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POLICY BRIEF

Hospital mergers increase costs and reduce the quality of patient outcomes

By Roger Stark, MD, FACS, Senior Fellow,
Center for Health Care

January 2021

Key findings

1. Hospital and medical provider consolidation has been occurring for the past several decades in the United States.
2. Although hospital mergers or acquisitions may save poorer performing facilities, research shows that hospital networks create monopolies and usually increase costs.
3. Spending on inpatient hospital care accounted for one third of the $3.4 trillion spent on health care in the United States last year.
4. The number of hospitals in the U.S. has decreased by one thousand over the past 40 years, with an accelerated rate of closure over the past 15 years. The overall number of remaining hospital beds has similarly decreased.
5. Along with the tragedy of thousands of lives lost to COVID-19, the financial impact on hospitals has been two-fold and substantial – the majority of cases are covered by low Medicare payments and hospitals have been forced to cancel higher-paying elective procedures.
6. Research suggests that hospital consolidation does not decrease the cost of health care, nor does consolidation improve patient quality of care.
7. The government is very aggressive about stopping monopolistic practices in other economic areas, yet hospital mergers seem to be immune to both federal and state intervention.
8. The basic difference between health care compared to other economic activities is the third-party payer system. Patients are financially isolated from the monopolistic consequences of hospital mergers.
9. The solution to this ever-increasing practice of combining hospitals is to allow patients to use their own health care dollars and shop for health care in an open competitive environment.

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Introduction

Hospital and medical provider consolidation has been occurring for the past several decades in the United States. Hospitals have become part of large corporate systems, and more doctors have become salaried corporate employees instead of running their own practices.

The main argument offered to justify hospital consolidation is that bigger is better with more efficiency at lower costs. Hospitals joining each other or being bought up by one corporation is called horizontal integration, while hospitals putting doctors on salary is called vertical integration.

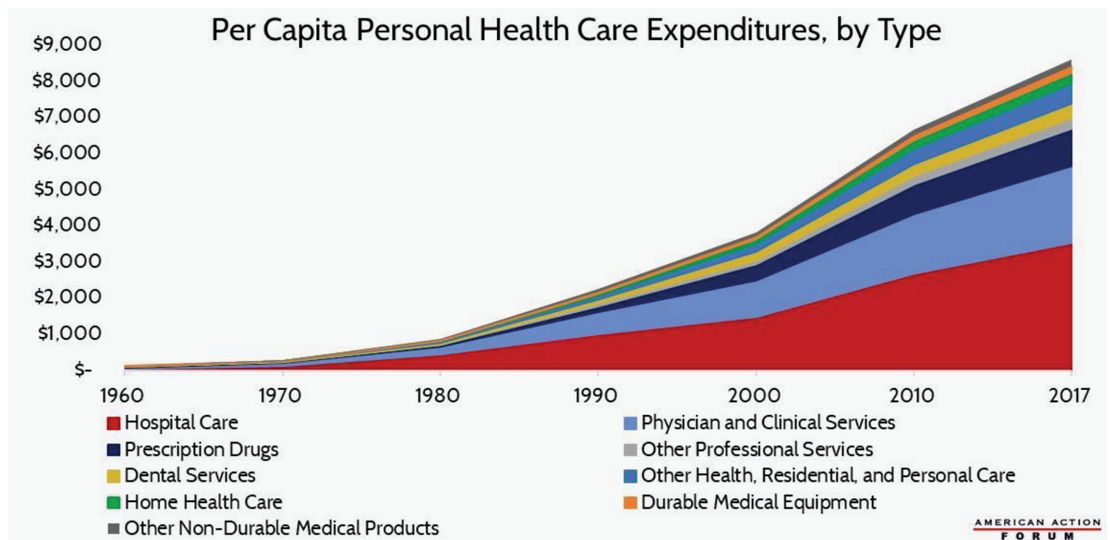
Although hospital mergers or acquisitions may save poorer performing facilities, research shows that hospital networks create monopolies, restrict choices for patients, and usually increase costs. This Policy Note reviews the available information on hospital and provider consolidation both nationally and in Washington state, and how it affects the cost of care and the quality of the care patients receive.

Background on hospital finances

Spending on inpatient hospital care accounted for one third of the $3.4 trillion spent on health care in the United States in 2019.[1] The American Action Forum charted health care spending per capita over the past 60 years.[2] Although each category of health care spending increased, especially since 1970, hospital expenditures rose the greatest.

1 "National health expenditure data," Centers for Medicare and Medicaid Services, December 17, 2019, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

2 "Hospital markets and the effects of consolidation," by T. O'Neill Hayes and K. Dixon, American Action Forum, October 8, 2019, at https://www.americanactionforum.org/research/hospital-markets-and-the-effects-of-consolidation/.



For the past decade, hospital spending increased by over 30 percent and is projected to increase a further 5.7 percent over the next seven years.[3] This is based on per capita growth and does not reflect an increase in population in the U.S.

Interestingly, the number of hospitals in the U.S. has decreased by about one thousand over the past 40 years, with an accelerated rate of closure over the past 15 years. The overall number of remaining hospital beds has likewise decreased.[4] Rural hospitals have experienced a larger drop than urban facilities, with 20 percent of existing rural hospitals still at risk of closing.[5] The average length of time a patient spends in the hospital has also decreased. The number of surgeries performed in hospitals has decreased, while the number of surgeries undertaken in outpatient facilities has increased dramatically.

On the reimbursement side, over the past decade and a half, payments to hospitals increased by between 30 percent to 40 percent, depending on the study, while doctor payments increased around 15 percent.[6] This income increase reflects more generous negotiated insurance payments and not an increase in patient volume. On average, the federal Medicare program pays hospitals about 20 percent of what they charge, which significantly distorts the market. To pay overhead, hospitals are forced to shift costs on to private insurance patients. Medicaid reimbursements are even lower than Medicare and this distorts the market even further, by forcing private patients to pay more.

Do hospital mergers reduce the cost of care? Research suggests that they do not.[7] When hospitals located in the same geographic location merge, their charges increase by 20 percent to 40 percent on average. In some areas post-merger costs rise by as much as 65 percent.

3 "National health expenditure data," Centers for Medicare and Medicaid Services, April 15, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

4 "True cost of health-care," by D. Belk, MD, truecostofhealthcare.org, at https://truecostofhealthcare.org/admissions_data/.

5 "The potential impact of a Medicare public option on U.S. rural hospitals and communities: a scenario analysis," by J. Goldsmith and J. Leibach, Navigant, August 2019, at https://guidehouse.com/-/media/www/site/insights/healthcare/2019/rural-hospital-public-option.pdf.

6 "Hospital prices grew substantially faster than physician prices for hospital-based care in 2007-2014," by Z. Cooper, et. al., Health Affairs, February 2019, at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05424.

7 "Hospital markets and the effects of consolidation," by T. O'Neill Hayes and K. Dixon, American Action Forum, October 8, 2019, at https://www.americanactionforum.org/research/hospital-markets-and-the-effects-of-consolidation/.

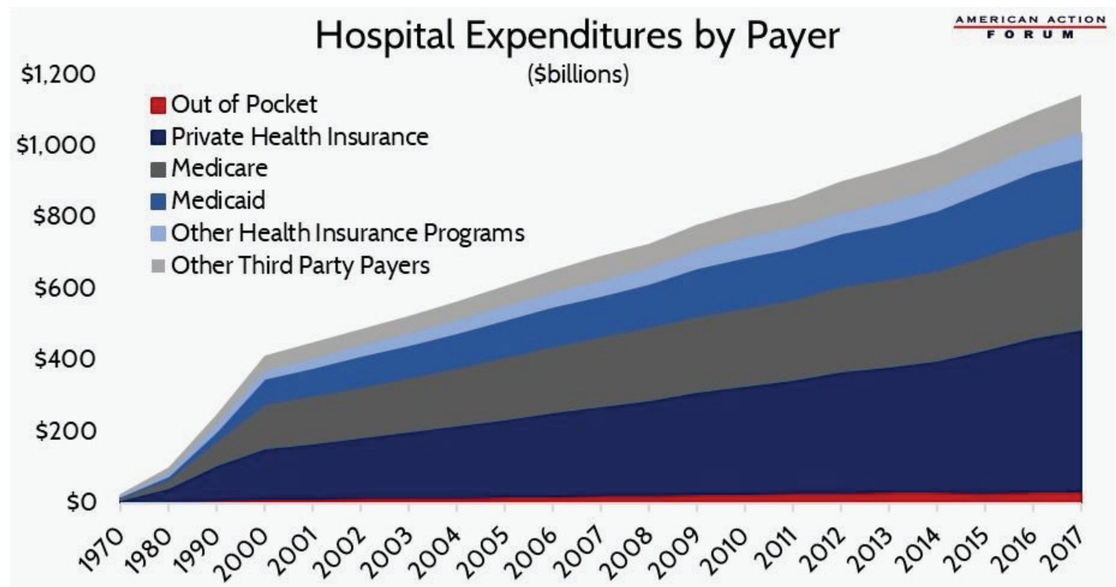
Profit margins for hospitals vary by location and by the distinction of public versus private. The range of profit margin is between five and eleven percent with the overall average being about eight percent.[8]

Do hospital mergers provide better quality of care for patients?

Better efficiency and improved quality of care are two of the arguments offered in support of hospital mergers. Research, however, shows otherwise. One of the largest studies found that patient outcomes were better in markets with hospital competition compared to areas with hospital monopolies.[9] Other studies analyzing specific diseases, for example cardiac problems, found that mortality rates were higher in less competitive markets.[10] The number of treatments and procedures performed, however, were definitely higher after hospital mergers.

The distortion imposed by third party payers

Almost 85 percent of health care is paid for by a third party – either employers through private insurance or the government through the Medicare and Medicaid programs, or through the Veterans Administration system, or through Obamacare. The following chart shows the dramatic increase in hospital payments from various third-party sources over a 50 year period.[11] At the same time, out-of-pocket spending on hospital care remained very low and quite stable.



Impact of COVID-19 on hospital consolidation

Along with the tragedy of thousands of lives lost to the virus, the financial impact on hospitals of the COVID-19 pandemic has been two-fold and substantial. The majority of patients requiring hospitalization in the U.S. have Medicare as their health

8 "The high price of hospital care," by E. Gee, Center for American Progress, June 26, 2019, at https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/.

9 "Death by market power: reform, competition and patient outcomes in The National Health Service," by M. Gaynor, et. al., National Bureau of Economic Research, July 2010, at https://www.nber.org/papers/w16164.

10 "The impact of hospital mergers on treatment intensity and health outcomes," by T. Hayford, Ph.D., Health Research Service, Wiley Online Library, November 18, 2011, at https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2011.01351.x#references-section.

11 "Hospital markets and the effects of consolidation," by T. O'Neill Hayes and K. Dixon, American Action Forum, October 8, 2019, at https://www.americanactionforum.org/research/hospital-markets-and-the-effects-of-consolidation/.

insurance. As discussed above, the more Medicare patients a hospital serves, the worse the financial status of that facility becomes.

In addition, hospitals rely on well-paying elective procedures to meet their financial overhead. With hospital beds taken up by COVID-19 patients, elective surgeries and tests have been cancelled or postponed.[12] The COVID-19 pandemic exacerbated the existing financial problems hospitals had in the U.S. It is anticipated that more hospitals will be forced to merge or close because of the crisis.

Hospital systems in Washington state

Last fall, *Seattle Business Magazine* reported on hospital mergers and systems in Washington state.[13] This was before the COVID-19 pandemic struck, but it does reflect the way hospitals were organized before the viral crisis. Not included in this list is the number of outpatient clinics each system has, nor does it reflect out-of-state facilities that a system may have.

MultiCare, Tacoma: Hospitals and medical centers include Allenmore, Tacoma General and Mary Bridge Children's in Tacoma, Auburn, Covington, Gig Harbor, Puyallup; and Deaconess, Valley and the Rockwood Clinic in Spokane.

CHI Franciscan, Tacoma: Harrison Medical Center, Bremerton and Silverdale; Highline Medical Center, Burien; St. Elizabeth Hospital, Enumclaw; St. Francis Hospital, Federal Way; St. Anthony Hospital, Gig Harbor; St. Clare Hospital, Lakewood; St. Joseph Medical Center, Tacoma; CHI Franciscan Rehabilitation Hospital, Tacoma; Wellfound Behavioral Health Hospital, Tacoma (in partnership with MultiCare).

Providence St. Joseph Health, Renton: Swedish Health Services, Pacific Medical Centers, Seattle.

Providence Health & Services, Renton: Hospitals in Everett, Colville, Centralia, Spokane, Chewelah, Olympia, Walla Walla.

Virginia Mason, Seattle: Virginia Mason Hospital and Seattle Medical Center; Virginia Mason Memorial, Yakima.

UW Medicine, Seattle: UW Medical Center; Harborview Medical Center; Northwest Hospital and Medical Center, Seattle; Valley Medical Center, Renton

Policy analysis

Hospital mergers are occurring at an accelerated pace, especially with the ongoing COVID-19 crisis. Although mergers do save financially inefficient facilities, research is clear that they do not hold down costs nor do they improve quality of care for patients.

The federal government is very aggressive about prosecuting monopolistic practices in other economic areas, yet hospital mergers seem to be immune to both federal and state intervention. Policymakers seem to think that the harm to the public

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12 "U.S. hospitals hit by financial 'triple whammy' during coronavirus pandemic," by A. Chang, National Public Radio, April 23, 2020, at https://www.npr.org/sections/coronavirus-live-updates/2020/04/23/843012119/u-s-hospitals-hit-by-financial-triple-whammy-during-coronavirus-pandemic.

13 "Hospital consolidation is changing Seattle's medical services landscape," by B. Virgin, Seattle Business Magazine, September, 2019, at https://www.seattlebusinessmag.com/health-care/hospital-consolidation-changing-seattles-medical-services-landscape.

imposed by most monopolies does not occur in the area of medical services. The irony is that hospitals are otherwise heavily regulated by the government through Medicare.

In addition, government officials determine hospital and doctor reimbursements for treating Medicare patients, regardless of what the true expenses or charges are. Over the past 50 years, the Medicare program has gradually decreased its payments to hospitals and doctors depending on the medical specialty.

Hospitals cannot bargain with the government programs of Medicare and Medicaid, which are powerful monopolies themselves. Through the use of contract negotiations, however, hospitals can bargain with private health insurance companies. Merged hospitals with monopolistic bargaining power have a better chance of securing favorable insurance contracts, which has put more independent hospitals at financial risk of closing.

Reduced payments or the threat of future reductions in reimbursements are also driving more doctors to be employed by hospitals, making doctors salaried workers. Employment by a hospital at least guarantees a base salary for the physicians regardless of future payments to the doctors. Plus, the administrative costs of running a practice are borne by the hospital, not the doctor's independent office.

The basic difference between health care compared to other economic activities is the distortion imposed by the third-party payer system. The overwhelming majority of health care in this country is paid for by employers or the government, with money channeled through heavily regulated insurance companies. In other economic activities, consumers pay directly for a product or service and consequently become savvy shoppers who can take advantage of marketplace competition and secure lower prices. In health care, patients are largely barred from shopping and have become isolated from the true costs they incur, meaning they have no influence on keeping prices in check.

Patients are therefore also financially isolated from the monopolistic consequences of hospital mergers. The solution to this ever-increasing practice of combining hospitals is to allow patients to use their own health care dollars and to shop for health care in an open competitive environment. Price transparency would be necessary, as well as restricting or eliminating third party payers, as we have outlined in our Washington Policy Center Policy Brief, *Health care reform; Lowering costs by putting patients in charge*.[14]

Conclusion

Hospital mergers are occurring at an ever-increasing rate because of the distorted economic environment created by state and federal health care policies. In spite of the arguments offered in support of hospital mergers, creating hospital monopolies does not improve the quality of patient outcomes nor does it decrease health care costs. The government has turned a blind-eye to this monopolistic practice. Only patients, as consumers of health care, can force competition in the market, prevent monopolistic practices, and improve health care quality while controlling costs.

14 "Health care reform: lowering costs by putting patients in charge," by R. Stark, MD, Policy Brief, Washington Policy Center, July 6, 2015, at https://www.washingtonpolicy.org/publications/detail/health-care-reform-lowering-costs-by-putting-patients-in-charge.

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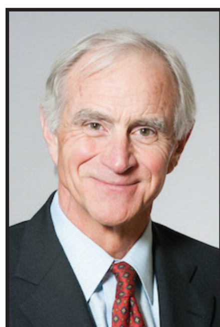

Roger Stark, MD, FACS, is the Senior Fellow at Washington Policy Center's Center for Health Care and a retired physician. He is the author of three books including *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He has also authored numerous in-depth studies on health care policy for WPC, including *The Impact of the Affordable Care Act in Washington State, A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States, What Works and What Doesn't: A Review of Health Care Reform in the States,* and *Health Care Reform that Works: An Update on Health Savings Accounts*. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees in Washington DC regarding the Affordable Care Act. Dr. Stark graduated from the University of Nebraska's College of Medicine and he completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He has served on the hospital's governing board. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. He currently serves on the Board of the Washington Liability Reform Coalition and is an active member of the Woodinville Rotary. He and his wife live on the Eastside and have children and grandchildren in the area.