

Health Care Consolidation and the Changing Health Care Marketplace

A Review of the Literature and Issues

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Issue Brief

- This *Issue Brief* examines the academic literature and issues in consolidation of the hospital sector in the context of responses to changes in the competitive environment. It analyzes the motivations for consolidation as well as its effects.
- Hospital merger activity has increased dramatically in recent years. The current wave of mergers is primarily a reaction to a competitive environment that is placing a greater emphasis on controlling costs and forcing high-cost providers out of the market. The growth of managed care has placed considerable pressure on providers of health care and, in particular, on hospitals.
- The evolution of insurance companies' behavior helps explain the recent hospital consolidation movement. As managed care has become the dominant type of coverage in the last decade, insurance companies have become more active in trying to control costs—a reversion to their previous practices before the advent of managed care. Insurance companies have placed cost constraints on providers, both in the early years of health insurance and currently, when there are strong competitive forces.
- Hospitals claim that their primary merger motives are improving efficiency and the quality of care. The empirical evidence on this claim is mixed.
- Vertical integration (between suppliers and buyers of health care services, such as between hospitals and physicians) has appealed to hospitals because of their need to obtain more patients. More research is needed to explore the effects of vertical integration in the health care sector.
- In one of the more significant recent legal rulings, the U.S. Justice Department lost a 1997 case challenging the merger of two hospitals in the New York City metropolitan area. This, along with other recent losses by the antitrust authorities, does not bode well for the government's ability to prevent hospital mergers in metropolitan areas. It is difficult to generalize on an appropriate antitrust policy for hospital mergers.
- Hospital consolidation is likely to continue at a rapid pace. Since some developments may reduce the cost of employee benefits while others may increase the cost of these benefits, the final effect on the provision of health care benefits by employers is uncertain.
- Employers must pay close attention to the hospital consolidation movement because it will lead to important changes in the provision of health care benefits.

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About the Author

Lawrence G. Goldberg is professor of finance at the University of Miami, and an EBRI Fellow. This *Issue Brief* was written with the assistance of the Employee Benefit Research Institute's research and editorial staffs. The EBRI Fellows Program provided a grant to support the author's research in this area. Any views expressed in this report are the author's and should not be ascribed to the officers, trustees, members, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comments on this research.

Introduction

Announcements of hospital mergers are appearing with increasing frequency, and

are causing much concern among participants in the U.S. health care system. These changes in the system's structural organization and other changes in health care are fostered by new developments that are occurring in the competitive marketplace. The recent growth of managed care has placed considerable pressure on hospitals and other providers of health care services and has stimulated competition among health care providers. The economic forces affecting the health care sector must be analyzed in order to understand changes such as hospital consolidation.

This *Issue Brief* examines the academic literature and issues in consolidation of the hospital sector in the context of responses to changes in the competitive environment. It analyzes the motivations for consolidation as well as its effects. The merging parties claim that the primary motivations for consolidation are efficiency and quality control, but opponents emphasize the serious anticompetitive effects of consolidations and advocate government action to limit merger activity.

Hospital mergers raise many questions: What is the relationship between structure and performance in health care? How do mergers affect efficiency? What is the effect of mergers on the quality of care? What are the competitive consequences of consolidation, and how does this affect appropriate government antitrust policy? Finally, how will consolidation affect the provision of employee benefits? This discussion cannot answer all of these questions, but the framework of analysis and previous research reviewed here can help address these important questions.

The first section of this *Issue Brief* analyzes the economics of health care and the impact of competition on health care. It addresses the question of whether health care is essentially different from other industries

and thus not amenable to economic analysis. In addition, it discusses past behavior of health insurers and the changing competitive environment, which help explain the current status of the health care marketplace. The following section examines both pro-competitive and anticompetitive motives for consolidation in a competitive environment. The next section evaluates the evidence on health care consolidation by examining the overall trends in both horizontal and vertical mergers and presents the effects of consolidation found in earlier studies. This is followed by a detailed examination of a recent large hospital merger in New York state in order to illustrate the previous arguments. (New York is particularly interesting to examine because it has moved away from its previous regulatory approach to health care.) The final section concludes with a discussion of the impact of the consolidation movement on the provision of employee health care benefits.

Impact of Competition

Can the health care sector be analyzed in the same fashion as other industries are analyzed?

Until recently, most observers would have answered this question with a resounding no. There were many arguments to support this answer: Health care decisions often involve life or death and thus are immune from traditional economic analysis. Patients have limited or no medical information and knowledge, and thus must rely on the decisions of knowledgeable and highly trained health care providers such as physicians. Third parties pay most of the bills, so most patients do not care what anything costs and health care decisions often can be made without any regard to cost. Before the advent of managed care, providers could perform unnecessary procedures because insured patients did not care about costs. Nonprofit institutions, which comprise a large but shrinking segment of the health care sector, do not have the same economic incentives as for-profit institutions.

As managed care has taken over as the dominant form of delivery of health care in the United States, the number of mergers among hospitals has grown sharply.

But recent evidence in the health care marketplace directly contradicts these traditional assertions. Most health care actions do not involve life or death decisions, and thus could be affected by economic factors. Sources of information for patients have vastly increased, and people are willing to pay to obtain information. Third parties are subject to severe pressure from employers who pay most of the health care premiums. In many cases, patients are reluctant to pay out-of-pocket costs. Finally, nonprofit institutions appear to act very similarly to for-profit institutions in response to economic pressure.

Perhaps the most important issues relating to the differences between health care and other industries revolve around the behavior of insurers, and the evolution of insurance companies' behavior helps explain the recent hospital consolidation movement. It is well known that as managed care has become the dominant type of coverage in the last decade that insurance companies have become more active in trying to control costs. But it is little known that this is a reversion to their previous practices.

In contrast to other developed countries, the United States has never had governmentally mandated health coverage for the full population. The American Medical Association, representing physicians, has strongly opposed nationalized health insurance for many years. Health insurance first became available in the United States in the latter part of the 19th century and early part of the 20th century, when mutual aid associations and other groups started to offer limited coverage for medical expenses.¹ The first prepaid group practice started in 1929. Blue Cross and Blue Shield developed rapidly, starting in the 1930s to cover hospital expenses and physician expenses, and other private insurers began to provide similar insurance coverage. In recent years, health maintenance organizations (HMOs) and other forms of managed care plans have grown rapidly, forcing the current health insurance industry to change greatly. Currently, the vast majority of Americans with

health insurance are covered by a managed care plan, while the number of people covered by traditional fee-for-service plans continues

to shrink (see chart 1).

Not coincidentally, as managed care has taken over as the dominant form of delivery of health care in the United States, the number of mergers among hospitals has grown sharply. Although there was a slight decline in merger activity in 1998 compared with a year earlier, according to one study, the number of hospital merger transactions more than doubled between 1994 and 1997 (see table 1). But in order to understand the recent hospital consolidation movement, it is important to examine the development of behavioral patterns in the health insurance sector.

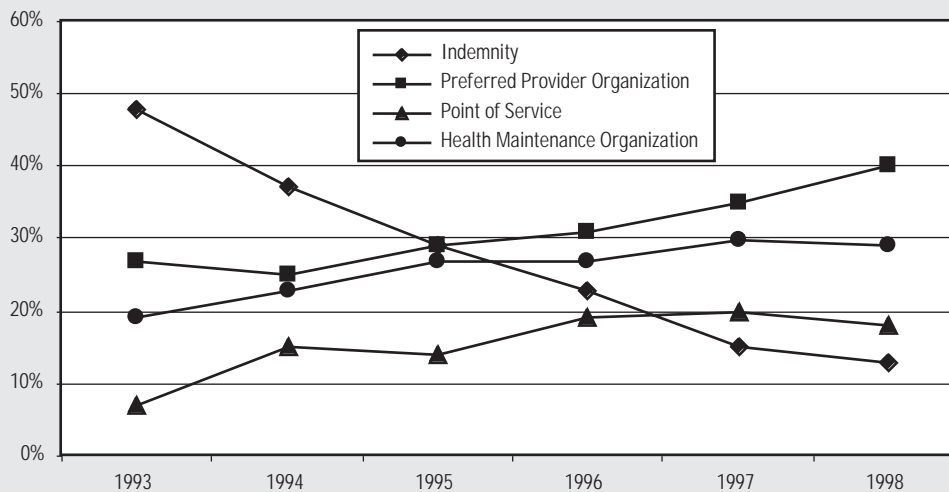
The historical development of the health insurance industry was analyzed by Goldberg and Greenberg (1977a) in an examination of a legal case argued before the U.S. Supreme Court in 1952.² Prior to the introduction of private and public health insurance, providers such as physicians had to collect payment from private patients. Since many patients could not afford the payments, remuneration for physicians was low. The introduction of health insurance was the major factor raising the income levels of physicians, because it enabled them to be well-compensated for treating all insured patients regardless of income levels.

The first hospital association was started in 1904, and hospital associations grew rapidly to become important entities in the marketplace. Both employers and employees paid premiums. Hospital associations were independent of national associations, such as Blue Cross and Blue Shield, and bore many similarities to current HMOs. They started with closed panels of

¹ This discussion is drawn from Chapter 2 of the Institute of Medicine (1993).

² The Supreme Court case involved independent private insurance companies, called hospital associations, in the state of Oregon. This case was brought by the Justice Department against the state and local medical societies for monopolization of prepaid medical care and agreements not to compete. The district court and the Supreme Court both ruled against the government.

Chart 1
 Percentage of Employees Participating in Health Plans, by Plan Type, 1993–1998



Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 1998* (New York, NY: William M. Mercer, 1999).

physicians, but in response to consumers' demands and the preferences of organized medicine, they switched to paying mainly on a fee-for-service basis.

Hospital associations recognized that without controls providers would be able to dramatically increase the cost of health care, so they monitored both the fees paid to providers and the procedures that were reimbursed. Physicians objected to the hospital associations' cost-control efforts, and initiated two courses of action in order to eliminate the actions that affected their autonomy and income: They formed their own insurance company in Oregon (Blue Shield) and boycotted the private hospital associations. This eventually forced the hospital associations to change their practices and effectively eliminated their cost-control efforts. The actions undertaken by physicians in Oregon and the implicit threat of this type of action in other areas forced insurance companies to play a passive role in the reimbursement process. Ultimately, the insurers merely paid the providers' bills and passed on cost increases to the policyholders.

The health insurance system followed this mode of behavior into the 1980s, until spiraling cost increases forced the payers of the premiums, particularly large employers, to look for ways to reduce costs. The closed-panel HMO model, which had incentives to minimize procedures and charges, grew rapidly as employers enlisted their services. However, many patients did not like the limited choice inherent in the HMO and preferred to have a wider choice of physicians. This led to many types of managed care arrangements that expanded patient choice but also imposed cost constraints on the providers.³ Many of these constraints had much

in common with the practices of the old hospital associations. These cost-control efforts today are characterized as managed care. Because of increased HMO enrollment and increased cost control activity by insurers, health care costs in the United States began to rise at a much slower rate between 1994 and 1997.⁴ It must be noted, though, that cost increases have accelerated in the last year.⁵

How have changes in the behavior of insurance companies and the increase in HMO penetration affected providers, and particularly, hospitals? The primary way that HMOs have saved money is by reducing the average number of days spent in the hospital. As was first shown by Goldberg and Greenberg (1977b), HMO competition stimulates the fee-for-service sector to reduce hospitalization rates. The greater the HMO market share, the lower the number of hospital days paid by insurers in order to remain competitive with the HMOs.⁶ This result has been replicated by numerous studies for different time periods and different markets. Faced with fewer patients in an era of increasing competitiveness,

³ See *Employee Benefit Research Institute, Fundamentals of Employee Benefit Programs, Fifth edition* (Washington, DC: Employee Benefit Research Institute, 1997), pp. 235–250.

⁴ See *Employee Benefit Research Institute, EBRI Health Benefits Databook, First edition* (Washington, DC: Employee Benefit Research Institute, forthcoming): Table 3.2.

⁵ In William M. Mercer's latest employer survey, employer health care costs were found to have increased by 6.1 percent in 1998 after being relatively flat for the four prior years. See William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1998* (New York, William M. Mercer, 1999).

⁶ See Goldberg and Greenberg (1977b) for both quantitative and qualitative evidence for this.

hospitals have reacted: They have consolidated and the number of beds has been reduced. This is exactly what would be expected in any industry facing reduced demand.

Motivations for Consolidation

Different parties have assessed the motivations for hospital consolidation very differently. Hospitals that are merging claim that their primary motive is to improve efficiency and control quality. They also claim that they are reacting to a competitive environment that is placing a greater emphasis on controlling costs and forcing high-cost providers out of the market. Critics have a very different viewpoint: They claim that consolidation is aimed at eliminating competitors, and that the mergers will have anticompetitive effects. These critics urge the federal antitrust authorities—the Department of Justice and the Federal Trade Commission—to take a more serious look at these mergers and to limit the consolidation movement. Following is an examination of some of the more recent evidence pertaining to these viewpoints.⁷

Efficiency

There are many claims that hospital consolidation will improve the positions of merging hospitals; however, it is necessary to examine the existing evidence in order to assess the validity of these claims. Among the possible benefits cited for mergers are the following: “cost savings from economies of scale and elimination of duplicative services; reduction in unused capacity through pooled staffing; improved management and production processes; better access to capital; quality improvements from higher volumes of specialized procedures; and broader geographic/network coverage.”⁸ If these benefits actually occur, prices to consumers could be reduced.

But the evidence on cost savings from mergers is

Table 1
Hospital Merger Activity, 1994–1998

| Year | Number of Transactions | Number of Hospitals ^a |
|------|------------------------|----------------------------------|
| 1994 | 92 | 229 |
| 1995 | 129 | 268 |
| 1996 | 161 | 310 |
| 1997 | 197 | 310 |
| 1998 | 144 | 298 |

Source: Irving Levin Associates, Inc., *The Hospital Acquisition Report*, Fifth Edition (New Canaan, CT: Irving Levin Associates, Inc., 1999).

^aTo avoid double-counting, this includes only hospitals sold.

mixed. Many studies are done at one point in time across different markets, and inferences are made about the probable effects of mergers. Several studies find higher hospital costs per day in areas with greater numbers of hospitals.⁹ These studies attribute the higher costs to the “medical arms race,” in which all the hospitals in a market feel that they need the most advanced equipment, leading to unnecessary duplication of expensive high-technology equipment. Lynk (1995a) made projections from nonprofit hospitals in California to show that mergers would reduce prices. However, a number of studies¹⁰ have found evidence directly opposed to this, showing that areas with more hospitals have lower hospital costs and prices. This is what would be expected if the markets are competitive. Another group of studies examined changes over time, and is a more direct test of the effects of mergers. Alexander, Halpern, and Lee (1996) examined the impact of mergers on scale of operation, operating efficiency, and staffing practices. The study sample consisted of 92 hospital mergers from 1982–1989. A control group of 276 non-merging hospitals was also analyzed. The study found that cost changes result from the mergers, but they occur selectively and depend on the conditions of the merger. They also found that the mergers affect the rate of pre-existing trends.

Bogue et al. (1995) found that 74 mergers between 1983 and 1988 led to reduced duplication of services. A study by the U.S. Department of Health and Human Services (1992) found a 9 percent cost savings from 11 mergers. Barro and Cutler (1997) found cost

⁷ A previous study by Shactman (1994) reviewed the economic forces prompting hospital consolidation and examined the role of the antitrust authorities.

⁸ See Connor, Feldman, Dowd, and Radcliff (1997), p. 63.

⁹ For example, see Robinson and Luft (1995) and Manheim, Bazzoli, and Sohn (1994).

¹⁰ For example, see Melnick, Zwanziger, and Bradley (1989), Melnick and Zwanziger (1988), and Dranove, Shanley, and White (1993).

The evidence on cost savings from mergers is mixed. . . . Greater price reductions resulting from mergers were found in areas with higher HMO penetration.

savings in Massachusetts mergers. Lynk (1995b) showed that pooling of services produced merger savings.

On the other hand, several studies of hospital mergers have found contrary results. Mullner and Andersen (1987) studied 32 hospital mergers between 1980 and 1985, and did not find any significant financial effects. Greene (1992) examined 14 hospital mergers, and found lower growth in cost per case but also increased prices. Simonson and Zwanziger (1997) studied 23 California hospital mergers, and found fewer beds but, again, higher prices.

Connor, Feldman, Dowd, and Radcliff (1997) have several possible explanations for the mixed empirical evidence on hospital merger savings. One explanation is that hospitals are using more price competition and less nonprice competition, which produces different results for different time periods. A second explanation is that only certain types of mergers will produce savings, and the mergers previously studied have varied by study. Consequently, the Connor, Feldman, Dowd, and Radcliff study includes more than 3,500 hospitals (with good longitudinal data from 1986 to 1994) and 122 "horizontal" mergers, or mergers between firms competing in the same market. The results of this study indicate that, on average, hospital mergers produce price reductions of approximately 7 percent.

However, the results differ significantly by hospital characteristics. They find merger-related price reductions to be greater for low-occupancy hospitals, nonteaching hospitals, nonsystem hospitals, and hospitals with greater pre-merger service duplication. The study also includes some results relating to antitrust policy: Market areas with higher hospital concentration levels experienced considerably fewer merger-related price reductions than those with lower concentration levels. Greater price reductions resulting from mergers were found in areas with higher HMO penetration. These results imply that greater antitrust scrutiny should be applied to mergers in high-concentration hospital mar-

kets and markets experiencing less competitive pressure from HMOs.

Quality of Care

Another issue involves the effect of mergers on the quality of care. Some indication of the probable effects of mergers can be found by examining the relationship between quality and size, since size will increase as a consequence of a merger.

As discussed by Pauly (1994), rating hospital quality can be difficult. Recent studies such as Showstack et al. (1987) found that mortality rates for coronary artery bypass surgery are lower in hospitals that perform higher volumes of the procedure. The higher-volume hospitals also have shorter lengths of stay. The authors recommend that surgery be concentrated in higher-volume hospitals and that certain such procedures not be performed in low-volume hospitals. Edwards et al. (1991) found that when high-volume physicians perform the carotid endarterectomy procedure,¹¹ patients experienced significantly lower mortality, postoperative stroke rates, and costs. Segal, Rummel, and Wu (1993) also found that, for the same procedure, surgical volume was inversely related to mortality and total charges.

Luft, Bunker, and Enthoven (1979) found specific levels of medical activity that are more efficient. For instance, they examined 12 surgical procedures in 1,498 hospitals, and found for four of these procedures that death rates were between 25 percent and 41 percent lower for hospitals performing more than 200 operations per year than for hospitals performing fewer than 200 procedures per year.

Market Structure and Antitrust

Brooks and Jones (1997) found that mergers are driven mainly by the existence of specific merger opportunities

¹¹ This procedure clears an artery in the neck.

Government antitrust officials must weigh the anticompetitive consequences of hospital mergers against the projected efficiency gains.

in the hospitals' local markets. These results are also consistent with two other scenarios: The mergers may increase hospitals' ability to exercise market power in setting prices, and they may, in addition, enable the surviving institutions to more effectively negotiate with managed care organizations.

Burns, Bazzoli, Dynan, and Wholey (1997) examined a model of the stages of health care integration. They suggest that this model can represent a snapshot of the markets, but not an evolutionary sequence. The study found that increasing HMO penetration is associated with increases in hospital consolidation and "vertical" integration, in this case meaning between hospitals and physicians. These results support the hypothesis that consolidation is undertaken to enable hospitals to deal more effectively with managed care organizations.

Clement et al. (1997) found that hospitals affiliated with strategic alliances (two or more hospitals in a market joining forces to compete with other hospitals or providers) may have gained market power but do not appear to have achieved significant economies. Much of the recent growth of strategic hospital alliances has been through loosely organized forms. Any cost differences found between aligned and nonaligned hospitals disappeared when other factors were held constant, the Clement study found.

Assessment of the antitrust consequences of hospital consolidation is difficult. Advocates of strict antitrust policies are concerned that hospital mergers will allow hospitals to monopolize markets or to collude effectively with other hospitals in the market. This could not only lead to higher prices but also reduce any incentives to improve the quality of care. The larger the number of competitors in a market, according to traditional economic theory, the more difficult it is for the firms to cooperate and impose anticompetitive practices.

But government antitrust officials must weigh the anticompetitive consequences of hospital mergers

against the projected efficiency gains. The analysis of health care markets has become much more complicated with the rapid introduction of new high-tech equipment and procedures; frequently these new techniques and equipment require sufficient volume levels in order to be economically feasible. This implies, for many markets, that either the hospitals must consolidate or they must develop cooperative arrangements such as joint venture agreements. While there is a danger that these types of arrangements can lead to collusive agreements among the hospitals in the market, they have not been sufficient by themselves to result in antitrust action by the government. Bazzoli, Marx, Arnould, and Manheim (1995) found that existing antitrust merger enforcement standards are not good predictors of when hospital mergers will be challenged. Zwanziger, Melnick, and Eyre (1994) concluded that the antitrust analysis of hospital markets must include the roles of other parties, such as insurers and physicians.

Another important structural development in the health care sector is the conversion of hundreds of public and not-for-profit hospitals to for-profit hospitals during the 1980s and 1990s. This hospital conversion process was complex and varied greatly by state. Whatever the troubling policy issues that are raised by hospital conversions, the basic question remains whether conversions achieve the goal of greater institutional strength: Needleman, Chollet, and Lamphere (1997) found that hospitals that converted to for-profit status generally came out of the process smaller and with weaker market positions.

In summary, results are mixed on the efficiencies gained by hospital consolidation, despite the seeming necessity of mergers prompted by changing technology and economics. Likewise, it is difficult to generalize about an appropriate antitrust policy for hospital mergers. Given currently available evidence, hospital mergers must be analyzed on a case-by-case basis.

Potential Competition

Another factor that needs to be considered in antitrust deliberations is potential new or emerging competition. Firms on the fringe of the market that are ready to enter under favorable circumstances can play an important role in keeping a market competitive.

For instance, if the hospitals in a market raise prices or fail to introduce new procedures and techniques, other health care providers may be able to compete directly by starting a new hospital or by acquiring a smaller existing hospital. Hospitals located in reasonable proximity to a market may be able to draw patients to their existing facility or open branch clinics. These circumstances arise frequently in metropolitan areas, especially if new competitors can serve patients in a local community where an existing hospital is not serving patients adequately.

A full antitrust examination of many hospital mergers would require detailed data on the choice of hospital by patients in a wide geographic region. The discussion below of a hospital merger in the New York City metropolitan area raises these issues.

Uncompensated Care

The growth in uncompensated care has placed further pressure on hospitals to consolidate. In 1995, hospital uncompensated costs totaled \$17.5 billion, or 6 percent of hospital expenses.¹² The current system of subsidies for uninsured patient costs has been eroding because of several factors: the growth of managed care, increased price competition, reductions in federal Medicare reimbursement, and an increase in the number of uninsured. The subsidies have not kept pace with the growth in hospital expenses or in the uninsured population. Atkinson, Helms, and Needleman (1997) examined the trends in hospital uncompensated care in seven states and found cost increases in all states through the late

1980s, although uncompensated costs declined in the 1990s. They also examined state responses to the uncompensated care issue, such as coverage expansions, uncompensated care pools, hospital rate setting, and public funding for uncompensated outpatient care.

Summary

It is apparent that hospital consolidation has been strongly influenced by the changes in the competitive environment of the health care sector. The increased economic power of HMOs and managed care organizations has placed tremendous cost pressures on hospitals, and by consolidating hospitals feel that they can reduce the bargaining power of managed care organizations. This can be illustrated with a simple example. Assume that there are two hospitals in a market; a managed care organization can play one hospital against another by threatening to take all of its business to the other hospital unless its price and coverage conditions are met. If the managed care organization represents a very large proportion of the business in the market, the hospitals will be forced to capitulate to the demands. However, if the hospitals consolidate, the resulting institution will have greater negotiating power and will be able to resist the demands of the managed care organization.

But as the number of new or emerging players in the health care sector increases and the resources of nearby markets are taken into account, the bargaining situation becomes more complicated and the final outcome more uncertain. Not only hospital mergers but also vertical mergers between hospitals and either physicians or insurers begin to look attractive as methods to increase the patient base and to maintain economic viability.

Merger Evidence

In recent years the American economy has experienced a tidal wave of

¹² These numbers and the discussion are drawn from Mann, Melnick, Bamezai, and Zwanziger (1997).

business mergers, rivaling previous periods of intense merger activity. Each month brings news of another multi-billion-dollar merger that in previous years would have been inconceivable: For example, the mergers between Travelers and Citicorp, Exxon and Mobil, and Daimler Benz and Chrysler.

In the past, large mergers of this type would never have been considered, in part because the firms knew that the Department of Justice or the Federal Trade Commission would challenge the merger, forcing delays and added legal costs if not stopping it. However, antitrust enforcement has become much more lenient in recent years, in large part because of changes in the world economy and the need to view competition in a global context. Companies from outside the domestic economy have become more aggressive and viable competitors. In addition, rapid changes in technology have been widely perceived as necessitating mergers in order to realize cost savings.

The hospital industry fits into this pattern. In the decade of the 1990s, hospitals have merged at a record rate¹³ (see table 1), with little sign of any slowdown. By 1997, merger deals more than doubled from the number just three years earlier.¹⁴ During the era when insurance companies were docile, hospital capacity expanded to meet the growing business, but in more recent years as insurance companies and managed care organizations have aggressively sought discounts from hospitals and have reduced the length of stay, hospitals have seen the need to reduce capacity.

A recent study of hospitals in St. Louis and Philadelphia, both areas that have witnessed extensive numbers of mergers, has found that neither the mix of hospital services nor hospital capacity has changed much. In fact, in St. Louis the number of beds dropped by 4 percent while demand for care dropped 9 percent. The authors of the study claim that the mergers have allowed troubled hospitals to remain in operation.¹⁵ It appears that the merger wave will continue, but there are some indications that the nature of hospital mergers is changing.

Recent merger activity is moving more toward nonprofit organizations than toward for-profit organizations. Whereas in 1994 only 36 percent of hospital buyers were nonprofit organizations, in 1997, 75 percent of the buyers were nonprofits. Moreover, almost 73 percent of the acquired hospitals were nonprofits in 1997.¹⁶ Part of this change is the result of the problems encountered by the largest for-profit chain of hospitals, Columbia/HCA Healthcare Corp. After gaining a reputation for acquiring ailing hospitals and squeezing costs and boosting efficiency, Columbia ran into financial problems and announced in April 1998 that it was selling 22 hospitals in Alabama, Tennessee, Kentucky, and North Carolina to a consortium of nonprofit hospitals for \$1.2 billion.¹⁷ In addition to its economic troubles, the company has been investigated by the federal government for potential Medicare fraud.

Vanguard Health Systems was formed in 1997 and is planning to build a network of nonprofit hospitals while allowing regional boards to make key decisions.¹⁸ This may provide nonprofit hospitals another viable alternative to succumbing to a for-profit merger. Nevertheless, nonprofit hospitals face formidable challenges, as reflected in a recent survey by a health care management consultant that found only 11 percent of nonprofit hospitals expect to remain independent by 2002. Physician and business community pressure has often hindered cost-reduction strategies, especially reductions in employment. Consolidation of administrative functions and duplicate services is much more easily accomplished than consolidation of clinical services. A

¹³ See Blecher (1998), p. 28.

¹⁴ See Blecher (1998).

¹⁵ See Blecher (1998) for a discussion of this study done by the Economic and Social Research Institute in Washington.

¹⁶ These facts are drawn from an annual hospital survey conducted by Irving Levin Associates and are discussed in Casey (1998).

¹⁷ See Casey (1998) for a discussion.

¹⁸ See Casey (1998).

Several vertical integration mergers have failed and lost considerable amounts of money. However, very little empirical work has been done to examine the motivation for vertical mergers or their effects.

recent survey by the American Hospital Association found that 31 percent of surveyed hospitals faced possible closure in the next few years due to financial pressures.¹⁹ These conditions lead to a desire to consolidate and, particularly, a need to increase market share in order to achieve a better bargaining position in the health care market.

Vertical integration has appealed to hospitals because of their need to obtain more patients. The two main types of vertical arrangements involving hospitals are joint ownership between hospitals and physicians, and between hospitals and HMOs. Of considerable interest are the recent acquisitions of HMOs by hospitals. As of 1997, 53 hospital firms (involving 216 hospitals) had acquired 44 HMOs in 24 states,²⁰ and in three of these cases a single hospital purchased more than one HMO (the University of South Alabama, Vanderbilt University Medical Center, and the Inter-mountain Health Plans). More than half of these hospital firms that acquired HMOs were members of a multi-hospital system, and 9 percent were for-profit (less than the 13 percent nationwide). Most of this vertical integration occurred after 1995, and all of it occurred after 1985.

Several vertical integration mergers have failed and lost considerable amounts of money.²¹ However, very little empirical work has been done to examine the motivation for vertical mergers or their effects. It has been suggested that the competitive environment has stimulated hospitals to acquire HMOs so that more of the hospitals' excess capacity can be utilized. More research is needed to explore vertical integration in the health care sector.

Case Study of a Merger

The previous arguments are illustrated by a detailed examination of a recent large

hospital merger involving North Shore University Hospital and Long Island Jewish Medical Center, two large teaching hospitals in the New York metropolitan area. In June 1997, the U.S. Justice Department challenged the legality of the merger, but later that year a federal district

judge in New York denied the Justice Department's request for an injunction against the merger. This ruling, which the Justice Department did not appeal, could have important implications for future hospital mergers.

This case is extremely interesting for a number of reasons.²² First, in recent years the state of New York has moved away from a highly regulated health care system to a more market-oriented approach. The facts in this case illustrate the primary importance of market considerations in hospitals' decision-making. Second, the Justice Department unsuccessfully attempted to introduce a new legal theory to try to stop the merger, and the court's rejection of this theory may hamper future government efforts to slow the merger movement in hospitals. Third, the case deals with the motivations for hospital mergers and confirms the conclusions already drawn in this report.

Long Island Jewish Medical Center is a 591-bed teaching hospital in the eastern part of Queens County, NY. North Shore University Hospital is a 729-bed teaching hospital in Manhasset, in the western part of Nassau County, NY. The two hospitals are approximately two miles apart, one inside the confines of New York City and the other in a suburban county. They are the two most prominent hospitals in the immediate area.

¹⁹ This discussion is drawn from Casey (1998).

²⁰ These data and succeeding data can be found in Greenberg and Sparks (1998).

²¹ See Greenberg and Sparks (1998) for examples.

²² Much of the following discussion is drawn from Padden (1998).

Mergers in metropolitan areas are almost always approved because the market shares of the combined institutions would not be that large for the region and the market would not be very concentrated.

Until recently, New York state regulated the prices that hospitals could charge, and removal of these regulations has made regulators concerned about higher prices resulting from mergers. A large number of mergers have taken place in the state of New York and, particularly, in the New York City area, where there are many teaching hospitals and medical schools. The large total number of hospitals in the area, and their excess supply of beds, has been a major impetus to hospital consolidation.

A crucial step in any merger analysis is the determination of the appropriate geographic market. Traditionally, courts have looked at patient origin data and have considered the market for urban hospitals to be the entire metropolitan area or a large part of the metropolitan area. Some measure of market concentration, such as the Herfindahl-Hirschman Index or the n-firm concentration ratio, is calculated for the market. The combined market share for the hospitals is also calculated, and the results are compared with data from previous merger cases in order to assess the likelihood of anticompetitive consequences from the merger. The antitrust agencies and the courts may also consider other factors in their analysis, such as the financial condition of the acquired hospital.

Based on this approach, mergers in metropolitan areas are almost always approved because the market shares of the combined institutions would not be that large for the region and the market would not be very concentrated due to the large number of hospitals it includes. However, in rural areas or small cities where there might be few hospitals, the combined market share from a hospital merger frequently could exceed 50 percent. In practical terms then, the traditional approach to market concentration analysis could stop mergers only in nonmetropolitan areas.

In this case, the Justice Department tried a novel approach in order to make the market share of the combined institution appear to be larger and to make the

market concentration measure appear to be higher. In order to establish anticompetitive effects, the Justice Department focused "on the character of the competition between the hospitals, particularly with

regard to serving managed care organizations."²³ It claimed that managed care plans needed prestigious teaching hospitals as "anchor hospitals," and that the product market therefore was anchor hospitals that were required by managed care plans. In addition, the geographic market was designated as the area in Queens and Nassau Counties, where the managed care plans could find substitutes for Long Island Jewish as an anchor hospital. Traditional market shares were ignored. The government produced internal hospital documents saying that the merger would reduce the managed care organizations' ability to play one hospital off against the other. It also cited a previous consent agreement prohibiting North Shore from orchestrating an agreement among six hospitals to prevent discounting.

But the district court rejected these arguments on many grounds. The product market was deemed to be contrary to established precedent from previous hospital merger cases. North Shore and Long Island Jewish were not found to be sufficiently distinguishable from other hospitals to establish a separate market for anchor hospitals. More than 85 percent of their services were found to be competitive with community hospitals. The two hospitals were found to be competitive for tertiary services with Winthrop University Hospital in nearby Mineola and with numerous teaching hospitals in Manhattan and in Suffolk County. Patients are more willing to travel greater distances for services for the more involved procedures and treatments.

Although the court acknowledged the importance of managed care organizations as purchasers of services, four other categories of consumers were also considered important: self-pay patients; physicians

²³ See Padden (1998), p. 35.

controlling admissions; employers; and government payers. The court rejected the argument that the prominent reputation of the two hospitals could distinguish them from other hospitals. It was noted that the existence of only one anchor hospital in Suffolk County did not lead to higher prices.

In addition, the court concluded that the Justice Department had failed to show any probable anticompetitive effects in the relevant market. Prices would not increase because half of the institutions' business involved Medicare and Medicaid patients for whom the government set reimbursement rates, and much of the other half of their business involved managed care patients. Executives of managed care organizations generally favored the merger, and said that they could work with other hospitals if the merger raised prices of the merged entity.

The court also addressed other issues. The hospitals' nonprofit status was not considered to be of major importance. The government and the hospitals had widely different estimates of cost efficiencies. The court estimated efficiencies at a level between the two assertions (but closer to the government claim), and found that these savings would benefit consumers. The court claimed that there were numerous potential entrants, including several Manhattan hospitals, that were already moving into the area, and that this would serve to constrain anticompetitive behavior. Finally, the court found that the economics of the health care industry, including a shrinking patient population, numerous empty beds, and lower revenues, was a major motivating force for the merger.

This decision was an important loss for the Justice Department, since its new theoretical legal approach was soundly rejected. This, along with other recent losses by antitrust agencies using more traditional approaches, does not bode well for the government's ability to prevent hospital mergers in metropolitan areas. The decision allows hospitals to adjust to a new competitive environment. But whether mergers ultimately will solve the multiple and complex

problems faced by hospitals is a question yet to be answered.

Impact on Benefits?

The increased pace of hospital consolidation appears to be a consequence of the changing

nature of competition in the health care marketplace. Hospitals feel constrained by the ever-increasing presence of managed care organizations, and feel compelled to consolidate in order to reduce the bargaining power of these organizations and to increase competitiveness by reducing costs. While there is some evidence that mergers do reduce costs, it is not overwhelming. Efforts by government antitrust authorities to thwart the merger movement have failed thus far. It is likely that the large-scale hospital consolidation witnessed in the last few years will continue unabated for the foreseeable future.

Other likely developments also should lead to more consolidation and cooperative arrangements among hospitals. Increased vertical arrangements could lead to less choice and more control by insurers. Proposed cutbacks in Medicare hospital payments could lead to increased incentives to consolidate. Another potential issue is the growth of specialty hospitals that cater to the well-insured and well-off. To the extent that cost shifting occurs, the high-volume and high-profit "cash cow" procedures could be skimmed off from community hospitals by specialty hospitals. In these instances, profitability could decrease, and incentives to consolidate could increase. Continued mergers and additional cutbacks in Medicare payments to hospitals would make it more difficult for managed care plans to negotiate discounts.

This could have important consequences for the provision of employee health care benefits, but it is not completely clear what these consequences would be. Consolidation will increase the bargaining power of

hospitals with managed care organizations, but, simultaneously, the power of managed care organizations is changing, and it is difficult to foresee what the relative power of the two sectors will be in the future.

Hospitals are being forced to reduce costs, and mergers probably will help reduce certain costs. As independent hospitals disappear, consumers will have less choice. Employers are likely to continue applying pressure on insurers and providers in order to reduce their health care expenditures. Consequently, the cost-cutting pressure placed on hospitals is unlikely to decrease. However, public opposition to some of managed care organizations' practices may result in legislation restricting certain behavior of managed care. This could ease the pressure on hospitals.

Also, hospital consolidation can have repercussions on other parts of the health care sector: Insurers may feel compelled to consolidate, and physicians may try to form unions. As all segments try to consolidate in order to increase bargaining positions, the ultimate relative bargaining powers of these segments is unclear.

With all of this uncertainty, it is difficult to predict accurately what will happen to the structure of the hospital industry. In the short term, it is likely that consolidation will continue at a rapid pace. Some developments may reduce the cost of employee benefits, while others may increase the cost. The final effect on the provision of health care benefits by employers is, therefore, highly uncertain.

However, employers must pay close attention to these developments, since they will significantly affect the demand for health care services and the ability of employers to provide health care benefits. The only real certainty is that there will continue to be important changes in the provision of health care benefits as the hospital and health care system continue to evolve.

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