

THE PROBLEM

Community Health and University Health are two healthcare organizations in a state that has recently seen the continued growth and rising market power of a large health system, as well as physician and insurer changes and challenges. Both organizations have been financially healthy, but downturns in the past three months suggest that the good times may be at an end.

THE SITUATION

Like many other markets, the state in this scenario has experienced widespread consolidation of providers over the past 10 years. One system, in particular, based in the largest metropolitan area in the state, has been especially aggressive in functioning as a consolidator. This system has captured a 45 percent share of the metro market (population of 1.5 million), is a significant presence throughout the southern and most populous half of the state, and now has about 15 percent to 20 percent of that market, too.

The provider landscape has changed dramatically in this metropolitan area. As a result of closures and consolidations, only one independent hospital (Children's) remains where there had previously been 20. In addition to the large system (which comprises five hospitals), the four other players, all of which operate essentially exclusively in the metro area, are:

- Community Health with three hospitals and a 13 percent share
- University Health with two hospitals and a 12 percent share
- Catholic Health with four hospitals and a 17 percent share
- North Suburban Health with two hospitals and an 8 percent share

The physician market is also consolidating. Each system has a large employed group that is roughly in proportion to its size and mostly, but not exclusively, primary-care-based. The only exceptions are University Health and Children's, where physician groups are dominated by specialty-oriented faculty practice plans. There are still a few large independent multispecialty groups and many single-specialty groups, but here, too, these groups are increasingly migrating to a relationship (employment or tight joint venture) with one of the systems.

The insurance market has been relatively benign until the past few years. The commercial insurers' favored product has been the preferred provider organization (PPO). But here, as well, the market is changing. Three years ago, there were six commercial insurers, and not one had more than a 25 percent share of the market. Since then, the two smallest have merged, and two of the remaining four have been bought by national companies. As a result, the competitive ante has been raised and providers have begun to be squeezed; and the competitive pressures are expected to become much more intense in the next two to three years.

In this environment, six months ago, the CEOs of University Health and Community Health began discussing a potential relationship. Concerned about the increasing market power of the large system and the developments involving physicians and insurers, both CEOs thought the time may be right to merge their organizations.

ALTERNATIVES CONSIDERED AND ANALYSIS

Initially, the two CEOs discussed a range of organizational affiliation options, from a shared services company or a full merger. As a result, they charged financial staff and consultants early on to define financial benefits in four categories (see exhibit):

- Low-risk, relatively easy-to-implement cost-reduction opportunities
- High-risk, relatively difficult-to-implement cost-reduction opportunities
- Capital cost avoidance opportunities
- Revenue improvement opportunities

Because both systems are themselves the product of previous mergers and had six and nine years of experience, respectively, functioning as merged entities, there was some skepticism as to the potential for significant additional economies. However, these two systems largely operate in different parts of the metro area, so combining could improve geographic coverage while avoiding conflict between the two organizations (for the most part) over the same markets.

Although the numbers may appear large in absolute terms, the combined entity has annual revenue of \$1.3 billion. And the two CEOs recognized that achievement of the financial benefits estimated would not be without extremely hard work and major organizational change and pain. So the question for the CEOs and the joint board oversight committee that will receive this analysis is: **What would you do and why?**

Exhibit 1

POTENTIAL FINANCIAL BENEFITS: UNIVERSITY HEALTH AND COMMUNITY HEALTH MERGER*				
	Year 1	Year 2	Year 3	Comments
Low-risk cost savings	\$13M	\$17M	\$20M	Total potential = \$25M; 80% yield by year three
High-risk cost savings	—	\$4M	\$12M	Total potential = \$60M; 20% yield by year three
Capital cost avoidance	See three-year total in year three		\$100M	Total potential = \$200M; 50% yield in first three years
Revenue improvement [†]	\$5M	\$15M	\$30M	Assumes joint development of cancer center and select other initiatives; excludes managed care improvements; potential five- to 10-year benefits are \$100M to \$200M annually, excluding managed care

* All estimates are in constant 2018 dollars.

Estimated 40% margin on all incremental revenue

FY 2018 Profile: University Health

Acute beds: 650

Inpatient admissions: 35,000

Outpatient visits: 550,000

FTE employees: 4,500

Net patient revenue: \$750 million

Operating margin: 8.0%

Unrestricted cash: \$500 million

Debt to capitalization: 29.4%

Age of plant (years): 6.4

FY 2018 Profile: Community Health

Acute beds: 500

Inpatient admissions: 26,000

Outpatient visits: 850,000

FTE employees: 4,200

Net patient revenue: \$575 million

Operating margin: 7.5%

Unrestricted cash: \$200 million

Debt to capitalization: 29.0%

Age of plant (years): 10.5