

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**THE EFFECTS OF HOSPITAL MERGERS  
ON THE AVAILABILITY OF SERVICES**



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# EXECUTIVE SUMMARY

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## PURPOSE

This report describes the effects on the availability of hospital services when hospitals merge.

## BACKGROUND

Changes in Medicare hospital reimbursement and other "belt-tightening" actions by public and private payers have forced hospitals to operate more efficiently. Among the cost-cutting measures considered by hospitals are resource-sharing arrangements and consolidation. Some hospitals conclude that merger is the best course to remain viable.

The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), however, maintain that mergers may, in some situations, reduce healthy competition. It is their responsibility to protect consumers from anti-competitive actions which may result in higher prices and restricted choices. The DOJ prepared the Federal Merger Guidelines ("Guidelines") in 1968. The DOJ uses the Guidelines to determine which proposed mergers may violate antitrust law. The FTC uses the Guidelines and other criteria for their merger analyses. The Guidelines do not mention the hospital industry specifically, nor issues of access to care.

Some members of the hospital industry are deeply concerned about DOJ's and FTC's increased interest in and challenge to hospital mergers in the past few years. Recent antitrust suits have caused a great deal of consternation in the industry and have complicated the decision-making process for hospitals considering merger. On the other hand, figures from the American Hospital Association indicate that 40 to 60 mergers (the term includes acquisitions) have occurred annually in the past decade. The DOJ and FTC have brought fewer than 10 antitrust cases against hospitals during that time.

In November 1989, Secretary Sullivan appointed a task force to examine hospital merger issues and asked the Inspector General to conduct certain studies to support the work of the task force. This report assesses the effects of hospital mergers on the availability of hospital services.

## FINDINGS

*This assessment of eight hospital mergers found that:*

- In all cases, one or both of the merging hospitals suffered from declining occupancy, lagging revenues, and/or rising costs. The mergers addressed these problems; all of the remaining hospitals are reported to be stronger as a result of merger.
- None of these mergers drew community opposition, and none were challenged by antitrust enforcement agencies.

- Of the 16 merging hospitals, four closed (ceased to provide general acute care) after the merger.
- No negative effects on the availability of hospital services resulted from any of the mergers. In all eight merger cases, the availability of hospital services was maintained or improved.

## **RECOMMENDATIONS**

This report contains no recommendations. However, the HHS Hospital Merger Task Force may make recommendations based on these and other studies.

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# INTRODUCTION

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## PURPOSE

This report describes the effects on the availability of hospital services when hospitals merge. Its findings are based on an assessment of eight hospital mergers that occurred in 1987.

## BACKGROUND

Observers of the health care industry note the dramatic changes in that industry in recent years, including an increase in the number of mergers. One independent surveyor has forecast that the number of hospitals in multi-hospital systems will increase from about 2,400 in 1986 to over 3,400 by 1995.<sup>1</sup>

Changes in Medicare hospital reimbursement and other "belt-tightening" actions by public and private payers have forced hospitals to operate more efficiently. Among the cost-cutting measures considered by hospitals are resource-sharing arrangements and consolidation. Some hospitals conclude that merger is the best course to remain viable.

The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), however, maintain that mergers may, in some situations, reduce healthy competition. It is their responsibility to protect consumers from anti-competitive actions which may result in higher prices and restricted choices. The DOJ prepared the Federal Merger Guidelines ("Guidelines") in 1968. The DOJ uses the Guidelines to determine which proposed mergers may violate antitrust law. The FTC uses the Guidelines and other criteria for their merger analyses. The criteria in the Guidelines take into account the geographic market, the product market, the market shares of each merging entity, the effects of competition on prices, imminent financial failure, and efficiencies to be gained through merger. The Guidelines do not mention the hospital industry specifically, nor issues of access to care.

Some members of the hospital industry are deeply concerned about DOJ's and FTC's increased interest in and challenges to hospital mergers in the past few years. Recent antitrust suits have caused a great deal of consternation in the industry and have complicated the decision-making process for hospitals considering merger.<sup>2</sup> On the other hand, figures from the American Hospital Association indicate that 40 to 60 mergers (the term includes acquisitions) have occurred annually in the past decade. The DOJ and FTC have brought fewer than 10 antitrust cases against hospitals during that time.<sup>3</sup>

In November 1989, Secretary Sullivan appointed a task force to examine hospital merger issues and asked the Inspector General to conduct certain studies to support the work of the task force. This report assesses the effects of hospital mergers on the availability of hospital services.

A companion report entitled “The Effects of Hospital Mergers on the Availability of Services: A Case Study of Eight Hospital Mergers” (OEI-04-91-00500) was issued at the same time as this report. That document describes, case-by-case, each of the hospital mergers in the study sample.

## SCOPE

The study examined eight cases of hospital merger that occurred during 1987.

For purposes of this study, the term *merger* includes acquisition. A *hospital* is defined as a facility that provides general, short-term acute medical and surgical inpatient services.

## METHODOLOGY

In selecting the eight mergers for the case studies, we began with the American Hospital Association’s (AHA) list of 1987 mergers. The AHA list contained 20 mergers that met the study criteria. From this list we identified:

- rural general acute care hospital mergers where both hospitals were located in the same county, and
- urban general acute care hospital mergers where both hospitals were located in the same Metropolitan Statistical Area (MSA).

We selected four mergers from each group.

We conducted on-site visits to each community in the eight case studies. The study team obtained information from hospital administrators and staff, hospital board members, business leaders, local physicians, other local health care providers, local public officials, concerned citizens, State hospital associations, and State health planning agencies.

This study examined the pre-merger versus the post-merger availability of hospital and related health care services. To ascertain the effect of the merger on availability, the pre-merger services offered by both merger partners were compared to the services still offered by the post-merger facility. If a service was deleted as a result of the merger, the study team ascertained the availability of that service from another provider, and the distance to that provider.

We did not analyze the broader and more complex issue of access to care that would have required examination of a number of factors beyond the scope of our review, such as: the availability or adequacy of health insurance coverage; patient and physician preferences to use a particular hospital; and the availability of related health care services in the area served by a hospital.

**SAMPLE**

The following eight hospital mergers were included in the study:

MERGER RESULT

Ottumwa Regional Health Center  
Ottumwa, IA

Newton Medical Center  
Newton, KS

Mercy Hospitals and Health Services of Detroit  
Detroit, MI

Trinity Lutheran Hospital  
Kansas City, MO

St. Francis Medical Center  
Grand Island, NE

Staten Island Hospital  
Staten Island, NY

MERGING HOSPITALS

Ottumwa Regional Health Center  
Ottumwa, IA

St. Joseph Health and Rehabilitation Center  
Ottumwa, IA

Axtell Christian Hospital  
Newton, KS

Bethel Deaconess Hospital  
Newton, KS

Samaritan Health Center  
Detroit, MI

Mount Carmel Mercy Hospital  
Detroit, MI

Trinity Lutheran Hospital  
Kansas City, MO

St. Mary's Hospital  
Kansas City, MO

St. Francis Medical Center  
Grand Island, NE

Grand Island Memorial Hospital  
Grand Island, NE

Staten Island Hospital  
Staten Island, NY

Richmond Memorial Hospital and Health Center  
Staten Island, NY



**SAMPLE cont.**

**MERGER RESULT**

The Allentown Hospital-  
Lehigh Valley Hospital Center  
Allentown, PA

Methodist Hospital of Middle Tennessee  
Winchester, TN

**MERGING HOSPITALS**

Allentown Hospital  
Allentown, PA

Lehigh Valley Hospital Center  
Allentown, PA

Methodist Hospital of Middle Tennessee  
Winchester, TN

Emerald-Hodgson Hospital  
Sewanee, TN

# FINDINGS

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This inspection found that among the eight 1987 hospital mergers studied:

- In all cases, one or both of the merging hospitals suffered from declining occupancy, lagging revenues, and/or rising costs. The mergers addressed these problems; all of the remaining hospitals are reported to be stronger as a result of merger.
- None of these mergers drew community opposition, and none were challenged by antitrust enforcement agencies.
- Of the 16 merging hospitals, four closed (ceased to provide general acute care) after the merger.
- No negative effects on the availability of hospital services resulted from any of the mergers. In all eight merger cases, the availability of services was maintained or improved.

## WHAT WERE THE HOSPITALS LIKE?

All of the 16 hospitals involved in these mergers were not-for-profit. Each hospital had its own administration and independent board. As a result of the mergers, the eight hospitals remaining each has an independent administration and board.

The eight hospitals operate at 12 acute care facilities: four of the merged hospitals maintain acute care services at two locations; the other four hospitals closed one of the locations as an acute care facility.

The hospitals, prior to the merger, varied in size from 32 beds to 470 beds. The average size of the 16 hospitals was 206 beds.

After merger, the eight remaining hospitals vary in size from 72 beds to 803 beds, averaging 365 beds.

## WERE THE MERGERS CHALLENGED?

No challenge was presented to any of the mergers by any antitrust enforcement agency. In Ottumwa, Iowa the Federal Trade Commission did informally inquire into the proposed merger but did not challenge it.

Further, there were no organized efforts within the hospitals or from the communities to prevent any of the mergers.

## **WHY DID THE HOSPITALS MERGE?**

In all of the cases, respondents said the decision to merge was prompted by problems within the hospitals. These problems varied widely in their severity and ultimate consequences, according to respondents. For example:

- Emerald-Hodgson Hospital in Sewanee, Tennessee was facing certain closure if it had not merged. Its closure would have deprived the Grundy County residents of a convenient and easily-accessible source of primary health care.
- In Newton, Kansas, continued competition between the two hospitals resulted in duplicative services and equipment. Continued competition would have driven both into financial failure, leaving the town without a hospital.
- In Allentown, Pennsylvania, the merging hospitals wanted to improve their position further by reducing overhead expenses.

The factors cited by respondents which prompted decisions to merge were similar to the factors found by the Inspector General in previous studies of hospital closure.<sup>4</sup> Those studies found declining occupancy, lagging revenues and/or rising costs weakened hospitals to the extent that they had no choice but to merge or close.

In this study, the factors cited are:

### ***Declining Occupancy***

- Medical advances and new technology have allowed some procedures that formerly required hospitalization to be performed on an outpatient basis.
- Lengths of stay have also shortened.
- Demographic changes have reduced admissions to certain services. For example, the families who were formerly served by St. Mary's Hospital in Kansas City, Missouri have migrated to the suburbs. The elderly population remaining in the area did not require obstetrical services offered by the hospital.

### ***Lagging Revenues***

- Insurers, in efforts to better control their costs, are limiting reimbursement.
- Economic changes in the community have increased the portion of indigent and under-insured patients.

### ***Rising Costs***

- New medical technology is a major capital expense, especially when hospitals must finance duplicate equipment to compete with each other.

- Labor costs are increasing and competition for staff, especially Registered Nurses and specialists, is keen.
- Liability insurance costs, especially in the tri-county area of Detroit, Michigan, have risen significantly.

## WHAT WERE THE RESULTS OF THE MERGERS?

Respondents at all of the hospitals said the mergers made the hospitals stronger institutions and provided benefits. Some examples of the benefits specifically identified by respondents are:

- The post-merger Allentown Hospital - Lehigh Valley Hospital Center, now the largest hospital in Pennsylvania, was able to recruit nationally-prominent heart and psychiatric specialists and retain staff physicians.
- In Ottumwa, Iowa, Ottumwa Regional Health Center was able to acquire more sophisticated equipment: a lithotripter and a magnetic resonance imager (MRI).
- In the Emerald-Hodgson Hospital in Sewanee, Tennessee, the post-merger hospital provided job security and employee benefits which had not been provided by the pre-merger management firm.
- By consolidating some administrative and management functions, Mercy Hospitals and Health Services of Detroit eliminated management positions and reduced overhead expenses.
- The merger in Newton, Kansas ended the "medical arms race" which resulted from competition between the hospitals. Costly duplication of technology and staff was no longer necessary.
- In Staten Island, New York, the "overflowing" hospital was able to better utilize available space by transferring some services to its "underused" merger partner.
- The hospitals in Grand Island, Nebraska and Ottumwa, Iowa were able to insure their Regional Referral Center status by halting declining admissions.

However, for one hospital the strength gained from the 1987 merger was not long-lived. For another, the opportunity for additional economies was a motivation to merge again several years later.

- Mercy Hospitals and Health Services of Detroit — the merger resulting from combining Mt. Carmel Mercy Hospital and Samaritan Health Center — lost approximately \$28 million in fiscal year 1989. Worsening conditions compelled the corporate parent to "demerge" them and to enter into new arrangements.

As of July 1, 1990, Mt. Carmel Mercy Hospital merged under a letter of intent with another hospital, agreeing to consolidate medical staffs and employees. Mt. Carmel will be purchased by the other hospital's parent organization on April 1, 1991.

Samaritan Health Center, the other hospital in the 1987 Detroit merger, entered into a joint venture agreement. As of July 1, 1990, another hospital system will manage Samaritan for the next five years. The managing system will provide "financial support" in return for the use of Samaritan Health Center and other health care facilities owned by Samaritan's parent corporation.

- Trinity Lutheran Hospital in Kansas City, Missouri has also entered into a new merger arrangement. Trinity and another acute care hospital will share administrative services and personnel. This arrangement is intended to accommodate peaks and valleys in activity at both hospitals.

### **DID THE MERGERS AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?**

Although four of the facilities closed after the merger, none of the mergers had a negative effect on the availability of hospital services. In fact, services have been added at most of the hospitals since the merger. For example, as a result of the merger:

- In Grand Island, Nebraska, a skilled nursing facility was opened and outpatient services were expanded, including radiation therapy, radioactive implants, hemodialysis, and cardiac catheterization.
- In Newton, Kansas, the newborn nursery has been upgraded from a Level I (well baby) facility to a Level II (intermediate care) facility. An "in-house" computed tomographic (CT) scanner has replaced the mobile scanner which visited Newton Medical Center three times a week.
- In Staten Island, New York, psychiatric emergency services, an MRI, a hospice, and cardiac catheterization services were added. A skilled nursing facility was also opened.
- In the case of the merger which created Methodist Hospital of Middle Tennessee, the availability of services and access to those services for the elderly poor was dramatically improved. The previously-troubled Emerald-Hodgson Hospital located in Sewanee opened a skilled nursing facility and implemented a free transportation system for the elderly poor in Grundy County. The system provides better access not only to Emerald-Hodgson Hospital, but also to its merger partner 13 miles away in Winchester. In addition to free transportation, a toll-free telephone line to Sewanee was installed for the use of Grundy County residents.

Only two of the eight merged hospitals deleted a service as a direct result of the merger:

- Trinity Lutheran Hospital in Kansas City, Missouri elected not to offer obstetrical services after the merger with St. Mary's Hospital. Trinity Lutheran had not offered obstetrical

services for at least a decade prior to the merger because of local demographic changes and the fact that hospitals nearby still offered obstetrical care.

The area served by Trinity Lutheran Hospital, "midtown," had become predominantly elderly. Statistics from the AHA on the number of births and bassinets for the period preceding the merger corroborated the claims of the Kansas City respondents that births were declining. Obstetrical services are still available from other hospitals nearby, including Truman Medical Center, only five blocks away, and from Menorah Medical Center, approximately 2 to 3 miles away.

Post-merger data on the average daily census at Trinity Lutheran Hospital and Medicare/Medicaid utilization figures all strongly indicated that the majority of St. Mary's non-obstetrical patients were, in fact, using Trinity Lutheran Hospital after St. Mary's closed as a general acute care facility.

- Due to religious affiliations in the Grand Island, Nebraska merger, elective tubal ligations were discontinued. That service can now be obtained from a hospital approximately 20 miles away.

In four of the eight mergers in the study sample, one of the hospitals closed as a general acute care facility. The additional distance that patients must travel due to the closure is insignificant, and appears to have had no impact on the availability of hospital services. The distance to the remaining facility in the four cases ranges from 1 block to approximately 1.5 miles.

In three of the four cases where one of the hospitals closed, the buildings are now used for other services:

- In Kansas City, Missouri, the building houses both inpatient and outpatient psychiatric and alcohol/chemical dependency services and some administrative offices.
- In Ottumwa, Iowa, the building is used for outpatient care, home health care, rehabilitation services, and office space.
- In Grand Island, Nebraska, the building houses an extensive range of outpatient services, a skilled nursing facility, offices, meeting rooms and a child daycare center.

## CONCLUSION

In all eight cases of the mergers studied here, even when a hospital closed, the availability of services was maintained or improved.

## RECOMMENDATIONS

This report contains no recommendations. However, the HHS Hospital Merger Task Force may make recommendations based on these and other studies.

## AGENCY COMMENTS

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The draft report entitled “The Effects of Hospital Mergers on Access to Care” was submitted for comment to the appropriate Operating Divisions within HHS and the Secretary’s Task Force on Hospital Merger. We received written comments on the draft report from the Assistant Secretary for Planning and Evaluation and verbal comments from members of the Secretary’s Task Force on Hospital Merger. Both remarked that the focus of the study is availability of services, not the broader and more complex issue of access to care. We agree. An analysis of the many issues relating to access to care is beyond the scope of this study. We, therefore, changed the name of the report to reflect more clearly its narrower focus.

## ENDNOTES

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1. Edward A. Grant, CPA and Edward J. Giniat, CPA. "Evaluating Mergers and Acquisitions with a Purchase Investigation." *Healthcare Financial Management*. April 1988.
2. For an overview of concerns in the hospital industry see Marybeth Burke. "Mixed Signals from Government Have Chilling Effect on Mergers." *Hospitals*. June 5, 1990. See also "HHS Neutral on Hospital Antitrust?" *Health Policy Week*. February 12, 1990 and Tinker Ready. "Court Axes Merger of Two Non-Profits." *HealthWeek*. March 6, 1989.
3. Merit C. Kimball. "Will HHS Advise Justice, FTC on Hospital Antitrust?" *HealthWeek*. February 26, 1990.
4. Office of Inspector General, Department of Health and Human Services. "Hospital Closure: 1987," OAI-04-89-00740, May 1989 and "Hospital Closures: 1988," OEI-04-89-01810, April 1990.