions preemptively. Sellers also face timing challenges. A healthy institution in a good market can control its destiny; however, such institutions must be mindful of those partners that provide the best merger terms or acquisition fit. Should their best partner acquire the hospital across the street, even a great hospital can find itself eventually merging with a less optimal partner. If the merger "dance" is starting in your marketplace, buyers and sellers should be mindful of these timing issues.

We do not have room here for a full discussion of the many decision-bias errors that occur in M&A (Lovallo 2007; Kahneman 2010); however, it may benefit hospital CEOs and chairpersons to speak with their banking counterparts about these matters. Certain bank CEOs might lament that they rushed into large transactions due to the "stampede of the herd"; others might comment that they missed important opportunities as better prepared and nimble competitors seized the day. Most bankers have been forced to learn the "M&A dance" as well as the complex and challenging tactics associated with merger integration. Indeed, M&A and integration have become a core competence at many commercial banks. Similarly, hospitals will need to develop M&A and integration expertise amongst boards and senior management if they are to help their institution navigate the turbulent waters of industry change.

Community Relationships: Because both banks and hospitals are large and important institutions in their communities, emotions regarding mergers and acquisitions often run high. As a result, there are many lessons that hospital executives can learn from the experience of the banking industry. First, be prepared for emotional responses, especially from elected officials, and implement reasonable tactics to address these concerns. Even more so than banking, elected officials view hospitals as a quasi-public organization similar to institutions they control, *e.g.*, schools, parks and libraries. This perception is also derived from the fact that public funds, *i.e.*, Medicare and Medicaid, are often the largest revenue streams for hospitals. During an intense effort to integrate with a new parent organization, it is all-too-easy for hospital leadership to have less time and energy to focus on community relations. This can feed the perception that the acquisition will cause the hospital to abandon the community. Professional public relations advice has become a "must" for hospitals considering mergers.

A second lesson is that "this too will pass." In time, patients and physicians will re-focus on what matters most, clinical outcomes and patient satisfaction. If the merger improves these two primary factors, eventually the "noise" will dissipate. In the end, patients, employees and physicians are most concerned about good healthcare, not the hospital's name or sponsoring the local parade. We consistently note this as we hear from former M&A clients.

Ownership conundrum: Hospital boards need to be cognizant of and faithful to their fiduciary duty. This is analogous to a bank board's duty to shareholders. It is very difficult, especially for volunteer board members from the community, to anticipate the true needs of a community. Boards should be integrated and respectful of the view of physicians and management, but make decisions based upon good, informed business judgment and faithfulness to fiduciary duties.

Conclusion

We present several important parallels between banking and healthcare industry consolidation. Both are historically fragmented industries, both are service industries, both are highly regulated with significant capital needs, firms in both industries were historically independent locally owned/controlled, and both have strong ties to their community. Both industries are turbulent and exhibit typical forces of consolidation including economies-of-scale, regulatory change and evolving customer preferences and behaviors. Given that banking is similar to healthcare and has perhaps a 20 year head start in the consolidation process, we describe a few observations from banking industry consolidation that are informative for hospital executives and trustees.

It is especially important to recognize the paradigm driving acquirers (is their objective achieving scale or is it expanding scope) and to proactively managing the timing issues (jumping too soon will prematurely truncate the institution's unique fulfillment of its mission; jumping too late can leave the hospital in the grasp of the wrong partner). Most bankers have been forced to learn the "M&A dance" as well as the complex and challenging tactics of merger integration. Indeed, M&A and integration have become a core competence at many banks. Likewise, hospitals will need to develop similar M&A and integration expertise in the board room and executive suite if they are to help their institution navigate the turbulent waters of industry change. We also note that the ownership and governance structure of non-profit hospitals might impede an appropriate and strategic response to consolidation forces in the industry, often to the long-run detriment of their institution.

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