Hospital Mergers

and the Threat to Women's Reproductive Health Services

Using Antitrust Laws to Fight Back

NATIONAL WOMEN'S LAW CENTER

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Part One

The Problem: Diminishing Access To Reproductive Health Services

I.

The Threat to Reproductive Health Services

Access to women's reproductive health services in the United States is seriously threatened. Abortion services in particular are becoming an increasingly scarce commodity in many parts of the country, legally guaranteed in theory but unavailable as a practical matter. For a woman forced to travel to a distant provider, this can mean significantly increased costs and risks to her health.

A. THE CURRENT PROVIDER SHORTAGE

The absence of a nearby abortion provider is clearly an important barrier to access, since the greater the distance a woman lives from a provider, the less likely she is to be able to use the provider's services.[1] This is a very real problem for many women in this country. In 1992, the most recent year for which national data is available, 84% of the counties in the United States had no abortion provider.[2] Nearly one-third of women of reproductive age lived in one of the counties where there was no abortion provider.[3] Moreover, the number of providers has been dropping precipitously in recent years; between 1982 and 1992 the number fell 18%, and the rate of decline has been accelerating.[4] The shortage of providers is most acute outside urban areas; in 1992, 94% of non-metropolitan areas had no abortion services, and 85% of non-metropolitan women lived in the unserved counties.[5] In both South Dakota and North Dakota, the entire state has only one provider.[6]

The number of hospitals providing abortion services has seen a particularly steep decline.[7] Between 1977 and 1992, the number of hospital abortion providers in non-metropolitan counties fell by 78% — from 427 to a total of only 96 nationwide.[8] In 1992, of all of the country's short-term, general hospitals, only 16% provided abortion services.[9] And while only 7% of all abortions were performed in hospitals as of 1992,[10] the availability of hospital abortion services is vital for several reasons. Many abortion patients, such as diabetics and those with heart conditions, require overnight post-operative observation or emergency equipment that only a hospital can provide.[11] Other women may be unable to obtain services if their personal physicians insist on performing abortions only in a hospital.[12] For low-income women, hospital emergency rooms often are the only option.[13] Further, even when abortion services are available in a freestand-

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ing clinic, the clinic must be able to transfer patients to a local hospital in emergencies.[14] Thus, for many women, the absence of nearby hospital-based abortion services can be significant even if a clinic or other provider is available.[15]

Hospitals are important providers of other reproductive health services as well. For example, surgical sterilization procedures such as tubal ligation are often provided in hospitals; indeed, many women choose postpartum tubal ligation because it is safer and less costly to have the sterilization procedure while in the hospital for childbirth than to undergo two separate hospitalizations. In addition, hospital emergency rooms routinely provide emergency postcoital contraceptives (the "morning-after pill") to rape victims.

B. THE HARM TO PATIENTS

Lack of access to a nearby provider can impose significant costs and other burdens on women seeking reproductive health services. For those seeking an abortion, these burdens are often compounded by legal obstacles such as mandatory waiting periods[16] and restrictions on public funding.[17] When a woman has to travel to a distant provider, she may incur expenses not only for transportation, but also for lodging (if the distance is too great for a day trip or where there is a waiting period), lost wages, and child care.[18] The delay entailed in such travel — especially where there are waiting periods and other restrictions, or time is needed to raise the necessary funds[19] — can be significant. Some clinics schedule abortions only one or two days a week; compliance with a mandatory 24-hour waiting period for an abortion at such a clinic can translate into a significant delay.[20]

These delays can be harmful not only to the patient's pocketbook but also to her health and well-being. Abortion is considered "semi-urgent" care: the risk of complications increases with gestation, abortion becomes impossible if it is delayed too long, and most women who have chosen to terminate their pregnancies want to do so as early as possible.[21] A survey of women who underwent abortions in Tennessee, a state with a mandatory waiting period, found that 59% of the women experienced one or more problems due to the delay.[22]

As the American Medical Association's Council on Scientific Affairs summarized:

> *Fewer providers mean that women have to travel increased distances, which may increase the cost of the procedure and delay pregnancy termination, thereby increasing the health risks to the woman. . . . Anything that delays the procedure increases the costs incurred . . . and increases the health risks associated with the procedure.*[23]

2. The Impact of the Hospital Merger Wave

The barriers to access outlined above are being exacerbated by a wave of mergers and consolidations among rival hospitals. Following is a description of this trend, including the increasingly common phenomenon of mergers between secular and religiously-affiliated hospitals; the nature of the religious restrictions on reproductive health services that come into play in these transactions; and what happens when such mergers are completed.

A. HOSPITAL MERGER MANIA

The hospital industry is experiencing an unprecedented wave of mergers, acquisitions, and other forms of consolidation. *Modern Healthcare* magazine, which tracks hospital mergers, reported 235 such transactions involving 768 hospitals in 1996, a large increase over previous years.[24] The authors reported that nearly 40% of the nation's 5,200 nonfederal hospitals were involved in merger and acquisition activity from 1994 through 1996.[25]

The reasons for this trend include an industry belief that hospitals must be larger in order to reduce costs and enhance their market power.[26] As managed care reduces and shortens hospital stays, hospital owners see mergers as offering a way to reduce excess capacity, enhance efficiencies, increase access to capital for new equipment, and exercise more control over how much a hospital pays for supplies and what it charges for services.[27]

Religiously-affiliated hospitals are by no means immune from these pressures, and they too are being swept along in the merger wave.[28] Indeed, consultants in the health care industry are advising Catholic hospitals to consolidate with other facilities in order to help obtain access to capital and to enhance their competitive position.[29] As a 1997 *Wall Street Journal* article concluded, religiously-affiliated institutions can be just as aggressive as their for-profit rivals when fighting to gain market share, and as a consequence, "a Catholic hospital merger mania is spreading."[30]

Until recently, Catholic health institutions tended to consolidate by aligning themselves with one another, rarely "marrying outside the church."[31] This has changed, however, as market pressures and the need for patient volume have led to an increasing number of affiliations between Catholic and non-Catholic institutions.[32] In a study of hospital consolidation agreements between 1990 and 1995, Catholics for a Free Choice (CFFC) identified 57 mergers and affiliations between Catholic and non-Catholic hospitals, in 27 states.[33] In an update of its study, CFFC has catalogued another 38 completed consolidations between Catholic and non-Catholic hospitals in 1996 and 1997, with 20 more pending completion as of January 1998.[34] A report released by the Kaiser Family Foundation in November 1997 counted 131 affiliations involving one or more Catholic hospitals or health systems between 1990 and 1996, representing 18% of all hospital affiliations, and nearly 80% of these transactions were between Catholic hospitals and non-Catholic providers.[35]

The Catholic health care system is no small factor in the nation's health care industry. Catholic hospitals account for about 10% of all U.S. hospitals, 12% of hospital beds, 16% of all hospital admissions, and 17% of surgical procedures nationwide.[36] According to the magazine of the Catholic Health Association of the United States, in 1996 there were over 600 Catholic hospitals with 140,000 beds, $40 billion in revenues, and assets of $44 billion, and in 19 states they had at least a 20% market share.[37] Moreover, in many rural areas, a Catholic hospital is the only hospital for many miles around.[38] In light of the significant role that Catholic hospitals play, Catholic hospital "merger mania" thus stands to have a major nationwide impact.

"A Catholic hospital merger mania is spreading." — The Wall Street Journal, Mar. 12, 1997

B. RELIGIOUS RESTRICTIONS ON REPRODUCTIVE HEALTH SERVICES

In December 1994, the National Conference of Bishops issued its revised "Ethical and Religious Directives for Catholic Health Care Services," which provide "authoritative guidance" to Catholic health care institutions and pro-

Notes

1/ Stanley K. Hensshaw & Jennifer Von Vort, *Abortion Services in the United States, 1991 and 1992*, Fam. Plan. Plan. Persp., May-June 1994, *reprinted in* Henry J. Kaiser Family Foundation, *What's Happening to Abortion Rates?*, 10 (1996) [hereafter Henshaw & Van Vort]; see also Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, Fam. Plan. Persp., March- April 1995, *reprinted in* Henry J. Kaiser Family Foundation, *What's Happening to Abortion Rates?* 26 (1996) [hereafter Henshaw].

2/ Henshaw & Van Vort, *supra*, at 10-11.

3/ *Id.* at 10. Moreover, 92% of countries had no provider that performed at least 400 abortions per year. This is significant because small providers often do not waant a large abortion case load, and they usually do not advertise; hence, women may have difficulty finding out about and obtaining services from these providers.

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15/ Stanley K. Hensshaw & Jennifer Von Vort, *Abortion Services in the United States, 1991 and 1992*, Fam. Plan. Plan. Persp., May-June 1994, *reprinted in* Henry J. Kaiser Family Foundation, *What's Happening to Abortion Rates?*, 10 (1996) [hereafter Henshaw & Van Vort]; see also Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, Fam. Plan. Persp., March- April 1995, *reprinted in* Henry J. Kaiser Family Foundation, *What's Happening to Abortion Rates?* 26 (1996) [hereafter Henshaw].

Appendix A

Sample Letter to the Antitrust Enforcement Agencies

Robert F. Leibenluft
Assistant Director for Health Care
Bureau of Competition
Federal Trade Commission
601 Pennsylvania Ave. NW -- S3115
Washington, D.C. 20580

Gail Kursh
Chief, Health Care Task Force
Antitrust Division
U.S. Department of Justice
325 7th Street NW, Suite 400
Washington, D.C. 20530

[Office of the Attorney General of your state: to identify the antitrust contact there, call the National Association of Attorneys General, in Washington, D.C. at 202-326-6000.]

Dear Mr. Leibenluft, Ms. Kursh, and _____:

We are writing to bring to your attention our concerns about a proposed hospital merger that we believe will have a harmful impact on competition and the delivery of health care in our community. We are [describe your organization or who you are and who else you represent].

We have learned that [Religious Hospital] in [city, state] is planning to merge or affiliate with [modify as appropriate to reflect whatever is known about the nature of the anticipated affiliation] [Secular Hospital] in [city, state]. We are concerned that this merger, by eliminating competition in the local health care market, will result in a loss of services, loss of consumer choice, and increased costs to consumers. Where now there are [#] hospitals in our community, after the merger there will be only [#]. [If there will be only one, express concern over creation of a monopoly -- a single entity with no checks on its ability to set prices arbitrarily.]

We are particularly concerned about the impact this proposed merger will have on the availability of reproductive health services in our community. [Religious Hospital] is affiliated with the Catholic church and governed by the Ethical and Religious Directives for Catholic Health Care Services, which prohibit abortion, contraceptive services and counseling, sterilization procedures, infertility treatments, and postcoital emergency contraceptives (the "morning-after pill"). [Modify as appropriate if other religious restrictions are at issue.] We understand that after the merger, if it is allowed to go forward, [Secular Hospital] would also be governed by these prohibitions. [Cite and enclose documentation of this intention.]

[Secular Hospital] currently provides the following services that would be banned under the Directives: [list the affected services]. The elimination of these services will have serious repercussions in our community. [Quantify the loss of services to the extent possible -- e.g., how many abortions or tubal ligations did the secular hospital perform in the past year?]

Patients seeking these services will be forced to travel as much as [xx] miles to other hospitals in [cities]. [Describe transportation difficulties, such as lack of public transportation.] Pregnant women seeking tubal ligations after delivery, who are not able or willing to make this trip when they are ready to deliver, will be forced to have their babies at the merged hospital and then undergo a tubal ligation at a later time -- at additional cost and risk to their health.

The [#] women who have received abortions each year at [Secular Hospital] will have to go elsewhere. [Describe problems this will pose -- e.g., distances to nearest facilities; if nearby clinic exists, what are its limitations, such as violent or harassing anti-choice activities around it.]

[Add any other pertinent information that is readily available -- see Appendix B for additional suggestions.]

The harmful consequences of this merger that we have outlined are, in our view, directly relevant to your review of the merger, and we urge you to take full account of them as you carry out your responsibilities under the antitrust laws. Further, we would respectfully request the opportunity to meet with you or the relevant investigatory staff to discuss the matter with you -- and to do so before your office reaches a conclusion about the likely impact of the transaction and makes a recommendation on whether to challenge it.

We will call you shortly to follow up, if we do not hear from you. Thank you for your consideration.

Sincerely,

Appendix B

Information to Gather for Presentation to Antitrust Enforcement Agencies

1. ***The number of hospitals in the community (under separate ownership) before the merger and the number after the merger (and the number of beds in each).***

2. ***Evidence that after the merger, religious restrictions will be applied to a previously secular facility.*** This would include, for example, pronouncements to this effect issued by the merging hospitals, or merger planning documents.

3. ***Identification of the specific health care services that are currently available at one of the merging hospitals and slated for elimination after the merger, and an explanation of why these services are important to the community.*** These may include, for example, abortions, sterilization procedures, infertility treatments, contraceptive services and counseling, HIV risk reduction counseling, and morning-after pills for rape victims. How many of each of these procedures or services were provided at the secular facility in the past (e.g., how many abortions or postpartum tubal ligations in the past year)? How many people will be affected by the elimination of these services (shown, for example, by estimates of the number of women of reproductive age, or the incidence of HIV or AIDS, in the community)? What services in addition to reproductive health services will be affected by the merger?

4. ***Information on how far patients would have to travel to get to other hospitals for these services after the merger and how difficult such travel would be -- to demonstrate that patients are not likely to be willing or able to overcome these burdens.*** What is the travel time to such other hospitals, by car ("drive time") or by public transportation (if it is available)? Are road conditions or weather or geographic barriers potential factors? Would an overnight stay be required, due to transportation difficulties or a waiting period required by state law? What would the associated costs amount to (transportation, lodging, etc.)? Is there a low-income population in the area that would be particularly burdened by such costs?

5. ***Information on what other barriers there are to using these other, more distant, hospitals.*** For example, will the patients' physicians have admitting privileges there? Will their health insurance cover services obtained there?

6. ***Information on why non-hospital alternatives are unavailable or inadequate.*** For example, even if there is a nearby women's health clinic, does it or can it provide the same range of services? If it doesn't perform deliveries, how will it perform postpartum tubal ligations? Will it perform abortions if the only hospital available as back-up is governed by religious restrictions? Has the clinic (or its staff or patients) been subject to violence or harassment, and is it financially stable?

7. ***An explanation of how hard it would be to bring in new providers to fill the gap in services.*** Would zoning or licensing laws, or local anti-choice sentiment, make it difficult to open a new facility? Is there reason to believe it would be hard to entice new physicians into the area to provide these services?

8. ***Information on the health risks and costs associated with fragmenting services among different providers.*** For example, what are the risks of undergoing a tubal ligation in a separate procedure instead of during hospitalization for delivery? Will insurance cover the sterilization in these circumstances?

9. ***Evidence that large purchasers of health care in the area (such as large employers or insurers) are concerned about an increase in prices as a result of the merger.*** Are they worried that if all area hospitals are under single management, purchasers will lose their ability to bargain for better prices?

10. ***Expressions of concern from prominent physicians in the community about the impact of the merger on the delivery of health care.*** What concerns do they have from the medical perspective? Do they fear that their own practices will be impaired in any way? Are any local physicians who provide abortions or other reproductive health services concerned that they may be denied privileges at religiously-affiliated hospitals if they continue to perform these services elsewhere, or if they publicly support the availability of such services?