HealthCare FUTURES DIRECT

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Get Ready for Another Wave of Health Care Consolidation

HEALTH CARE FUTURES IS AN IDEA COMPANY PROVIDING VALUE-ADDED STRATEGIC THINKING TO LEADING HOSPITALS AND HEALTH CARE SYSTEMS, ACADEMIC MEDICAL CENTERS, AND LARGE MEDICAL GROUPS. FROM TIME TO TIME WE PREPARE A THOUGHT PIECE THAT ATTEMPTS TO ANTICIPATE A FUTURE "BIG PICTURE" IDEA, WITH THE INTENT OF BETTER PREPARING OUR CLIENTS TO SUSTAIN THEIR ABILITY TO ACHIEVE THEIR MISSIONS.

THIS ARTICLE LAYS OUT OUR PREDICTIONS FOR A RENEWAL IN MERGER AND CONSOLIDATION ACTIVITY IN THE HEALTH CARE INDUSTRY OVER THE NEXT 36 TO 48 MONTHS, ALONG WITH OUR RATIONALE. WE WELCOME YOUR REACTION AND COMMENTS. IN ADDITION, IF YOU WOULD LIKE TO RECEIVE AN ELECTRONIC COPY OF THIS ARTICLE, WRITE TO US AT INFO@HEALTHCAREFUTURES.COM

The strategic value produced in most mergers to date has been mixed, largely anecdotal, situation specific, mostly outside the core business of clinical care, and for some organizations, very elusive to achieve. The strategic value has usually been more obvious and immediate when a weaker organization joins a much stronger one, but less obvious when two or more strong organizations have come together.

Recent independent research funded by the Robert Wood Johnson Foundation suggests that in metropolitan areas where significant mergers have occurred, the measurable impacts have been higher prices, lower costs, higher margins and neutral to negative effects on quality. So far, most health care systems have had limited success in making broad-based progress, particularly in clinical care improvement. Our sense is that Boards and management teams have been hesitant to tackle the big opportunity areas (clinical care and physician integration) for fear of risking their current financial performance and existing physician relationships.

However, we believe broader environmental factors are likely to cause a major change in Board and management appetite to produce more strategic value through stronger and more directive regional health systems, because their Boards and management teams will no longer be able to maintain the status quo. Consider the following analysis and predictions.

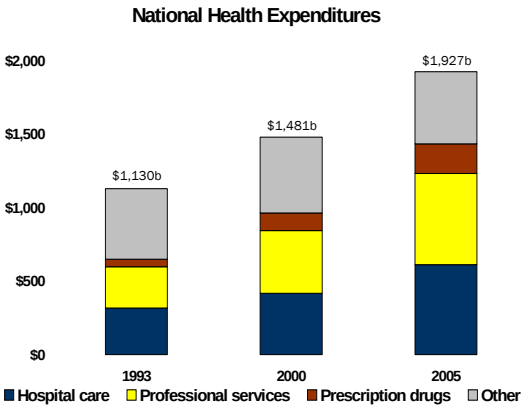
To put health care expenditures in a big picture context, a recent Federal report put 2005 total U.S. health care expenditures at just under $2 trillion, or 16% of the Gross Domestic Product (GDP) of the U.S. Hospital care totaled $612 billion, or 5% of the GDP and professional services (mostly physicians) totaled $622 billion, or another 5% of the GDP. Retail sales of medical products (of which prescription drugs represented the largest component), home health and nursing home care, program administration and investment in national research, infrastructure and equipment made up the 6% balance.

The latest American Hospital Association analysis shows that in 2005 hospital care in the U.S. was delivered through about 5,000 hospitals, 1.3 million nurses and 3.4 million technicians, support and administrative personnel (combination of full and part time).

About 3,000 of these hospitals are not-for-profit community hospitals (the remaining balance includes 900 investor-owned hospitals and 1,100 governmental hospitals). Of the 5,000 hospitals, about 2,700 are organized into multi-hospital systems, ranging in size of under $100 million to as large as $10+billion in revenues.

Most of these governmental and not-for-profit community hospitals are governed by part-time, unpaid boards of 12 to 30 individuals, most having limited understanding of the bigger picture framework impacting health care, other than what they pick up from their hospital management teams, from each other, or at the occasional board retreat or seminar. Some are governed by religious congregations, who due to an aging membership will soon require more lay leadership in order to govern. Our best guess is that 50,000 to 100,000 unpaid, part-time volunteers are governing about 5 percent of the U.S. GDP. That is a lot of fragmentation.

The situation on the physician side is even more fragmented. A recent study by the Centers for Disease Control and Prevention estimated 311,000 physicians are in office-based practices, providing 908 million patient visits annually (2003-2004). Consider that with the exception of a small number of very large medical groups (e.g., Mayo, Cleveland Clinic, Henry Ford, Geisinger, Kaiser, academic health center practice plans, etc.), about 90% of office-based physicians have chosen to be in smaller practice sites of less than 10 physicians, and 79% of all physicians practice at single specialty sites. Many of those in office-based practice are simply sharing overhead costs and not



accumulating capital for future investment or building a business sustainable past the current generation of owners. This fragmented physician organization model decides how another 5% of the U.S. GDP is spent.

Unlike the delivery side of health care, a relatively few number of giant pharmaceutical/medical device/imaging companies supply the industry with various products—largely at prices they set. It is interesting to note that while hospital and physician costs have roughly doubled since 1993, retail prescription drug costs were roughly four times larger in 2005 than in 1993 ($51 billion to $201 billion).

In addition, two large payers (Medicare and Medicaid) dictate prices to hospitals and physicians—there is no negotiation. Most of the remaining commercial business is in the hands of five or six mega-insurance companies---Aetna, WellPoint, Anthem/Blue Cross, Humana and United Healthcare. These negotiations are increasingly difficult for hospitals and physicians. We predict more consolidation among the commercial insurance carriers, which inevitably will increase price pressures on hospitals and physicians.

Virtually all experts have concluded that the current U.S. health care system is unsustainable, and without major re-design is likely to be in severe financial condition within the next six or seven years. The most recent predictions have health care costs at 20% of GDP by 2014, and Federal budget deficits skyrocketing in 2013-2014 as boomers retire. Even at 20% of GDP, the uninsured continues to grow, and will soon exceed 50 million U.S. citizens, or one in every six of us.

In order to address Federal budget deficit issues and societal pressure, we believe a major Federal health care reform initiative will begin shortly after the next presidential election, to be enacted sometime in 2010, and to be fully implemented by a 2013-2014 time period. At the outside, that is seven years from now.

The "form of the reform" will probably vary based on which party controls the White House and Congress and how fast states move on this issue. This reform will probably be accompanied by Federal and state tax reforms (e.g., more tax on the wealthy, higher business taxes, means testing for Medicare and Social Security benefits, etc.) designed to provide some additional funding for the uninsured.

We believe the implications of Federal and state reform on insurers, suppliers and hospitals/physicians will be to serve more people, including the currently uninsured, and do it with less money per person and lower growth rates going forward.

We believe that the consequences of such a massive change are very predictable. We believe there will be a renewed wave of consolidation by hospitals, insurers and suppliers in order to achieve economies of scale and leverage what little clout they can—mostly with adverse consequences to those who are left behind. We believe physicians will increasingly pursue groups of greater size, and health system-physician networks will grow. Similarly, single specialty and larger group practices will continue to increase in size through mergers as physicians pursue greater access to in-office technology.

We believe that in the next five to seven years retail medicine will expand beyond the current low acuity visit models. It may include higher acuity care, ambulatory surgery, imaging services, etc., directly competing with community hospitals for their most profitable services. We believe that current regulations that protect some specialty physician cartels will be eliminated in the next five to seven years (example—state licensing requirements limiting radiologist ability to read images from an out of state or out of U.S. location).

We believe that technology advances in the next five to seven years will make it more practical for clinical services to be delivered remotely and at lower cost (examples—imaging studies done in India by their local radiologists at lower costs, growth in remote monitoring of ICU and other inpatients, growth in remote monitoring of patients at home, etc.)

If the above predictions are even close to being accurate, imagine the scramble of 50,000-100,000 part-time community board members and thousands more in management, as they attempt to respond to a chain of events that could begin rolling out in less than 36 months. Even if the predictions are only partially correct, it seems likely to us that hospital and health system Boards and management teams will be asking whether there is a better way to organize and make decisions about care for their communities.

It seems to us that hospitals and smaller health care systems are better off being on the front end of the potential consolidation that will occur, rather than waiting and having fewer options and less leverage. It also seems to us that the two most practical choices are to either align with a not-for-profit system of sufficient size that is likely to have more political and economic leverage as the transformation takes place and afterwards, or sell to a strong national for-profit operator of hospitals that is more likely to survive the transformation.

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