THE CORROSIVE COMBINATION OF NONPROFIT MONOPOLIES AND U.S.-STYLE HEALTH INSURANCE: IMPLICATIONS FOR ANTITRUST AND MERGER POLICY

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I

INTRODUCTION

Rising health care costs are a matter of universal alarm, and in addition to the popular causal explanations,[1] Clark Havighurst's and my centerpiece paper for this symposium (hereafter *Distributive Injustices*) identifies a new culprit: "the corrosive combination of nonprofit monopolies and U.S.-style health insurance."[2] Not only has market power in the health care sector, which we observe pervades the industry, unleashed a torrent of supracompetitive—and even supramonopoly—prices, but much of the recent rise in health costs is directly attributable "to increasing supply-side market power as a result of hospital consolidations and the growth of provider organizations."[3] If this is so, one might expect help from federal antitrust enforcers to put a halt to growing hospital market power. Unfortunately, antitrust enforcers have sustained a regrettable losing streak: though the Federal Trade Commission (FTC), Department of Justice (DOJ), and state antitrust enforcers have mustered a number of ambitious challenges to proposed hospital mergers, their record in these challenges since 1994 contains seven losses and zero victories.[4] The losing

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1. For a brief overview of commonly identified sources of rising health care expenditures, see HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION 38–53 (1991) (attributing rising expenditures to the stimulation of demand through third-party payment, rising provider compensation, the aging of the American population, malpractice litigation, and (especially) the growth of expensive new technologies).

2. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 24 (Autumn 2006).

3. *Id.* at 18.

4. *See* FTC v. Tenet Healthcare Corp., 186 F.3d 1045, 1047 (8th Cir. 1999); FTC v. Freeman Hosp., 69 F.3d 260, 273 (8th Cir. 1995); California v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *aff'd*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302–03

streak has been sufficiently severe to cause one knowledgeable commentator to suggest that "the role of antitrust law in monitoring the health care industry faces an increasingly uncertain, and perhaps diminishing, future."[5]

This paper aims to reinvigorate antitrust scrutiny of the health care industry by highlighting certain observations made in *Distributive Injustices* that have important implications for the antitrust debate over hospital market concentration. That debate has revolved around, and has devolved into, the question of how nonprofit hospitals set prices. Since 1994, courts have largely reasoned that because nonprofits, by law, may not distribute profits to shareholders, they do not (and would not) abuse market power like for-profit institutions and raise prices to monopoly levels.[6] They have reached this conclusion while expressing substantial sympathy for nonprofit hospitals and hostility toward health care institutions that do seek profits, making declarations such as, "In the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars."[7] Some judges and many academics retort that though nonprofits do not seek to maximize returns to shareholders, they seek returns of other kinds and therefore would utilize market power—including implementing monopoly prices—just as for-profit hospitals do.[8]

Distributive Injustices brings a new perspective to this antitrust policy debate. Like many academics, we warn of rising hospital consolidation as a source of rising prices, but we argue that the effects of market concentration are severely magnified because of U.S.-style private insurance. We observe that assorted political, regulatory, and institutional constraints prevent U.S. insurers from denying coverage for health services, even if those services are priced at gouging levels. Moreover, since the income tax exclusion induces employers to provide health insurance, workers remain largely unaware of these prices, even as they are the ultimate payers, and thus are not positioned to make informed decisions as to whether those prices exceed their willingness to pay. As a result, U.S.-style insurance is unable and unwilling to confront providers with monopoly power and instead succumbs to inflated prices; meanwhile, the moral hazard that accompanies health insurance leads insurers to pay for inflated levels of consumption.

Nonprofit monopolists, we submit, are equally as likely to translate their market power into inflated prices. But our objection to nonprofit market power goes beyond the question of whether it leads to higher or lower prices—we also

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(W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997) (unpublished table decision); United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); *In re Adventist Health Sys.*, 117 F.T.C. 224, 224 (1994).

5. Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, HEALTH AFF., Mar.–Apr. 2002, at 185.

6. *See infra* Part II.

7. *Butterworth Health Corp.*, 946 F. Supp. at 1302.

8. *E.g.*, Judge Posner, *infra* note 16; Judge Tjoflat, *infra* note 17; Professors Dranove & Ludwick, *infra* note 63.

express concern that such power both reduces allocative efficiency and enables providers to avoid the scrutiny of market competition. We warn that rising nonprofit market power allows nonprofits to "suck large amounts of cash out of the economy either to support ongoing health-related activities or to create new health facilities or new health-sector monopolies."[9] In doing so, these nonprofits not only do economic damage by subsidizing services of questionable value, but also do harm to certain democratic principles:

> Over time, this one-way flow of capital into the health sector has built enormous enterprises that can legally use their untaxed income and assets only for health-related activities, whatever the economy's or the public sector's or premium-paying individuals' other needs. Too little attention has been given, we submit, to the involuntary flow of substantial funds from premium payers into the coffers of powerful private institutions that are largely unsupervised and unconstrained with respect to their use of those resources.[10]

This article takes up the plea to pay closer attention to those "powerful private institutions" and hopes to provoke renewed attention from antitrust policymakers and judges. It begins by reviewing the treatment nonprofit hospitals have received in recent merger cases ("The Setting"[11]), discusses the academic quarreling over the merger rulings, in particular the debate surrounding the courts' factual findings and empirical justifications ("The Debate"[12]), and then illustrates how we hope *Distributive Injustices* will refocus the debate over merger policy ("The Real Problem"[13]).

II

THE SETTING: COURTS' PROTECTION OF NONPROFITS

When courts are asked to review an FTC challenge to a proposed merger between nonprofit hospitals, they are ideally situated to comment on the consequences of nonprofit market power. After all, proposed mergers between nonprofits, by definition, lead both to additional market concentration and to a stronger hand for nonprofits within that concentration, so the proposed mergers require courts to evaluate the potential benefits and harms created by the growth of nonprofits within increasing market concentration. Consequently, these cases offer useful windows into how many courts view nonprofits.

The central issue in many of these cases is whether nonprofit hospitals would use market power to inflate prices to supracompetitive levels, just as economic theory predicts a for-profit hospital would. This issue is paramount when a proposed merger would otherwise be rejected if the resulting entity were a for-profit corporation, so the question becomes whether nonprofits deserve special treatment under the antitrust laws. In an important 1986

9. Havighurst & Richman, *supra* note 2, at 23.
10. *Id.*
11. *See infra* Part II.
12. *See infra* Part III.
13. *See infra* Part IV.

decision, Judge Richard Posner dismissed such an exception for nonprofits, remarking, "The adoption of the nonprofit form does not change human nature, as the courts have recognized in rejecting an implicit antitrust exemption for nonprofit enterprises."[14] Judge Posner went further to suggest that nonprofits might be even *more* likely than for-profits to charge supracompetitive prices and engage in anticompetitive conduct: "Moreover, compelled as they are to treat charity cases while minimizing the cost to the taxpayers of supporting the hospital, public hospitals are under added pressure to charge high prices to their paying (or insured) patients, which may make collusion particularly attractive to these hospitals."[15]

A subsequent ruling from Judge Posner, in another FTC-challenged merger four years later, reiterated the same skepticism toward treating nonprofits differently from other hospitals: "We are aware of no evidence—and the defendants present none, only argument—that nonprofit suppliers of goods or services are more likely to compete vigorously than profit-making suppliers. Most people do not like to compete, and will seek ways of avoiding competition by agreement tacit or explicit . . . ."[16] One year later, Judge Gerald Tjoflat expressed the same inclination to impose the antitrust laws with equal rigor to both nonprofits and for-profits. Citing both of Judge Posner's opinions, Judge Tjoflat concluded, "the nonprofit status of the acquiring firm will not, by itself, help a defendant overcome the presumption of illegality."[17]

In contrast, many recent court rulings in antitrust cases have been quite generous to nonprofit hospitals.[18] The first antitrust opinion to take this position in recent decades was the 1989 ruling in *United States v. Carilion Health System*.[19] In rejecting the FTC's challenge to a proposed merger between nonprofit hospitals, the court ruled that the merger would improve the efficiency of both hospitals and thus would "strengthen, rather than reduce, competition."[20] Then, the court continued,

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14. Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986) (citations omitted).

15. *Id.* at 1391.

16. United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990). Judge Posner also reiterated that nonprofits are likely to pose greater danger to competition than for-profits, adding "[t]he ideology of nonprofit enterprise is cooperative rather than competitive. If the managers of nonprofit enterprises are less likely to strain after that last penny of profit, they may be less prone to engage in profit-maximizing collusion but by the same token less prone to engage in profit-maximizing competition." *Id.*

17. FTC v. Univ. Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991). In addition, Judge Tjoflat invoked *National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 100 n.2 (1984), to conclude that "the Supreme Court has rejected the notion that nonprofit corporations act under such a different set of incentives than for-profit corporations that they are entitled to an implicit exemption from the antitrust laws." *Univ. Health*, 938 F.2d at 1224.

18. Richard Schmalbeck observes in this volume that nonprofit hospitals enjoy a similar generosity from tax courts and IRS rulings. Richard L. Schmalbeck, *The Impact of Tax-Exempt Status: The Supply-Side Subsidies*, 69 LAW & CONTEMP. PROBS. 121, 124–27 (Autumn 2006).

19. 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989) (unpublished table decision).

20. *Id.* at 849.

> Defendants' nonprofit status also militates in favor of finding their combination reasonable. Defendants' boards of directors both include business leaders who can be expected to demand that the institutions use the savings achieved through the merger to reduce hospital charges, ... [T]he court concludes that [defendants'] nonprofit status weighs in favor of their merger's being reasonable.[21]

The neutral observer might consider this statement to be largely innocuous—particularly since the court provided many alternative holdings that did not rely on the tax status of the merging entities and based its analysis predominantly on the definition of the hospitals' geographic market.[22] Moreover, when the Fourth Circuit upheld the lower court's ruling, it did so in an unpublished opinion that did not mention the district judge's assertion that boards will restrain a nonprofit's managers from capitalizing on market power.[23] But the issue emerged again in 1995, in *FTC v. Freeman Hospital*.[24] This case, like *Carilion*, involved a proposed merger of two nonprofit hospitals in which the parties disputed the geographic and product markets,[25] and the court's ruling to permit the merger rested primarily on its adoption of the defendants' market definitions. Without citing *Carilion*, the court reached almost the identical conclusion, though in more sweeping terms. The court wrote,

> Arguably, a private nonprofit hospital that is sponsored and directed by the local community is similar to a consumer cooperative. It is highly unlikely that a cooperative will arbitrarily raise prices merely to earn higher profits because the owners of such an organization are also its consumers. Similarly, if a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level even if it has the power to do so.[26]

In applying this principle to the merging entities, the court then concluded, "it would not be in their best economic interest to permit prices to rise beyond a normal competitive level."[27]

Even though *Freeman* issued a sweeping generalization on the nature of nonprofit-hospital pricing policies, it—like *Carilion*—did not rest its conclusion exclusively on the merged entity's being nonprofit. Moreover, also like *Carilion*, the *Freeman* ruling was upheld in a brief ruling that did not discuss the relevance of nonprofit status to competitive behavior.[28] Again, one might

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21. *Id.*

22. *See id.* at 847–48.

23. *See* United States v. Carilion Health Sys., No. 89-2625, 1989 WL 157282 (4th Cir. Nov. 29, 1989).

24. 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995).

25. Under the FTC's alternative market definitions, the proposed merger would create a market with a Herfindahl-Hirschman Index (HHI) of between 2288 and 4356. *Id.* at 1222. The hospitals argued that the merger would result in an HHI between 1322 and 1624. *Id.* Under the Department of Justice's merger guidelines, a market is not "highly concentrated" until the HHI reaches 1800. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines, 57 Fed. Reg. 41,552 41,558 (Sept. 10, 1992), *available at* http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html.

26. *Freeman Hosp.*, 911 F. Supp. at 1222 (citations omitted).

27. *Id.* at 1227.

28. *See* FTC v. Freeman Hosp., 69 F.3d 260 (8th Cir. 1995). The court briefly confirmed that the hospitals' nonprofit status did not defeat the FTC's jurisdiction in the case. *Id.* at 266–67.

consider these comments little more than insignificant dicta, but the language in *Freeman*—like the proverbial "loaded weapon"[29]—was on hand for a dispute involving a dramatically different set of facts.[30]

Those different facts arose in *FTC v. Butterworth Health Corp*.[31] *Butterworth* again involved a proposed merger between two nonprofit hospitals, but unlike the rulings in *Carilion* and *Freeman*, the court in *Butterworth* accepted the FTC's market definition and agreed that the resulting hospital market would be highly concentrated.[32] Nonetheless, the court permitted the merger because "nonprofit hospitals do not operate in the same manner as profit maximizing businesses."[33] And in so deciding, the court cited the excerpt from *Freeman* quoted above.[34]

In a lengthy opinion, the court supported its distinction between for-profits and nonprofits on two separate, but interrelated, grounds. First, it concluded from expert testimony that for nonprofit hospitals, "market concentration appears to be positively correlated not with higher prices, but with lower prices."[35] And second, it determined that "the involvement of prominent community and business leaders on the boards of [both] hospitals can be expected to bring real accountability to price structuring," especially since those leaders have "employees [who] depend on these facilities for services [and] have demonstrated their genuine commitment to serve the greater Grand Rapids community."[36] The Sixth Circuit affirmed the decision for the hospitals in a terse, unpublished per curiam ruling, concluding "[t]he record presented

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29. Korematsu v. United States, 323 U.S. 214, 246 (1944) (Jackson, J., dissenting).

30. It appears that the *Freeman* opinion did not capture widespread attention. In *United States v. Mercy Health Services*, another challenge to a proposed merger of two nonprofit hospitals, the court wrote, "The hospitals have also asserted as a defense their non-profit status and procompetitive intent. The hospitals cite *United States v. Carilion Health* for the proposition that the non-profit status of the hospitals can be considered in determining whether the hospitals would act in an anticompetitive manner. The government points out, this is a questionable legal proposition. No other courts have explicitly adopted this theory of defense." 902 F. Supp 968, 989 (N.D. Iowa 1995) (citation abridged), *vacating as moot* 107 F.3d 632 (8th Cir. 1997).

31. 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997) (unpublished table decision).

32. *Id.* at 1294. For general acute inpatient care, the post-merger HHI would be between 2767 and 4521, reflecting a gain of 1064 to 1889 points as a result of the merger. For primary inpatient care, the post-merger HHI would range from 4506 to 5079, reflecting a gain of 1675 to 2001 points. The court concluded that "the proposed merger would result in a significant increase in the concentration of power in two relevant markets, and produce an entity controlling an undue percentage share of each of those markets." *Id.* For concentration standards under the Department of Justice's merger guidelines, *see supra* note 25.

33. *Butterworth*, 946 F. Supp. at 1296.

34. *Id.* (citing FTC v. Freeman Hosp., 911 F. Supp. 1213, 1222 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995)).

35. *Id*.

36. *Id.* at 1297, 1302. In addition, the court gave significant weight to a "Community Commitment" that the hospitals signed, which pledged to freeze certain prices, limit profit margins, and maintain a commitment to serve the medically needy. *Id.* at 1298. The document, which the FTC regarded as "unenforceable, illusory, or inadequate," was designed "to assuage any purchaser concerns and to reiterate [the hospitals'] strong conviction that the purpose and intent of the transaction is to reduce costs." *Id.* (alteration in original).

here does not leave us with a firm conviction that the district court erred in its analysis of the facts."[37]

The *Butterworth* opinion was a sweeping victory for nonprofit hospitals and, by carving out a different standard for nonprofits in the application of antitrust laws, understandably sparked some heated academic commentary. One leading antitrust scholar called the ruling a "rejection of conventional norms that guide competition law" and a decision that "turned antitrust law on its head."[38] Another critic charged that *Butterworth* "push[ed] the envelope of antitrust enforcement with an adherence to a paradigm of the health care industry that is, at least, in tension with the pro-market mandate of antitrust law and, at most, fundamentally inconsistent with the dictates of antitrust law" and warned that the ruling "may undermine the ability of the enforcement agencies to apply the procompetitive policies of the antitrust law—for all their substantive and symbolic importance—to an important component of the health care marketplace."[39]

Butterworth might also signal the depth of difficulties that confront antitrust enforcement in the health care sector. In addition to its evident departure from traditional applications of competition law, the *Butterworth* opinion reflects the genuine hostility some judges have to subjecting health care providers to competition. The ruling concluded with some revealing language:

> Managed care organizations' interest in maintaining a competitive edge cannot be allowed to trump either hospitals' conscientious endeavors to continue to provide comprehensive, high quality health care in this rapidly evolving field, or the consuming public's right to receive the same.
>
> Permitting defendant hospitals to achieve the efficiencies of scale that would clearly result from the proposed merger would enable the board of directors of the combined entity to continue the quest for establishment of world-class health facilities in West Michigan, a course the Court finds clearly and unequivocally would ultimately be in the best interests of the consuming public as a whole.[40]

In short, the court concluded simply that competition itself does not serve the public interest. To the contrary, it concluded that the public benefits most when hospitals grow and dominate a market. The court in *Freeman*, in orally denying the FTC's motion for a temporary restraining order to enjoin the proposed merger, had even harsher words for FTC officials:

> I don't feel that the Federal Trade Commission has shown sufficient factual basis that they are entitled to a TRO . . . . I don't think you've got any business being in here. I don't see how the Federal Trade Commission can claim there is lack of competition when there [are] four or five hospitals in the area, and reducing it by one is not going

37. FTC v. Butterworth Health Corp., No. 96-2440, 1997 WL 420543, at *3 (6th Cir. July 8, 1997).

38. Greaney, *supra* note 5, at 188.

39. James F. Blumstein, *The Application of Antitrust Doctrine to the Healthcare Industry: The Interweaving of Empirical and Normative Issues*, 31 IND. L. REV. 91, 117 (1998). Though academic defenders of *Butterworth* were fewer in number, some did weigh in, including one who praised the court for using expert testimony and empirical evidence to "reconsider[] old presumptions in the light of new evidence." Michael S. Jacobs, *Presumptions, Damn Presumptions and Economic Theory: The Role of Empirical Evidence in Hospital Merger Analysis*, 31 IND. L. REV. 125, 142 (1998).

40. 946 F. Supp. at 1302.

> to wipe out competition. . . . It looks to me like Washington D.C. once again thinks they know better what's going on in southwest Missouri. I think they ought to stay in D.C.[41]

Thus, antitrust enforcers have more than precedents such as *Butterworth* to combat. They also must fight against strong judicial predispositions.

The FTC's failed challenge against the Butterworth merger was one of seven such losses, unaccompanied by any victories, from 1994 to 2000.[42] The string of losses has alarmed many antitrust policymakers[43] and has caused some to wonder whether the core principles of competition law are being abandoned in favor of political expedience and favorable predispositions toward the health care sector.[44] But the FTC has persisted, and another chapter is now being written in *In re Evanston Northwestern Healthcare Corp.*, in which the FTC is challenging a completed merger of an academic and a community hospital that since 2000 have been operated by a nonprofit corporation.[45] On October 21, 2005, the FTC's chief administrative law judge issued an initial decision ordering divestiture of the merger. Included among its findings of fact was that the corporation's nonprofit status failed to restrain price increases, alter management's profit-maximizing incentives, or induce the board to monitor management's pricing decisions.[46] The decision has been appealed to the FTC Commissioners, who may adopt, modify, reject, or ignore the decision altogether, but the FTC's decision to pursue this retrospective merger review has been described as "a renewed commitment to hospital merger enforcement."[47] Moreover, "given how much the FTC has invested in this case in terms of time, resources and reputation, the importance of this case to the future of the FTC's health care antitrust enforcement mission, the FTC cannot afford to reverse course. . . . The high stakes involved virtually guarantee that

41. FTC v. Freeman Hosp., 69 F.3d 260, 263 (8th Cir. 1995) (alteration and omissions in original) (quoting from the district court's oral denial of the temporary restraining order).

42. FEDERAL TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch. 4, at 1 (2004), *available at* http://www.usdoj.gov/atr/public/health_care/204694.pdf, at 165.

43. *See, e.g.*, William M. Sage, *Protecting Competition and Consumers: A Conversation with Timothy J. Muris*, HEALTH AFF., Nov.–Dec. 2003, at 101, 103 (quoting the former Chairman of the Federal Trade Commission as saying, "In hospital merger cases, the government is zero for the last seven. I don't know the specifics of every case, but what's striking is the zero. I can certainly accept the idea that the government should not have won them all. But it seems very unlikely the government should have lost them all").

44. *See* Greaney, *supra* note 5, at 193.

45. *See* Complaint, In re Evanston Northwest Healthcare Corp., No. 9315 (Fed. Trade Comm'n Feb. 10, 2004), *available at* http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf; Federal Trade Comm'n, Evanston Northwestern Healthcare Corp. and ENH Medical Group, Inc., http://www.ftc.gov/os/adjpro/d9315/index.htm (last visited May 9, 2006) (showing all actions taken in the case).

46. In re Evanston Northwestern Healthcare Corp., No. 9315, at 120–22 (Fed. Trade Comm'n Oct. 20, 2005) (ALJ initial decision), http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf.

47. Michael R. Bissegger, FTC ALJ Finds That Evanston Hospital Merger Violated Antitrust Law and Orders Divestiture (Oct. 28, 2005), http://www.ebglaw.com/article_1198.html.

this case will continue to be hard-fought and is likely to become a bellwether of future government antitrust enforcement in hospital mergers."[48]

III

THE DEBATE: ACADEMIC RESPONSES TO WAYWARD COURTS

Judicial sympathy for nonprofit hospitals in merger cases, and tolerance of their market power, is largely driven by a confidence that nonprofit market concentration does not lead to higher prices. Such a view is not entirely unfounded, and the courts in *Carilion*, *Freeman,* and *Butterworth* relied on expert testimony and some academic scholarship—in particular, the work of William J. Lynk—to reach their conclusions that nonprofits would not impose monopoly prices.[49] The reliability of this research and testimony has occupied the focus of the debate over nonprofit-hospital mergers.

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48. *Id.*

49. The court in *Carilion* relied on expert testimony to arrive at two key factual findings that favored the defendants. First, the court concluded, "as a general rule hospital rates are lower, the fewer the number of hospitals in an area"—in other words, nonprofit market concentration is correlated with lower prices. 707 F. Supp. at 846. And second, "charitable, nonprofit hospitals tend to charge lower rates than for-profit hospitals," suggesting that nonprofits do not utilize market power like for-profits. *Id.* The court offered little analysis explaining how it arrived at these conclusions but mentioned in a footnote that the FTC's expert witness, who predicted that the merger would increase prices, "did not explain the basis of his findings to the court's satisfaction," and that the defendant's witness "raised serious questions about [the FTC's] method of analysis." *Id.* at 846 n.6. The defendants' expert witness, David Eisenstadt, was also employed by the *Butterworth* defendants. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1290 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997).

In *Freeman*, the court dedicated slightly more of its opinion to exploring the nature and economic effects of nonprofits and rested its analysis chiefly on a published article by William Lynk, who also served as the defendants' chief expert witness. *See* FTC v. Freeman Hosp., 911 F. Supp. 1213, 1222 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995) (citing William J. Lynk, *Property Rights and the Presumption of Merger Analysis*, 39 ANTITRUST BULL. 363, 377 (1994) [hereinafter Lynk, *Property Rights*]). The court drew upon the article to support the proposition, "if a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level even if it has the power to do so." *Id.*; *see also supra* note 26 and accompanying text. It then examined "who controls the hospitals" and, after revealing that twelve of the Board's eighteen members were owners, employees, or retirees of local businesses, concluded, "the vast majority of the combined Board of Trustees is comprised of persons who indirectly represent the interests of hospital consumers." *Id.* at 1222–23. Consequently, the court reasoned, "it would not be in these individual Board member[s'] best economic interest to permit prices to be raised beyond a normal competitive level." *Id.* at 1223; *see also id.* at 1227 (reiterating the same conclusion).

The *Butterworth* opinion engaged in a more empirical analysis to determine how nonprofits set prices. Similar to the court in *Freeman*, it began by citing another Lynk article, which concluded from an empirical study of California hospital markets that "on balance increased nonprofit market share is associated with lower, not higher, prices." 946 F. Supp. at 1295 (quoting William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 459 (1995) [hereinafter Lynk, *Hospital Mergers*]). The court then accepted expert testimony from Lynk, who was also an expert witness for the *Butterworth* defendants, that analyzed the Grand Rapids hospital market that included the merging parties. Lynk "concluded that in Michigan, too, higher hospital concentration is associated with lower nonprofit hospital prices." *Id.* Finding this evidence consistent with pledges from the hospitals' chairmen (who "have community interests at heart") that the merger was intended to lower health care costs and to improve quality, and not to increase prices, the court concluded that the merger would enhance consumer welfare. *See id.* at 1296–97, 1301–03. (These findings were also consistent with observations the judge himself made during tours of the hospitals, in which he noted that the

Lynk's 1994 article, *Property Rights and the Presumptions of Merger Analysis*, cited in *Freeman*, summarizes the empirical literature that investigated hospital pricing behavior and concludes that "[t]he results of these research efforts support, on balance, the proposition that nonprofit hospitals behave differently than for-profit hospitals. In particular, they support the proposition that nonprofit hospitals set lower prices than otherwise comparable for-profit hospitals."[50] Lynk explains these findings through the lens of "property rights": because the primary "property right" of for-profit firms—the investor's individual share—is not present in the nonprofit, the incentive to maximize the value of that share is absent.[51] Though the paper does not present any original empirical findings, and thus does not provide support for a particular theory of pricing behavior, Lynk argues that the survey of prior research is sufficient to challenge those who believe that nonprofits maximize like other hospitals. Economists and antitrust policymakers, therefore, should at least hesitate before presuming that maximizing shareholder value—and the associated behaviors of seeking profit-maximizing prices—drives nonprofit behavior.[52]

In *Nonprofit Hospital Mergers and the Exercise of Market Power*, published in 1995 and cited in *Butterworth*, Lynk reports his own empirical test of whether nonprofits price lower than for-profits. Studying a cross-section of California hospitals, he examines 1989 pricing data for the ten most prevalent Diagnosis-Related Groups (DRGs), 1988 hospital-level data (including patient admissions, proportion of admissions paying with Medicare and Medicaid, and total annual revenue from non-Medicare, non-Medicaid sources) and the market concentration for each California county as measured by its Herfindahl-Hirschman Index (HHI).[53] From this analysis, Lynk concludes, "nonprofit hospitals, whether private or public, have statistically significantly lower list and net prices than for-profit hospitals."[54] He further finds that nonprofit hospitals exhibit a lower association between market share and price, and that for-profit hospitals (and government hospitals) tend to raise their prices following a merger while non-profit hospitals tend to slightly reduce theirs.[55] In conclusion, Lynk notes the evidence "suggests simply that we should think twice before assessing both for-profit and nonprofit hospital mergers with the same ex ante presumptions about their probable effects on price."[56]

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hospitals were "well-maintained" and during which he became convinced that the Board of Directors will adhere to their "fiduciary responsibilities" to renovate and upgrade their facilities. *Id.* at 1301.)

50. Lynk, *Property Rights*, *supra* note 49, at 372.

51. *See id.* at 366.

52. *See id.* at 368–70.

53. Lynk, *Hospital Mergers*, *supra* note 49, at 442–43, 445–46. The sample excludes hospitals in Los Angeles County and federal hospitals because, Lynk reasoned, those institutions catered to outlier populations. *Id.* at 442. Kaiser hospitals and some others were also excluded because they do not release pricing data. Price data was time-lagged from individual hospital data to allow for prices to adjust to market conditions. *Id.* at 442.

54. *Id.* at 449, 452.

55. *Id.* at 453.

56. *Id.* at 459.

Lynk's published work and his testimony in the merger cases sparked significant interest, particularly since his 1995 article was "the only published empirical study that provided direct evidence on the pricing behavior of nonprofit hospitals."[57] But within a few years following its release, a forceful backlash ensued. Some initial controversy arose after Lynk's 1995 article first appeared in the prestigious *Journal of Law and Economics*, when it was revealed that one of the article's reviewers called Lynk's study "seriously flawed," and later said, "I was very surprised when I saw [the article] appear in print" because it had not been returned to him for review after he expressed his concerns.[58] One year later, employees of the FTC and DOJ conducted a study that examined a different data sample and generated conflicting results, concluding instead that nonprofit hospitals in concentrated markets set prices that are statistically indistinguishable from for-profits.[59] These lingering questions over Lynk's findings, and the importance of the debate, prompted the *Journal of Health Economics* to dedicate three of its January 1999 articles to investigating the matter in greater detail—two by scholars critiquing (and attempting to replicate) Lynk's findings and a third in which Lynk and a coauthor could respond to Lynk's critics.

In the first critique, RAND scholars Emmett Keeler, Glenn Melnick, and Jack Zwanziger replicate Lynk's empirical analyses after introducing a series of methodological changes.[60] This study assembles a larger dataset of California hospital discharge data that includes prices from four selected years between 1986 and 1994, includes prices from hospitals in Los Angeles County, excludes discharge data for Medicare patients (since prices for those patients are determined by federal regulation, not market forces), and controls discharge prices for local wages using an area wage index derived for Medicare regulations.[61] Implementing otherwise similar analyses, the researchers find that nonprofit-hospital mergers, just like mergers of government hospitals and for-profit hospitals, "lead to higher prices, not lower ones," and that these price increases grow over time.[62] Although the RAND scholars' results do not rebut Lynk's findings that, in a given year, for-profit hospital pricing exhibits a

57. Glenn Melnick et al., *Market Power and Hospital Pricing: Are Nonprofits Different?*, HEALTH AFF., May–June 1999, at 167, 168.

58. Mary Chris Jaklevic, *Ownership and Pricing*, MODERN HEALTHCARE, Oct. 6, 1997, at 2, 16 (quoting David Dranove of Northwestern University's Kellogg Graduate School of Management). Additional controversy arose out of Lynk's employment in the consulting group Lexecon because Dennis Carlton, one of the *Journal of Law and Economics* editors, was also one of Lexecon's principals. *Id.* The journal's editors, however, said Professor Carlton had recused himself when the editors selected Lynk's article for publication. *See* Dennis W. Carlton, Letter to the Editor, *Professor: Article Was Misleading*, MODERN HEALTHCARE, Dec. 1, 1997, at 52; Sam Peltzman, Letter to the Editor, *Journal Story Gave Incomplete Account,* MODERN HEALTHCARE, Oct. 20, 1997, at 28.

59. John Simpson, Fed. Trade Comm'n & Richard Shin, U.S. Dep't of Justice, Do Nonprofit Hospitals Exercise Market Power? 16 (Nov. 1996), http://www.ftc.gov/be/workpapers/wp214.pdf.

60. Emmett B. Keeler et al., *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69, 72–76 (1999).

61. *Id.* at 72–73.

62. *Id.* at 83.

stronger correlation with market concentration than nonprofit-hospital pricing, the results do suggest that those same nonprofits can be expected to raise prices after merging, and those price increases will rise in magnitude as the hospitals' market shares increase.

In the second critique, David Dranove and Richard Ludwick also attempt to improve and replicate Lynk's 1995 analysis.[63] They first identify two sources of empirical bias in Lynk's empirical specification,[64] and after correcting for both (plus making other minor corrections[65]) find that mergers of nonprofit hospitals are associated with, "[i]f anything," higher prices.[66]

Lynk's response to the two critiques could be read as a bit of a retreat. He and coauthor Lynette Neumann state that the central research question raised in Lynk's 1995 article is not whether prices would rise after a merger of nonprofit hospitals (which is the question of central interest to competition policy), but rather, whether prices after a merger of nonprofit hospitals would be statistically different from the merger of similar for-profit hospitals.[67] This alternative research perspective is critical because one could find, as the critics did, that mergers of nonprofit hospitals lead to inflated prices and anticonsumer outcomes while also statistically confirming that nonprofits price differently, perhaps less aggressively, than comparable for-profits. With this second issue—whether nonprofit hospitals are unique or different from for-profit institutions—in focus, Lynk and Neumann reinterpret both studies' results to confirm, not contradict, Lynk's earlier 1995 findings that nonprofit hospitals price systematically differently from for-profits.[68] Their resulting conclusions

63. David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87, 87 (1999).

64. The two sources of bias are Lynk's simultaneous use of correlated coefficients and potential correlations due to omitted variables. *Id.* at 88. The first problem arises because both hospital market share and market concentration are used as explanatory variables, so a merger affects two—not one—coefficients, thus creating a simultaneity bias (where it is hard to measure the movement in one coefficient while holding the other constant). *Id.* at 88–89. Dranove and Ludwick correct this bias by examining only post-merger prices set by merged hospitals. *Id.* at 89. The second problem is caused by Lynk's failure to measure the severity of patients' claims properly. *Id.* at 90–91. This might invite an omitted variable bias, such as if hospitals in highly concentrated markets specialized in delivering expensive care for severely ill patients. *Id.* Dranove & Ludwick correct for this source of bias by controlling illness severity by measuring the number of secondary diagnoses accompanying a hospital claim. *Id.* Dranove & Ludwick note that ideally, service quality should be controlled as well. *See id.* at 90–91.

65. Like Keeler et al., *supra* note 60, Dranove and Ludwick also exclude Medicare and Medicaid patient claims from the data but found the different sample still produced Lynk's same results when Lynk's empirical specification was used. *Id.* at 92. Dranove and Ludwick also restrict the sample to hospitals in markets with an HHI greater than 0.10, thus eliminating hospitals in highly diffuse markets. *Id.* They otherwise make every effort to execute analyses identical to Lynk's.

66. *Id.* at 97.

67. William J. Lynk & Lynette R. Neumann, *Price and Profit*, 18 J. HEALTH ECON. 99, 100–01 (1999).

68. *Id.* at 101–08. Lynk & Neumann then reexamine pricing data from the *Butterworth* hospitals to reveal that updated analyses confirm Lynk's testimony in that case that the nonprofit hospitals would price lower than comparable for-profits. *Id.* at 108–10.

and implications for antitrust policy do not necessarily sound like a vigorous case for permissive merger policy:

> The policy question that our work addresses is simply whether the distinction between for-profit and nonprofit ownership matters, and therefore whether informed antitrust review of proposed hospital mergers *should add that consideration to the checklist of other relevant considerations*.[69]

This debate spilled into the FTC when the Commission gathered scholarly testimony for its 2004 report, *Improving Health Care: A Dose of Competition*,[70] but the report's drafters clearly tried to put the debate to rest. The report first shares William Lynk's testimony before the Commission, discussing his empirical work and his repeated conclusion "that nonprofits that attain market power behave differently from for-profits when it comes to pricing."[71] The report then continues, "By contrast, several panelists maintained that the best available empirical evidence indicated no significant differences between the pricing behavior of for-profit and nonprofit hospitals."[72] And, after listing the growing number of studies that reach that conclusion,[73] the report concludes,

> Although institutional status has loomed large in debates and legal disputes, the best available evidence indicates that nonprofits exploit market power when given the opportunity to do so. Accordingly, the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.[74]

With this, the FTC aimed to bring the *Carilion–Freeman–Butterworth* legacy to an end. And at around the same time, it initiated its complaint against Evanston Northwestern Healthcare.[75]

IV

THE REAL PROBLEM: INSURANCE, MORAL HAZARD, AND CROSS-SUBSIDIES

In attributing recent rises in health care costs to growing market power for providers, and to nonprofit hospitals in particular, *Distributive Injustices*

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69. *Id.* at 101 (emphasis added). On the question of the nature of ownership, however, Lynk & Neumann are far less conciliatory, maintaining there are institutional differences between for-profits and nonprofits that demand attention. *See id.* at 110–11. They assert in closing:

> [I]f a hospital were effectively controlled by those with interests parallel to the interests of hospital consumers, it is hard to see why those who control such a hospital would consciously choose to exercise any monopoly power that the hospital might possess. To assume that they would willfully do so is to deny the principle of self-interest.

Id.

70. IMPROVING HEALTH CARE, *supra* note 42.

71. *Id.* ch. 4 at 31.

72. *Id.*

73. The studies listed, in addition to those cited above, include: Robert Connor et al., *The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices*, 5 INT'L J. ECON. BUS. 159 (1998); Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001); Elaine Silverman & Jonathan Skinner, *Medicare Upcoding and Hospital Ownership*, 23 J. HEALTH ECON. 369 (2004). *See* IMPROVING HEALTH CARE, *supra* note 42, ch.4 at 32 nn.169–71.

74. IMPROVING HEALTH CARE, *supra* note 42, ch. 4, at 33.

75. *See supra* notes 45–46.

implicitly suggests the twin hopes that U.S. antitrust enforcement will become more rigorous and that the *Carilion–Freeman–Butterworth* line of cases will come to an end. We are thus greatly skeptical of the position that nonprofit hospitals construct policies that incorporate the community's preferences for low prices. However, our analysis also suggests that those critical of Lynk's research, and those who argue that nonprofits and for-profit hospitals price similarly, are also not entirely correct. The central problem in the debate is that it asks the wrong question. Academics—both Lynk and his critics—employ the wrong empirical tests and thus misinform merger policy.

A. The Effects on Prices: Market Power *Plus* U.S.-Style Insurance

The logic employed in the debate over Lynk's findings is simple: market concentration through mergers gives firms the opportunity to raise prices; higher prices are contrary to consumer welfare and therefore warrant scrutiny from antitrust enforcers;[76] but, if nonprofit hospitals with market power do not raise prices like for-profit hospitals with comparable market power, then vigorous antitrust scrutiny is less deserved.

The problem with this syllogism is that the baseline reference is how a for-profit monopolist would price. *Distributive Injustices* argues, however, that the presence of health insurance should substantially alter the antitrust calculus. We observe, "U.S.-style private health insurance, by greatly weakening price elasticity of demand as a constraint on monopoly pricing by health care providers and suppliers, facilitates the latter's exercise of market power, producing profits substantially exceeding the usual returns to lawful monopoly."[77] Consequently, monopoly power in the health care sector leads to prices that are more inflated than monopolies in other industries, and however concerning market concentration might normally be, its combination with health insurance is cause for particular alarm. Thus, even assuming Lynk is correct that nonprofit hospitals with market power set prices statistically lower than for-profit hospitals with equal market power, it would be premature—and, we argue, grossly inaccurate—to conclude that merger review should be permissive. To the contrary, the presence of health insurance means hospital market power—for nonprofits and for-profits alike—is a cause for great alarm and deserves heightened antitrust scrutiny.

Under this alternative perspective, the appropriate empirical tests would assess the combination of market power and health insurance. The crucial test to determine whether nonprofit-hospital market concentration is benign is to

76. Though antitrust law is chiefly concerned with matters of efficiency, the concern over higher prices fits neatly within our emphasis on distributive justice. So, in addition to the traditional objections to a monopolist's supracompetitive prices, we also detail how the health system redistributes wealth in undesirable ways, including the preponderance of inflated prices that channel dollars from middle-income consumers to wealthy providers. Havighurst & Richman, *supra* note 2, at 14 (referring to the "regressive redistribution of income from consumers to producers").

77. Havighurst & Richman, *supra* note 2, at 30.

compare nonprofit-hospital pricing in the presence of market power to nonprofit-hospital pricing in the absence of market power. We predict that, because of how health insurance affects consumers' price sensitivities, such a study would reveal a significant difference. A second empirical test would examine the effect of insurance on prices. For example, whether, controlling for market concentration, medical services that typically are not insured, such as elective cosmetic surgery, are priced differently from insured services. These tests would not only evaluate our hypothesis but would appropriately inform antitrust policymakers when they should be concerned, and when they should be *very* concerned, about pockets of market power.

Therefore, although we join the FTC's chorus that warns of increasing market concentration in the health care industry, our insights regarding the *combination* of market power with U.S.-style health insurance both reshape and reemphasize the problem of market power. Whether the monopolist is nonprofit can be only marginally relevant. Of far greater antitrust concern is whether the monopolist serves a market covered by insurance.

B. The Effects on Output: The Antitrust of Overconsumption

However, even if one accepts our argument that health insurance enables hospitals with market power—nonprofit and for-profit alike—to charge supracompetitive prices, we also observe that U.S.-style insurance subsidizes demand such that (even obscenely) inflated prices do not prompt reductions in consumption of medical services.[78] If the traditional antitrust concern over rising prices is that they lead to a reduction in output,[79] one might argue that this unusual effect of insurance-stimulated demand might be reason to restrain, rather than reinvigorate, antitrust scrutiny.

The health care industry, however, is an instance in which maximizing output does not translate into maximizing total surplus. *Distributive Injustices* calls this the "too much of a good thing" problem.[80] Even though rising prices might not reduce total output—and, in fact, total output might even achieve theoretically optimal levels if insurance co-payments are set at the marginal costs to deliver care—there are instead severe allocative inefficiencies, which are certainly a matter of antitrust concern.[81] Since insurance-facilitated moral

78. *Id.* at 15 ("By effectively steepening the demand curve a monopolist faces, health insurance enhances the monopolist's pricing freedom and ability to exploit consumers, enabling it to charge even more than the theoretical 'monopoly price.'"); *id.* at 31 (describing "the tendency of insurance to induce consumption that would not otherwise occur").

79. *See, e.g.*, Nat'l Collegiate Athletic Ass'n v. Bd. of Regents, 468 U.S. 85, 107–08 (1984) ("Restrictions on price and output are the paradigmatic examples of restraints of trade that the Sherman Act was intended to prohibit."); Broad. Music, Inc. v. Columbia Broad, Sys., 441 U.S. 1, 19–20 (1979) ("[O]ur inquiry must focus on . . . whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output . . . .").

80. Havighurst & Richman, *supra* note 2, at 24.

81. Cal. Dental Ass'n v. FTC, 526 U.S. 756, 784–85 (1999) (Breyer, J., dissenting) (evaluating a restraint's likely effect on prices to determine whether it is anticompetitive); ROBERT H. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 91 (1978) ("The whole task of antitrust can be

hazard induces individuals to consume services at prices they otherwise would forgo,[82] the ultimate price consumers pay for such services (including the appropriate portion of their insurance premiums) exceeds what consumers would otherwise choose for themselves in the presence of a well-working market and in the absence of insurance.[83] Consequently, moral hazard and resulting overconsumption do not correct for antitrust problems created by inflated prices; rather, because they induce inefficient expenditures despite those prices, they are additional reasons for alarm.

Overconsumption that benefits nonprofits creates a particularly difficult antitrust problem. To be sure, inflated prices pervade the health care industry in areas occupied by both for-profit and nonprofit players, but monopoly rents created by for-profit monopolies are at least unrestrained to pursue efficient, market-driven uses. Those born out of nonprofit monopolies, on the other hand, are restricted to remain in the health care system regardless of how efficient or inefficient such investments might be. Ironically, nonprofits often justify their supracompetitive prices by claiming a need to finance other activities, such as charity care and research. And indeed, this argument has been successful. The court in *Butterworth*, for example, relaxed its antitrust scrutiny in part because the merging entities pledged to invest in new facilities and "to provide quality healthcare programs for the underserved . . . without regard to ability to pay."[84] However, if allocative efficiency is of any antitrust concern, courts scrutinizing proposed mergers of nonprofits should consider such cross-subsidies as a reason to oppose, not support, the mergers.

In the end, courts have correctly noticed that nonprofit hospitals gather surplus through supracompetitive pricing and spend it on excess health care,[85] but whereas courts have deemed this to be admirable, and a reason to protect nonprofit hospitals from standard antitrust scrutiny, it in fact should be a reason to subject nonprofits to *additional* scrutiny. Antitrust's priority on allocative efficiency should cause courts to be very wary of market power in general, since inflated prices for health care services are likely to cause overconsumption to be inefficient, and to be particularly wary of market power enjoyed by nonprofits, since their monopoly rents are trapped in a system that might not offer efficient

summed up as the effort to improve allocative efficiency without impairing productive efficiency so greatly as to produce either no gain or a net loss in consumer welfare.").

82. Havighurst & Richman, *supra* note 2, at 31 (describing "the tendency of insurance to induce consumption that would not otherwise occur").

83. This is particularly true when one considers the dynamic consequences of moral hazard, whereby subsidized demand stimulates investments in expensive new technologies in which many consumers would prefer not to invest. See *id.* at 29; *see also* Mark Pauly, *The Tax Subsidy to Employment-Based Health Insurance and the Distribution of Well-Being*, 69 LAW & CONTEMP. PROBS. 83, 99–100 (Autumn 2006).

84. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1300, 1306 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997). *See also* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 146 (E.D.N.Y. 1997).

85. This, in fact, is a precondition to obtaining nonprofit status. *See* Schmalbeck, *infra* note 95 and accompanying text.

uses for those revenues. Antitrust law has not recognized as a legitimate defense a claim by an otherwise illegal monopolist or cartel that its economic rents are spent toward socially useful applications,[86] and arguments by nonprofit hospitals to justify their monopoly rents should meet similar skepticism. By refocusing on allocative efficiency, antitrust law can play a constructive role in ending the misallocation of significant social resources by nonprofit hospitals.

C. The Effects of Cost-Shifting: The Antitrust of Cross-Subsidies

In addition to the regressivity of the health care system's inflated prices and inefficiency of its subsidized overconsumption, *Distributive Injustices* finds other aspects of the growing market power accruing to nonprofit hospitals even more objectionable. The roots of this additional concern over nonprofit market power lies in the article's extensive discussion of cross-subsidies.

Even if Lynk's empirical analyses do have conspicuous shortcomings, his ultimate hypothesis contains some merit. Since the surplus gained from a nonprofit's supracompetitive prices does not pass on to shareholders, the proceeds remain within the health care system such that institutions can, and indeed must, "plow excess earnings back into the health care enterprise."[87] Those excess earnings largely appear in the form of cross-subsidies for certain services that are dispensed either free of charge or at a reduced price. Consequently, even if one accepts the FTC's conclusion that "nonprofits exploit market power when given the opportunity to do so,"[88] and that nonprofit market power will surely lead to supracompetitive prices for some services, by necessity it means there will be reductions in prices for other services. Put another way, Lynk is ultimately correct that nonprofits price differently than for-profits, even if his hypotheses are incorrect as applied to profit-generating services.[89]

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86. *But see United States v. Brown Univ.*, 5 F.3d 658, 672 (3d Cir. 1993) (allowing "the undisputed public interest in equality of educational access and opportunity" to be considered as justification for a group of colleges' collusion on financial aid). For criticisms of *Brown University*, see Lee Goldman, *The Politically Correct Corporation and the Antitrust Laws: The Proper Treatment of Noneconomic or Social Welfare Justifications Under Section 1 of The Sherman Act* , 13 YALE L. & POL'Y REV. 137, 148 (1995) ("Even assuming that the defendants genuinely intend to benefit the public, they still cannot be trusted to balance properly the asserted public interest benefits against the resulting harms to competition so long as they receive direct financial advantages.").

87. Havighurst & Richman, *supra* note 2, at 20.

88. *See supra* note 74 and accompanying text. Judge Posner also holds this view, *see supra*, note 14, and Judge Easterbrook apparently does as well. Easterbrook remanded a Sherman Act section 2 claim against Blue Cross/Blue Shield to determine whether the nonprofit defendants had sufficient market power to shift costs to rivals. *See* Ball Mem'l Hosp. v. Mut. Hosp. Ins., 784 F.2d 1325, 1340–41 (7th Cir. 1986).

89. It is possible that the surplus from supracompetitive prices is whittled away in inflated salaries, administrative inefficiencies, or undesired quality improvements. *See* Havighurst & Richman, *supra* note 2, at 22–23 ("[I]n the absence of either market discipline or effective political oversight, there is no assurance that easily gained revenues will not be squandered in low-priority activities, in overpaying for inputs, or simply through managerial slack."). But this kind of waste can itself be characterized as a subsidy. *See id.*

Though a nonprofit's inflating some prices while reducing others can be objectionable under antitrust principles,[90] *Distributive Injustices'* criticism of such pervasive cross-subsidies provides a further justification for rigorous antitrust enforcement. After listing the many activities that likely enjoy subsidies—including publicly minded services, such as uncompensated and undercharged care for the indigent and low-income, underpayments by Medicare and Medicaid, and other such "activities that the market would not otherwise support," and less munificent services such as discounted medical instruction, research, and loss-leaders in growing markets that might translate into future market power and lucrative services[91]—*Distributive Injustices* observes,

> The buck obviously does not stop with the payer. Instead, the heavy costs of activities unrelated to the care of the payer's own patients are inevitably passed on to the working Americans more or less in proportion to the health insurance premiums that employers largely pay on their behalf. The result is a well-entrenched method of financing important health-related activities, many of uncertain value, through what amounts to a hidden 'head tax.' True to the nature of such a tax, the burden is distributed more or less equally across all premium payers rather than in proportion to their wealth or income.[92]

Antitrust law thus has the capacity to contain health care costs through mechanisms not commonly appreciated. Antitrust enforcement has frequently been invoked to defeat collusion, entry barriers, and other mechanisms that prop prices above their competitive levels,[93] but health care costs are driven not just by inflated prices, but also by hidden expenditures. Curtailing the elaborate system of cross-subsidies that abound in nonprofit hospitals will bring more transparency to this process of doling out health care dollars. Antitrust enforcement and merger review can bring market discipline to the health care system (in addition to compelling price competition) by subjecting many health-industry services to the rigors of consumer preferences, ending their protection by secretive administrators, and enabling the value and sustainability of such services to be determined by market demand.

The implication of this argument is that antitrust enforcers serve an important political purpose that extends far beyond combating inflated prices. If mitigating market power handicaps this system of cross-subsidies, then antitrust enforcement can keep the provision of public goods within the public political arena and thus subject to transparent policy debate. It might also stem the reach and the magnitude of the health system's hidden head tax. However

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90. *See supra* Part IV.B.

91. Havighurst & Richman, *supra* note 2, at 20–21.

92. *Id.* at 24.

93. *See, e.g.*, FTC v. Ind. Fed. of Dentists, 476 U.S. 447, 459 (1986) (holding a group of dentists liable for collectively refusing to submit x-rays to insurance companies and thus maintaining an information imbalance); Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 341, 357 (1982) (holding that "maximum" price-fixing by a group of doctors violates the Sherman Act); Am. Med. Ass'n v. FTC, 638 F.2d 443, 447 (1980) (reviewing an FTC order forbidding medical associations from interfering with doctors' non-deceptive advertising).

desirable cross-subsidized activities might be, they persist by skirting the political process and collect their revenue regressively on the backs of working individuals. Antitrust, seeking competition and efficiency, might also bring about a more democratic financing system if courts reviewing hospital mergers properly considered these aspects of cross-subsidies.

Of course, disassembling the health care industry's system of cross-subsidies is a daunting task. The system is deeply rooted within accounting and delivery systems, and the powerful industry is highly incentivized to do what it can to maintain control over its captured rents. But more importantly, the system of cross-subsidies enjoys the thorough protection of several legal authorities and has become part of the very fabric that defines nonprofit status. As Professor Schmalbeck writes in this volume, the earliest revenue rulings determining whether hospitals were exempt from paying taxes actually hinged upon the maintenance of a healthy system of cross-subsidies. On the seminal Revenue Ruling 56-185,[94] which provided a list of "requirements" for exemption of a nonprofit hospital, Professor Schmalbeck writes:

> [T]he ruling explained that such a hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered . . . ." The clear implication of the paragraph was that an exempt hospital was expected to engage in more or less explicit cross-subsidization among patient groups, with those who could afford treatment paying for the total costs of operating the hospital, including costs attributable to care for those who could not afford to pay the full costs, if they could indeed afford to pay anything at all.[95]

Even now, cross-subsidies remain at the heart of nonprofit status in the health care sector—but as something the law requires, not something deemed undesirable. For example, when health maintenance organizations (HMOs) sought nonprofit status, they encountered hostility when they suggested they deserved the tax exemption because they could provide care at more competitive costs. Instead, the IRS and a recent Tenth Circuit ruling demanded "some additional 'plus.'"[96] Professor Schmalbeck explains that "[t]he amorphous 'plus' factor can vary, but the Tenth Circuit suggested that devoting surpluses to research or teaching, or providing free or below-cost services would normally qualify."[97]

The great irony in these tax cases and revenue rulings is that an entity must exercise market power in order to implement the cross-subsidies necessary to obtain tax exempt status; therefore, all entities that qualify for nonprofit status must necessarily exercise some market power. But this irony, and the implicit alarm it sounds to antitrust law, is largely lost on the courts. To the contrary, recent merger cases make explicit allowances, and impose implicit requirements, for nonprofit hospitals to engage in cross-subsidies. For example,

94. Rev. Rul. 56-185, 1956-1 C.B. 202 (1956).
95. Schmalbeck, *supra* note 18, at 124 (internal citations omitted).
96. IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188, 1197 (10th Cir. 2003).
97. Schmalbeck, *supra* note 18, at 128 (citing *IHC Health Plans*, 325 F.3d at 1197).

in permitting two nonprofit hospitals to merge in 1997, the Eastern District of New York explained,

> [B]oth hospitals provide millions of dollars worth of free medical care to individuals in need. Any profit is funneled back into the community in the form of new programs and facilities. . . . All of these beneficial factors support the defendants' contention that community service[,] not profit maximization, is the hospitals' mission.[98]

In short, the hospitals' cross-subsidies helped defend a merger, rather than serve as a troubling indication that the hospitals enjoyed market power. Such language demonstrates how far courts have strayed from the central economic goals of antitrust law.

V

CONCLUSION

This comment follows the plea issued in *Distributive Injustices* to pay closer attention to nonprofit health care institutions, including how the law has treated them, what empirical research reveals about them, and how money flows inside them. Indeed, paying closer attention is instructive: it reveals certain judicial predispositions toward health care institutions, the effect of market structure on health-services competition, and most of all, the meaningful economic and political damage that many nonprofit hospitals inadvertently inflict upon the health-services market. From these observations, a series of antitrust arguments emerge that reason strongly for more rigorous scrutiny of proposed nonprofit hospital mergers. No less than foundational antitrust principles—lower prices, allocative efficiency, and market competition—are at stake. In addition, increased scrutiny offers an opportunity for antitrust to reclaim important allocation decisions from health care institutions and return them to the democratic political process. Hopefully, these arguments will join the many others to help turn the FTC's hospital merger record around.

98. United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 146 (E.D.N.Y. 1997).