

ANTITRUST AND NONPROFIT HOSPITAL MERGERS:
A RETURN TO BASICS

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Courts reviewing proposed mergers of nonprofit hospitals have too often abandoned the bedrock principles of antitrust law, failing to pay heed to the most elemental hallmarks of socially beneficial competition. This Article suggests that courts’ misapplication of antitrust law in these cases reflects a failure to understand the structural details of the American health care market. After reviewing recent cases in which courts have rejected challenges to proposed mergers between nonprofit hospitals, it documents how courts have engaged in a faulty analysis that ultimately protects nonprofit hospitals from the rigors of standard antitrust scrutiny. It then identifies the core principles of antitrust law—preventing supracompetitive prices, optimizing output, and maximizing allocative efficiency—that have been absent from, if not violated by, the rulings in these merger cases.

INTRODUCTION121
 I. THE SETTING: COURTS’ PROTECTION OF NONPROFITS125
 II. A RETURN TO PRINCIPLES: UNDERSTANDING INSURANCE,
 MORAL HAZARD, AND CROSS-SUBSIDIES136
 A. *The Effects on Prices:*
 Market Power Plus U.S.-Style Health Insurance137
 B. *The Effects on Output:*
 The Antitrust of Overconsumption140
 C. *The Effects of Cost-Shifting:*
 The Antitrust of Cross-Subsidies.....143
 CONCLUSION.....148

INTRODUCTION

In recent years, courts reviewing proposed mergers of nonprofit hospitals have abandoned the bedrock principles of antitrust law. The hallmarks of socially beneficial competition—maximizing allocative

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efficiency and total surplus—are absent from their analysis. Not surprisingly, this trend has yielded a string of cases in which antitrust enforcers have lost challenges to proposed mergers that courts likely would have prohibited had they occurred in other industries.¹ This string of losses has troubled many antitrust policymakers,² causing some to wonder whether the core principles of competition law are being forsaken in favor of political expedience and favorable predispositions toward the health care sector.³ One knowledgeable commentator has suggested that “the role of antitrust law in monitoring the health care industry faces an increasingly uncertain, and perhaps diminishing, future.”⁴

The futility of Federal Trade Commission (FTC) and Department of Justice (DOJ) challenges in federal courts has caught the attention

¹ See *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (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), *amended by* 130 F. Supp. 2d 1109, 1137 (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 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997); *Adventist Health Sys./West*, 117 F.T.C. 224, 285 (1994).

² 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.”).

³ See James F. Blumstein, *The Application of Antitrust Doctrine to the Healthcare Industry: The Interweaving of Empirical and Normative Issues*, 31 IND. L. REV. 91, 111, 112 (1998) (arguing that some approaches to mergers of nonprofit hospitals “abandon[] reliance on the structural guarantees of a competitive marketplace in favor of reliance on alternative mechanisms” and that such an “analysis is really driven by normative rather than empirical concerns”); see also Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, HEALTH AFF., Mar.–Apr. 2002, at 185, 187, 188 (discussing the apparent “judicial disdain” for applying traditional antitrust principles to health care providers, as well as the outright “rejection of conventional norms that guide competition law” in decisions reviewing hospital mergers).

⁴ Greaney, *supra* note 3, at 185; see also *id.* at 193 (“Case law has constrained enforcers’ ability to control concentration and has given overly permissive signals to providers who are contemplating further consolidation.”). Additional erosion of antitrust scrutiny is attributable to state legislatures. In the early 1990s, eighteen states enacted programs to “provide an exemption from state antitrust laws and also provide immunity from federal antitrust enforcement under the state action immunity doctrine.” U.S. GEN. ACCOUNTING OFFICE, HEALTH CARE: FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY 11 (1994).

of many scholars and has prompted a search for explanations. Some scholars have concluded that, as a general matter, courts do not want competition in the health care sector and prefer instead to entrust benevolent monopolists to act in the community's best interests. They thus delegate health care allocations to paternalistic hospitals rather than empower consumers to motivate the competitive process.⁵ Alarmed by judicial declarations such as "[i]n the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars,"⁶ commentators in this camp conclude that the hospital merger cases amount to a carve-out of antitrust enforcement and "present some of the most serious and successful challenges to traditional economic presumptions that can be found anywhere in contemporary antitrust law."⁷

Other scholars attribute the losing streak to the complexity of hospital merger cases and the subsequent likelihood that judges will make mistakes in various steps of the legal analysis.⁸ Determining the relevant geographic and product markets, for example, requires significant technical sophistication and commonly leads to judicial error.⁹ Courts have also tended to underestimate a merged facility's

⁵ See Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 614-15 (2002) ("In [hospital merger] cases, antitrust courts occasionally veer towards heresy, explicitly questioning the desirability of competition . . ."). For this reason, Martin Gaynor has urged antitrust enforcers who litigate such cases to advance rudimentary objectives to the judge and jury by articulating "convincing arguments about . . . the desirability of competition in health care markets" and that "monopoly harms health care consumers just like it harms the consumers of conventional products." Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gasses? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497, 502 (2006).

⁶ *Butterworth*, 946 F. Supp. at 1302.

⁷ Hammer & Sage, *supra* note 5, at 616. Hammer and Sage go on to suggest that courts' aversion to applying antitrust principles to nonprofit hospitals might be attributable to natural sympathies that federal judges have for those who run health care organizations. See *id.* at 617 ("The small, elite club of individuals from which hospitals draw their boards of trustees shares much with the privileged pool from which most federal district court judges emerge.").

⁸ See Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191, 192 (1997) ("[C]ourts deciding hospital merger cases are asked to make exceedingly fine-tuned appraisals of complex economic relationships. . . . Like pilots landing at night aboard an aircraft carrier, courts are aiming for a target that is small, shifting and poorly illuminated."); Jennifer R. Connors, Comment, *A Critical Misdiagnosis: How Courts Underestimate the Anticompetitive Implications of Hospital Mergers*, 91 CAL. L. REV. 543, 562 (2003) (arguing that courts have erred in, inter alia, defining product and geographic markets and estimating market power).

⁹ See, e.g., Cory S. Capps et al., *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, 47 ANTITRUST BULL. 677, 679-80 (2002) (criticizing a method

market power.¹⁰ In addition, recent decisions suggest that many courts fail to understand the nature of nonprice competition, such that a concern about escalating health care costs leads to an interpretation of duplicative investments in technologies as socially wasteful, rather than as a reflection of robust competition on quality.¹¹

However, although some judges may be hostile toward competition in the health care industry, and even if the requisite antitrust analysis in these cases is difficult, the inability of courts to properly apply antitrust law in these cases reflects a more fundamental, and arguably more troubling, problem: a failure to understand how the structure of the American health care sector shapes market competition.

The most important features of the U.S. health care system include the financing of care through insurance, a tax system that subsidizes health insurance, a legal and regulatory system that tends to require all “medically necessary” care, and a reliance on private nonprofit institutions to provide care to the indigent, technological innovation, and other public goods. These features are critical in understanding the market for health care, and they accordingly shape a proper antitrust analysis. However, because courts have not adequately recognized the economic significance of these structural features, they have misunderstood the dangers of market power in the health care sector and have thus inappropriately relaxed the standards of antitrust law.

This Article attempts to refocus hospital merger review on the foundations of antitrust law. It begins with a review of recent cases in which the FTC and DOJ unsuccessfully challenged proposed mergers between nonprofit hospitals, documenting how courts have engaged in a faulty analysis that ultimately protects nonprofit hospitals from the rigors of standard antitrust scrutiny. The Article then identifies bedrock principles of antitrust law—preventing supracompetitive prices, optimizing output, and maximizing allocative efficiency—that

commonly used by courts to assess market power); Gregory J. Werden, *The Limited Relevance of Patient Migration Data in Market Delineation for Hospital Merger Cases*, 8 J. HEALTH ECON. 363, 363, 376 (1989) (attributing discrepancies in court decisions to difficulties “delineating the geographic scope of markets”); Matthew Reiffer, Note, *Antitrust Implications in Nonprofit Hospital Mergers*, 27 J. LEGIS. 187, 192 (2001) (lamenting that judicial analyses of market definition are often “derived primarily from ‘guesswork’”).

¹⁰ James Langenfeld & Wenqing Li, *Critical Loss Analysis in Evaluating Mergers*, 46 ANTITRUST BULL. 299, 323-24 (2001).

¹¹ Peter J. Hammer, *Questioning Traditional Antitrust Presumptions: Price and Non-Price Competition in Hospital Markets*, 32 U. MICH. J.L. REFORM 727, 755 (1999).

have been absent from, if not violated by, the rulings in these merger cases.

I. THE SETTING: COURTS' PROTECTION OF NONPROFITS

There is little dispute that when courts are asked to evaluate the potential benefits and harms of nonprofit market power, they are addressing issues of substantial policy importance. Rising health care costs are a matter of national alarm, and increasing attention has been paid to the growing market power accumulated by health care providers. Recent studies suggest that market power pervades the health care sector and is responsible for a torrent of supracompetitive—and even supramonopoly—prices.¹² Moreover, much of the recent rise in health care costs is directly attributable to increases in supply-side market power that are products of hospital consolidations and the growth of provider collaborations.¹³ Antitrust agencies, which are

¹² See Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, HEALTH AFF., Mar.–Apr. 2004, at 175, 179 (finding that “most consolidating hospitals raise prices by more than the median price increase in their markets”); Katharine Levit et al., *Health Spending Rebound Continues in 2002*, HEALTH AFF., Jan.–Feb. 2004, at 147, 155 (ascribing rising costs, in part, to hospitals’ growing market power). For a detailed study of growing market concentration in the health insurance sector, see AM. MED. ASS’N, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS: 2007 UPDATE (2007), available at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf, and for a discussion of the related increase in prices, see James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, HEALTH AFF., Nov.–Dec. 2004, at 11, 17, 19 (empirically showing the “consolidation of the [health insurance] industry at the hands of the largest health plans,” as well as the fact that from 2000 through 2003, “health plans . . . were able to raise prices consistently above the rate of growth in costs”). This evidence has been sufficient to convince the FTC that “increased hospital concentration is associated with increased prices.” See FTC & DOJ, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch. 3, at 10-16 (2004), available at http://www.usdoj.gov/atr/public/health_care/204694.pdf [hereinafter A DOSE OF COMPETITION].

For a brief overview of commonly identified sources of rising health care expenditures, see HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION 39 (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).

¹³ See Martin Gaynor & William B. Vogt, *Competition Among Hospitals*, 34 RAND J. ECON. 764, 764 (2003) (“During the second half of the 1990s, a dramatic wave of hospital consolidation occurred in the United States. . . . [M]any local markets, including quite a few large cities such as Boston, Minneapolis, and San Francisco, have come to be dominated by two or three large hospital systems. Not surprisingly, many health plans have complained about rising prices as a result of this consolidation.”); Gaynor, *supra* note 5, at 498-99 (documenting that the median and mean Herfindahl-

empowered by the Clayton Act to investigate and challenge in federal court mergers that would lead to anticompetitive consequences,¹⁴ appropriately identified growing hospital market power as an enforcement priority. As the merger wave of the 1990s spread to hospitals, federal and state antitrust policymakers mustered a number of ambitious challenges to proposed mergers of nonprofit hospitals.¹⁵

However laudable these enforcement efforts were, antitrust enforcement agencies have found little success, losing each of the seven suits initiated since 1994 to challenge proposed hospital mergers.¹⁶ Antitrust scholars have already spilled significant ink criticizing the judicial reasoning and outcomes in those cases.¹⁷ However, retracing the development of these cases illustrates not only how the courts erred, but also how they became mistakenly preoccupied with a narrow legal question, how that preoccupation developed into a wholesale exemption, and how antitrust enforcers inadvertently fueled the mistaken emphasis. The narrow question that preoccupied the courts in each of these cases was whether nonprofits, especially when enjoying market power, exhibited pricing behavior that was statistically different from that of for-profit hospitals. While the question is potentially of great importance, since a nonprofit's failure to capitalize on market power (as for-profits are presumed to do) might militate against rigorous antitrust enforcement, its answer does not reveal whether nonprofits decline to exercise market power, which is the

Hirschmann Index (HHI) for U.S. hospital markets rose steadily from 1985 to 2000, with a "very concentrated" mean HHI of 3995 in 2000).

It is a matter of additional concern that substantial evidence suggests that these mergers produced price increases that far outweighed their alleged efficiencies. On the price-increasing effects of mergers and consolidations, see DAVID DRANOVE, *THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE* 122 (2000) ("I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power."); Jack Zwanziger & Cathleen Mooney, *Has Price Competition Changed Hospital Revenues and Expenses in New York?*, 42 *INQUIRY* 183, 190 (2005) (finding that mergers undermined price- and cost-reducing effects of hospital competition following deregulation). Hospital mergers have also limited the ability of insurers to reduce prices. See MEDPAC, *REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY* 57 (2005) (noting that insurers' use of selective contracting "has been limited by both hospital consolidation and consumers' reluctance to accept limitations on their choice of providers").

¹⁴ See Clayton Act § 7, 15 U.S.C. § 18 (2000).

¹⁵ See *supra* note 1.

¹⁶ See *supra* note 1; see also A DOSE OF COMPETITION, *supra* note 12, ch. 4, at 1.

¹⁷ See, e.g., Capps & Dranove, *supra* note 12, at 180; Greaney, *supra* note 8, at 220; Greaney, *supra* note 3, at 193; Hammer & Sage, *supra* note 5, at 617.

central concern in merger cases. Nonetheless, by myopically focusing on whether corporate form has any statistical significance at all, courts absolved nonprofits from appropriate scrutiny.

Antitrust agencies had little reason to believe that courts in the 1990s would be so unreceptive to their merger challenges, since earlier courts were skeptical of carving out an antitrust exemption for nonprofit hospitals. In an important 1986 decision, Judge Richard Posner remarked, “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.”¹⁸ Judge Posner then went further, suggesting that nonprofits might even be more likely than for-profits to charge supracompetitive prices and engage in anticompetitive conduct: “[C]ompelled 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.”¹⁹

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”²⁰ One year later, Judge Gerald Tjoflat expressed the same inclination to impose the antitrust laws with equal

¹⁸ *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1390 (7th Cir. 1986) (citing *NCAA v. Board of Regents*, 468 U.S. 85, 100 n.22 (1984); Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1447, 1465 (1980)).

¹⁹ *Id.* at 1391.

²⁰ *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,

The 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. Judge Frank Easterbrook similarly presumed that nonprofits would exploit market power if presented with the opportunity. See *Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325, 1340-41 (7th Cir. 1986) (remanding a Sherman Act section 2 claim to determine whether nonprofit defendants had sufficient market power to shift costs to rivals).

rigor on both nonprofits and for-profits. Citing both of Judge Posner's opinions, Judge Tjoflat concluded that "the nonprofit status of the acquiring firm will not, by itself, help a defendant overcome the presumption of illegality."²¹

These remarks, intended merely to subject nonprofits to the demands of antitrust law, may have inadvertently introduced the question of whether nonprofit hospitals' competitive strategies differed from those of for-profits. That question was seized upon in more recent antitrust court rulings, in which courts have expressed a far more generous attitude toward nonprofit hospitals.²² The first antitrust opinion to take this position in recent decades was the 1989 ruling in *United States v. Carilion Health System*.²³ In rejecting the FTC's challenge to the 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."²⁴ The court then continued,

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.²⁵

²¹ *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1224 (11th Cir. 1991). Judge Tjoflat also invoked *NCAA v. Board of Regents*, 468 U.S. 85, 100 n.22 (1984), in concluding 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.

²² Richard Schmalbeck observes 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*, LAW & CONTEMP. PROBS., Autumn 2006, at 121, 126.

²³ 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, No. 89-2625, 1989 WL 157282, at *4 (4th Cir. Nov. 29, 1989).

²⁴ *Id.* at 849.

²⁵ *Id.* To reach this conclusion, the court relied on expert testimony to arrive at two key factual findings that favored the defendants. First, the court concluded that "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. *Id.* 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 defendants' witness "raised serious questions about [the FTC's] method of analysis." *Id.* at 846 n.6.

The neutral observer might consider this statement largely innocuous—particularly since the court provided many bases for its decision that did not rely on the merging entities' tax status and since the court based its analysis predominantly on the definition of the hospitals' geographic market.²⁶ 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.²⁷ But the issue emerged again in 1995, in *FTC v. Freeman Hospital*.²⁸ This case, like *Carilion*, involved a proposed merger of two nonprofit hospitals in which the parties disputed (among other issues) the geographic and product markets.²⁹ Without citing *Carilion*, the court reached an almost identical, though more sweeping, conclusion regarding the significance of the hospitals' corporate form:

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.³⁰

In applying this principle to the merging entities and approving the merger, the court concluded that "it would not be in [the defendants'] best economic interest to permit prices to rise beyond a normal competitive level."³¹

²⁶ See *id.* at 847-48.

²⁷ See *United States v. Carilion Health Sys.*, No. 89-2625, 1989 WL 157282 (4th Cir. Nov. 29, 1989).

²⁸ 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260, 273 (8th Cir. 1995).

²⁹ Under the FTC's alternative market definitions, the proposed merger would create a market with an HHI 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. 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41,552, 41,558 (Sept. 10, 1992).

³⁰ *Freeman Hosp.*, 911 F. Supp. at 1222 (citations omitted).

³¹ *Id.* at 1227. In asking "who controls the hospitals," the court revealed that twelve of the board's eighteen members were owners, employees, or retirees of local businesses and concluded that "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. It is questionable, of course, whether employers adequately represent the interests of their employees as health care consumers since employees ultimately pay for the cost of health insurance. See *infra* note 43.

Even though *Freeman* issued a sweeping generalization about the nature of nonprofit-hospital pricing policies, its conclusion, like *Carilion's*, did not rest exclusively on the nonprofit status of the merged entity, and instead primarily relied on the defendants' market definitions. Moreover, also like *Carilion*, the *Freeman* ruling was upheld in a brief circuit opinion that did not discuss the relevance of nonprofit status to competitive behavior.³² The *Freeman* opinion was, however, distinct from *Carilion* in that it introduced some scholarship to support its characterization of nonprofits. The court cited³³ William Lynk's *Property Rights and the Presumptions of Merger Analysis*, which concluded that "nonprofit hospitals behave differently than for-profit hospitals. In particular, . . . nonprofit hospitals set lower prices than otherwise comparable for-profit hospitals."³⁴ Nonetheless, since the nonprofit's pricing behavior was not central to the court's determination, the court's musings into the nature of nonprofits appeared to be little more than insignificant dicta. But the language in *Freeman*—like the proverbial "loaded weapon"³⁵—became available to subsequent courts reviewing mergers in which a nonprofit's pricing behavior was a critical issue.³⁶

³² 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.

³³ *Freeman Hosp.*, 911 F. Supp. at 1222.

³⁴ William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTI-TRUST BULL. 363, 372 (1994). 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. 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. *Id.* at 366-70.

³⁵ See *Korematsu v. United States*, 323 U.S. 214, 246 (1944) (Jackson, J., dissenting) ("The principle then lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need.").

³⁶ It appears that the *Freeman* opinion did not immediately 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 pro-competitive intent. The hospitals cite *United States v. Carilion Health Sys.* 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.

Such a proposed merger arose in *FTC v. Butterworth Health Corp.*³⁷ *Butterworth* was also a challenge to a proposed merger between two nonprofit hospitals, but unlike the rulings in *Carilion* and *Freeman*, the *Butterworth* court accepted the FTC's market definition and agreed that the resulting hospital market would be highly concentrated.³⁸ Nonetheless, the court permitted the merger after concluding that "nonprofit hospitals do not operate in the same manner as profit maximizing businesses."³⁹ And in so deciding, the court cited the excerpt from *Freeman*, quoted above, that analogized a nonprofit hospital to a consumer cooperative.⁴⁰

In a lengthy opinion, the court supported its distinction between for-profits and nonprofits on two separate but interrelated grounds. First, relying on scholarship and expert testimony from William Lynk,⁴¹ the court concluded that for nonprofit hospitals, "market con-

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 omitted), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997).

³⁷ 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997).

³⁸ *See 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 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41,552, 41,558 (Sept. 10, 1992).

³⁹ *Butterworth*, 946 F. Supp. at 1296-97.

⁴⁰ *Id.* at 1296 (citing *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995)).

⁴¹ The *Butterworth* court cited Lynk's article, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437 (1995), which examines 1989 pricing data from a cross-section of California hospitals to determine whether nonprofits price lower than for-profits. 946 F. Supp. at 1296. The article finds that "nonprofit hospitals, whether private or public, have statistically significantly lower list and net prices than for-profit hospitals." Lynk, *supra*, at 449-52. It also determines 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 nonprofit hospitals tend to slightly reduce theirs. *Id.* at 459. The article concludes 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." *Id.* The *Butterworth* court also relied on Lynk's expert testimony analyzing the Grand Rapids hospital market that included the merging parties, in which Lynk "concluded that in Michigan, too, higher hospital concentration is associated with lower nonprofit hospital prices." 946 F. Supp. at 1295.

centration appears to be positively correlated not with higher prices, but with lower prices.”⁴² 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.”⁴³ The Sixth Circuit affirmed the decision for the hospitals in a terse, unpublished per curiam ruling, concluding that “[t]he record presented here does not leave us with a firm conviction that the district court erred in its analysis of the facts.”⁴⁴

The *Butterworth* opinion was a sweeping victory for nonprofit hospitals because it carved out a different standard for nonprofits in the application of antitrust laws. It also 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.”⁴⁵ Another critic charged

⁴² 946 F. Supp. at 1296. Lynk uses nearly identical language, concluding from his study of California hospital markets that “on balance increased nonprofit market share is associated with lower, not higher, prices.” Lynk, *supra* note 41, at 459.

⁴³ 946 F. Supp. at 1297, 1302. To reach this conclusion, 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. The pledge 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.* at 1298 (alteration in original). The FTC regarded the document as “unenforceable, illusory or inadequate.” The court, however, found it to be consistent with pledges from the hospitals’ chairmen (who “have community interests at heart”) that the merger was intended to lower health care costs, improve quality, and enhance consumer welfare. *See id.* at 1297, 1302. These conclusions were also consistent with observations the judge himself made during tours of the hospitals, which convinced him that the hospitals were “well-maintained” and that the Board of Directors would adhere to their “fiduciary responsibilities” to renovate and upgrade their facilities. *Id.* at 1301.

There is an important but unappreciated irony in the judiciary’s confidence in pledges by local business leaders to contain health care costs. Labor economists have consistently found that even though employers purchase most health coverage for their employees, the full costs are ultimately shouldered by employees, principally in the form of reduced wages. *See* Jonathan Gruber, *Health Insurance and the Labor Market* 55 (Nat’l Bureau of Econ. Research, Working Paper No. 6762, 1998) (reviewing the empirical literature and concluding that “the results that attempt to control for worker selection, firm selection, or (ideally) both, have produced a fairly uniform result: the costs of health insurance are fully shifted to wages”).

⁴⁴ *FTC v. Butterworth Health Corp.*, No. 96-2440, 1997 WL 420543, at *3 (6th Cir. July 8, 1997).

⁴⁵ Greaney, *supra* note 3, at 188.

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.”⁴⁶ This critic warned further 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.”⁴⁷ Several scholars also lamented the court’s reliance on Lynk’s scholarship, which was heavily criticized in subsequent studies.⁴⁸

⁴⁶ Blumstein, *supra* note 3, at 117. 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). For a more nuanced view that is sympathetic to the emerging trend and supportive of a flexible application of antitrust laws to nonprofit hospitals, see Thomas L. Greaney, *Antitrust and Hospital Mergers: Does the Nonprofit Form Affect Competitive Substance?*, 31 J. HEALTH POL. POL’Y & L. 511, 527 (2006) (“[C]ourts might be well advised . . . [to] keep open the possibility of fashioning new presumptive rules tailored to more complete economic accounts of nonprofit firm behavior.”).

⁴⁷ Blumstein, *supra* note 3, at 117.

⁴⁸ Questions over Lynk’s work, 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 who criticized Lynk’s findings and a third in which Lynk and a coauthor could respond to Lynk’s critics. Most of the scholarly attention was directed at Lynk’s examination of simulated hospital mergers using 1989 California pricing data. See *supra* note 41. One article was able to replicate Lynk’s findings but arrived at opposite results after making small methodological changes; it also discovered from data over several years that price increases from merging nonprofits grew larger over time. See Emmett B. Keeler et al., *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69, 83 (1999). The second article argued that two sources of bias led to Lynk’s results and, after introducing adjustments, concluded that mergers of nonprofit hospitals are associated with, “[i]f anything,” higher prices than mergers of for-profits. David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk’s Analysis*, 18 J. HEALTH ECON. 87, 97 (1999). Lynk’s response attributed the conflicting findings to methodological differences, but he also emphasized that his 1995 paper was modest in its normative conclusions, noting that the “policy question that [his earlier] 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.” William J. Lynk & Lynette R. Neumann, *Price and Profit*, 18 J. HEALTH ECON. 99, 100-01 (1999). Echoing his 1995 call for a case-by-case analysis, Lynk urged that determining nonprofit hospital pricing behavior remained an open empirical question. *Id.* at 111.

The debate over whether nonprofit and for-profit hospitals price differently remains lively, though most studies dispute Lynk’s findings and do not support a case-by-

In addition to carving out a generous antitrust exemption, *Butterworth* also lent support to those who argued that judges have a deep-seated hostility to subjecting health care providers to competition. The ruling concluded with some revealing language: “[m]anaged 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.”⁴⁹ Thus, the court concluded simply that competition itself does not serve the public interest. To the contrary, it entrusted market power to the directors of nonprofit hospitals and concluded that

case approach. *See infra* notes 52-55 and accompanying text; *see also* John Simpson, FTC & Richard Shin, U.S. DOJ, *Do Nonprofit Hospitals Exercise Market Power?* 15-16 (FTC Bureau of Econ., Working Paper No. 214, 1996), available at <http://www.ftc.gov/be/workpapers/wp214.pdf> (concluding that nonprofit hospitals in concentrated markets set prices that are statistically indistinguishable from those set by for-profits).

⁴⁹ 946 F. Supp. at 1302. The court then issued an even more sweeping indictment of market forces, counterintuitively arguing that competition had impeded the realization of certain efficiencies:

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.

Id. The court’s hostile language could alternatively be interpreted to issue a narrower indictment of the competitive pressures brought by managed care organizations (MCOs). The court could have been responding to an argument advanced at trial: that MCOs might negotiate lower prices for their own subscribers and thereby indirectly increase prices for all other consumers. Thus, rather than expressing hostility to competition writ large, the court might have been suggesting that the competition introduced by MCOs is detrimental because it helps some but hurts others. And in remarking that “the interests of managed care organizations, as health care intermediaries, pale in comparison with those of the actual health care consuming public,” *id.*, the court perhaps was merely placing greater value on the welfare of certain consumers and providers than on the benefits competition brought to MCOs.

Nonetheless, there is also reason to interpret the court’s language as a broad condemnation of competition in the health care sector: MCOs were the primary sources of price competition; the court explicitly asserted that “even though competition may be lessened, the interests of consumers are, under the unique circumstances of this case, likely to be advanced rather than hurt,” *id.*; and the court’s reasoning relies, above all, on the presumed altruism of nonprofit entities, their boards, and certain pledges they made to expand output.

the public benefits most when such hospitals grow and dominate a market.⁵⁰

Wounded by its resounding defeat in *Butterworth* and its other court losses, the FTC assembled a counterpunch in its 2004 report, *Improving Health Care: A Dose of Competition*.⁵¹ Gathering scholarly testimony on hospital pricing behavior, 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."⁵² 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."⁵³ And, after listing the growing number of studies that reach that conclusion,⁵⁴ 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 anti-competitive.⁵⁵

⁵⁰ This same hostility was reflected in *Freeman* as well. In orally denying the FTC's motion for a temporary restraining order to enjoin the proposed merger, the *Freeman* court 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 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.

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).

⁵¹ A DOSE OF COMPETITION, *supra* note 12.

⁵² *Id.* ch. 4, at 31.

⁵³ *Id.*

⁵⁴ *Id.* ch. 4, at 31-33 nn.166-79. 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); Elaine Silverman & Jonathan Skinner, *Medicare Upcoding and Hospital Ownership*, 23 J. HEALTH ECON. 369 (2004); and Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001).

⁵⁵ A DOSE OF COMPETITION, *supra* note 12, ch. 4, at 33.

The FTC's assertive language is a transparent effort to bring an end to the *Carilion-Freeman-Butterworth* legacy,⁵⁶ even though it is unclear how far the trilogy advanced in carving out an established doctrine. While the cases cited and built upon each other, their lenient antitrust approach has been neither recognized by a circuit court nor acknowledged by Judge Posner in his recent academic writings.⁵⁷ Unfortunately, the entire debate that worked its way through the litigation, the academy, and into the FTC report has focused on a question that is secondary, and possibly irrelevant, to antitrust analysis. Even as the courts regularly displayed wide-ranging antagonism to antitrust actions against nonprofit hospitals, their approvals of proposed mergers rested, in part, on finding that nonprofit and for-profit hospitals exhibit different pricing behaviors. The FTC report, understandably aiming to refute the conclusions and scholarship that motivated these judicial opinions, focused on the same narrow question and thus inadvertently contributed to moving the debate toward a myopic and unconstructive target. The debate has allowed antitrust analysis to stray from what should be the focus.

Attention should instead focus on the consequences of nonprofit market power and whether market power in the hands of nonprofit hospitals is socially undesirable (regardless of whether it is more or less desirable than market power in the hands of for-profits). Investigating this question could lead to a meaningful examination of how market power combines with health insurance, affects output, and enables cross-subsidies. Refocusing the analysis in this direction is the first step toward a return to antitrust principles.

II. A RETURN TO PRINCIPLES: UNDERSTANDING INSURANCE, MORAL HAZARD, AND CROSS-SUBSIDIES

A confidence that nonprofit hospitals' market concentration does not lead to higher prices largely drives judicial sympathy for nonprofits in merger cases, and in turn a tolerance of nonprofits' market power. This view is not entirely unfounded, and the courts in *Carilion*,

⁵⁶ At around the same time the FTC released its report, it launched a new attack in this battle against nonprofit hospital mergers and initiated its complaint against Evans-ton Northwestern Healthcare. See *infra* notes 101-106 and accompanying text.

⁵⁷ See, e.g., Tomas J. Philipson & Richard A. Posner, *Antitrust in the Not-for-Profit Sector* 4 (Nat'l Bureau of Econ. Research, Working Paper No. 12132, 2006) ("[D]efendants will often argue that their [nonprofit] status entitles them either to an outright exemption from antitrust scrutiny or to a different, more permissive standard of liability. These arguments fail.").

Freeman, and *Butterworth* relied on expert testimony and some academic scholarship to reach their conclusions that nonprofits would not impose monopoly prices.⁵⁸ But this is altogether the wrong focus. Instead, attention should concentrate on prices, output, and efficiency. Even as the structural complexity of the health care system is unbundled, a return to antitrust's central principles reveals a surprisingly straightforward analysis.

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

With courts focusing on potential differences between for-profit and nonprofit hospitals, the antitrust debate has unfortunately revolved around, and has devolved into, the question of whether nonprofit hospitals set prices differently from for-profits. The primary problem with this approach is that the baseline question is how a for-profit monopolist would price, when the concern should be whether nonprofits exploit market power at all.

There is good reason to believe that market power yields especially pernicious consequences in the U.S. health care market, regardless of whether the owner of such market power is for-profit or nonprofit. Understanding the exploitation of market power in this industry requires appreciating the critical role of health insurance in determining market prices.

U.S.-style health insurance offers health care services to insureds for a copayment that is far below the actual price charged for the desired care. It has long been understood that insurance of this sort creates a moral hazard, which induces those with insurance to consume more than they otherwise would if they faced market prices.⁵⁹ But insurance also means that providers face consumers who are significantly less price conscious, and thus present a steeper and less elastic demand curve.⁶⁰ In a competitive market for health care services, the pervasiveness of insurance would likely have little effect on the prices ultimately charged by providers, since competing providers would drive the price charged down toward the marginal cost.⁶¹ In a

⁵⁸ See *supra* notes 25, 34, 41, and accompanying text.

⁵⁹ See, e.g., CHARLES E. PHELPS, HEALTH ECONOMICS 116 (3d ed. 2003).

⁶⁰ *Id.* at 117 (noting that insurance "makes the demand curve less elastic in general").

⁶¹ However, it is possible that, if the marginal cost curve of a particular service is upward sloping, insurance could increase the equilibrium market price by stimulating demand.

concentrated market, however, providers facing a steep demand curve will set prices where marginal revenue equals marginal cost, which would be at prices that are even higher than monopoly prices would be in the absence of insurance. Many assume that consumers' lack of price sensitivity is overcome by their heavy reliance on private insurers acting as informed, aggressive purchasing agents that can negotiate providers' prices downward to competitive levels.⁶² But even if health insurers can leverage their scale economies and industry expertise to stimulate competition and negotiate attractive prices with some providers, they are toothless against a true monopolist. Effective bargaining against a monopolist provider would require insurers to threaten not to cover a service that, by definition, has no adequate substitute, and any such refusal would come into tension with the pervasive legal requirement to cover all "medically necessary" care.⁶³ Even if insurers overcome regulatory and legal hurdles, those who refuse to cover any such service subject themselves to likely lawsuits, angry protests, and the scorn of judges who accuse them of saving dollars rather than human life.⁶⁴

⁶² See Roger D. Blair & Jill Boylston Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis*, 71 ANTITRUST L.J. 989, 997 (2004).

⁶³ See Mark V. Pauly, *Competition and New Technology*, 24 HEALTH AFF. 1523, 1528-29 (2005) (arguing that technology costs are uncontrolled, in part, because insurers do not enjoy the contractual freedom to exclude coverage for expensive care); Clark C. Havighurst, *How the Health Care Revolution Fell Short*, LAW & CONTEMP. PROBS., Autumn 2002, at 55, 73 (lamenting that managed care organizations do not enjoy the legal ability to limit coverage to care that meets appropriate cost-benefit benchmarks). On the pervasiveness of the "medically necessary" standard, and its effect on limiting the ability to constrain health care costs, see Timothy P. Blanchard, "Medical Necessity" Determinations—A Continuing Healthcare Policy Problem, 37 J. HEALTH L. 599, 623-24 (2004); Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1549-51 (1996); and William M. Sage, *Managed Care's Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 605-09 (2003).

⁶⁴ Recall the *Butterworth* court's admonition to the FTC that "[i]n the real world, hospitals are in the business of saving lives, and managed care organizations are in the business of saving dollars." *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997). Managed care organizations were consumed by a political firestorm in the 1990s when they were accused of "rationing" arguably beneficial care. See Michael E. Cherner et al., *Barriers to Constraining Health Care Cost Growth*, HEALTH AFF., Nov.–Dec. 2004, at 122, 127-28 (noting that "the backlash against managed care" could "limit the effectiveness of . . . managed competition"); Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL'Y & L. 427, 427 (2005) (discussing state regulations enacted in the late 1990s and the managed care industry's "retreat" from the use of "key cost-containment techniques").

These observations force the conclusion that “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.”⁶⁵ This has significant implications for antitrust policy. Though it belabors the obvious, it is worth emphasizing that inflated prices are a foundational target for antitrust policy,⁶⁶ and policing the health care industry is of heightened importance if monopoly power in that sector leads to prices that are even more inflated than monopolies in other industries. However objectionable market concentration might normally be, health sector concentration combined with health insurance is cause for particular alarm.

Thus, the emphasis on the significance of corporate form—which has preoccupied the courts—is highly misplaced. Even assuming that nonprofit hospitals with market power set prices statistically lower than for-profit hospitals with equal market power, it would be premature—and grossly inaccurate—to conclude that merger review should be permissive. To the contrary, the presence of health insurance means that hospital market power—whether held by nonprofits or for-profits—is a cause for great alarm and deserves heightened antitrust scrutiny. Rather than focusing on corporate form, empirical scrutiny should focus on the economic consequences of combining market power with health insurance. The crucial test to determine whether nonprofit-hospital market concentration is benign is to compare nonprofit-hospital pricing in the presence of market power to nonprofit-hospital pricing in the absence of market power. Since health insurance affects consumers’ price sensitivities, such a study would likely reveal a significant difference. A second empirical test would examine the effect of insurance on prices. For example, it would study whether, under conditions of market concentration, medical services that typically are not insured—such as elective cosmetic surgery—

⁶⁵ Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 7, 30.

⁶⁶ See *Cal. Dental Ass’n v. FTC*, 526 U.S. 756, 784-85 (1999) (Breyer, J., concurring in part and dissenting in part) (stating that a restraint’s likely effect on prices will determine whether it is anticompetitive); see also HERBERT HOVENKAMP, *FEDERAL ANTI-TRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE* 50 (3d ed. 2005) (discussing the suggestion that “the primary intent of the Sherman Act’s framer” may have been “the distributive goal of preventing monopolists from transferring wealth away from consumers” in the form of higher prices).

exhibit smaller mark-ups than insured services.⁶⁷ These tests could determine the actual effect of insurance on health care prices, and thus might usefully inform antitrust policymakers as to when they should be concerned, and when they should be *very* concerned, about pockets of market power.

Given the potent combination of health insurance and market concentration in the health sector, it is a matter of significant concern that many services in the health care industry are highly concentrated.⁶⁸ But the FTC's concern with growing industry concentration in the health care sector, and its desperate call for greater competition,⁶⁹ does not specify why hospital consolidations should evoke such alarm. It is the specific *combination* of U.S.-style health insurance with health care provider market power that demands remedial attention, with health insurance both reshaping and reemphasizing 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*

In addition to the pervasiveness of insurance, a second prominent feature of the U.S. health care landscape is the tax exclusion of insurance premiums. Compensation paid to workers in the form of employer-paid health insurance premiums is excluded from both individuals' taxable income and employers' payroll taxes.⁷⁰ Consequently, it is mutually beneficial for both employers and employees to create compensation packages that substitute income for generous health insurance, causing individuals to purchase health coverage that is more generous than they otherwise would purchase without the tax subsidy.⁷¹

⁶⁷ A correlation between mark-ups and insurance, however, might be confounded by variations on demand elasticity. Services for which there is elastic demand would, by definition, exhibit smaller mark-ups for a given degree of market concentration, and it is possible that these services are also less likely to receive insurance coverage.

⁶⁸ See *supra* note 13 and accompanying text.

⁶⁹ See A DOSE OF COMPETITION, *supra* note 12, ch. 4, at 1.

⁷⁰ For an overview and critique of the health-related tax exclusions, and a proposal for reform, see PRESIDENT'S ADVISORY PANEL ON FEDERAL TAX REFORM, SIMPLE, FAIR, AND PRO-GROWTH: PROPOSALS TO FIX AMERICA'S TAX SYSTEM 78-82 (2005), available at <http://www.taxreformpanel.gov/final-report/>.

⁷¹ *Id.* at 80. The panel emphasized that "tax preferences for health care represent the largest tax expenditure and have an outsized impact on health care spending in America." *Id.* at 79.

Even unsubsidized health insurance, by presenting insureds with copayments that are a fraction of market prices, induces individuals to consume more than they otherwise would without insurance.⁷² By subsidizing the purchase of health insurance, the tax exclusion leads to insurance benefits that even further reduce copayments and expand coverage of health services. Thus, despite widespread provider market power—enjoyed by nonprofits and for-profits alike—and the pervasiveness of supracompetitive prices,⁷³ U.S.-style insurance subsidizes demand and maintains the moral hazard problem of overconsumption. Thus, America’s health system faces the sad irony that monopoly prices, and even “supramonopoly” prices, do not prompt reductions in consumption of medical services. To the contrary, the tax subsidy and U.S.-style insurance overcome any depressive effect on demand that monopoly prices would normally have.

Perhaps the stimulating effect of subsidized insurance on consumption should be applauded. If the traditional antitrust concern over rising prices is that they lead to a reduction in output,⁷⁴ then health insurance’s stimulation of demand *despite* the presence of monopolies might be reason to restrain, rather than reinvigorate, antitrust scrutiny in this area. The health care industry, however, is an instance in which maximizing output does not translate into maximizing total surplus. This has been labeled the “too much of a good thing” problem.⁷⁵ Even though rising prices might not reduce total output—and, in fact, total output might even achieve theoretically optimal levels if insurance copayments are set at the marginal costs to deliver care—there are instead severe allocative inefficiencies, which are certainly a matter of antitrust concern.⁷⁶ Since insurance-facilitated

⁷² See *supra* note 59 and accompanying text.

⁷³ See *supra* note 13.

⁷⁴ See, e.g., *NCAA 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., Inc.*, 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 . . .”).

⁷⁵ Havighurst & Richman, *supra* note 65, at 24.

⁷⁶ See, e.g., *NCAA*, 468 U.S. at 107 (commenting that being “unresponsive to consumer preference . . . is perhaps the most significant [anticompetitive consequence], since Congress designed the Sherman Act as a consumer welfare prescription” (internal quotation marks omitted)); ROBERT H. BORK, *THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF* 91 (1978) (“The whole task of antitrust can be 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.”).

moral hazard induces individuals to consume services they otherwise would forgo,⁷⁷ 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.⁷⁸ With such distortions on price, and their mute effect on consumption behavior, the costs of many services likely far exceed the surplus they generate.

Moreover, subsidized insurance and the resulting overconsumption create severe dynamic inefficiencies. Health care providers expand costly services with the confidence that most of the visible costs will be covered by insurance, and they have little incentive to meet consumer benefit-cost priorities because the subsidized moral hazard problem prevents consumers from being appropriately cost conscious. In addition, providers make ambitious investments to deliver newer and costlier services that are unlikely to enhance overall welfare but are nonetheless profitable to providers.⁷⁹ Health policy experts agree that investments in new health care technologies, whose profitability has been virtually guaranteed by comprehensive health insurance, are the primary culprit for escalating health care costs.⁸⁰

Consequently, moral hazard and subsequent overconsumption do not correct for the antitrust problems created by inflated prices; rather, because they induce inefficient expenditures despite those prices, and because they institute inefficient incentives to overinvest in future health care consumption, they are additional reasons for alarm. These harms of overconsumption have important implications for antitrust law since they suggest that antitrust policies should take steps to stem the proliferation of output. But courts, to the contrary, are seduced by such pledges to expand output, and overconsumption is ironically applauded. In fact, the harms of overconsumption often re-

⁷⁷ See Havighurst & Richman, *supra* note 65, at 31 (describing “the tendency of insurance to induce consumption that would not otherwise occur”).

⁷⁸ 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 25-27; see also Mark Pauly, *The Tax Subsidy to Employment-Based Health Insurance and the Distribution of Well-Being*, LAW & CONTEMP. PROBS., Autumn 2006, at 83, 100.

⁷⁹ See Pauly, *supra* note 78, at 100 (arguing that “the health-insurance tax subsidy harms low-income people in a dynamic context by fueling the already-present eagerness on the part of higher-income people to have access to the latest, expensive technology”).

⁸⁰ See AARON, *supra* note 12, at 48-49.

inforce supracompetitive pricing, since nonprofits have successfully justified their supracompetitive prices by claiming a need to finance additional activities, such as charity care and research. The *Butterworth* court, 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.”⁸¹ One year later, a New York court—relying heavily on the *Carilion-Freeman-Butterworth* trilogy—approved a merger between nonprofit hospitals in part because the merged entity promised to expend an additional \$50 million “to provide high quality health care to economically disadvantaged and elderly members of the community.”⁸² However admirable such activities might be, they do not warrant amnesty from the antitrust laws. Unfortunately, such assurances have become a common tactic to solicit community support and judicial sympathy, even though they reduce the efficiency of health care investments and further damage the market for health care services. By lending credence to, and perhaps even encouraging, pledges by merging entities to invest in new health care delivery, these courts and others have enabled a substantial departure from antitrust principles.⁸³

If allocative efficiency is of any antitrust concern, courts scrutinizing proposed mergers of nonprofits should consider such investments in additional output as a reason to oppose, not support, the mergers. Increases in output of this sort survive only because of insurance subsidies and other rents, not because they enhance the efficiency of the market and direct resources to best meet society’s needs.

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

In addition to inflating prices and facilitating overconsumption, nonprofit hospitals’ accrual of market power imposes additional inefficiencies that are closely connected to their nonprofit status. These harms are motivated by the nondistribution constraint, the founda-

⁸¹ *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1300, 1306 (W.D. Mich. 1996), *aff’d*, No. 96-2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997).

⁸² *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997).

⁸³ An admirable exception, in which a court did recognize that promising additional output and investments do not excuse an antitrust violation, is *United States v. Rockford Memorial Corp.* See 717 F. Supp. 1251, 1289 (N.D. Ill. 1983) (holding that the stated intention of the merging hospitals “to create a state-of-the-art tertiary referral center” is irrelevant to the antitrust inquiry), *aff’d*, 898 F.2d 1278 (7th Cir. 1990).

tional rule in the U.S. tax code that prohibits the nonprofit organization from distributing net earnings to any individual or shareholder.⁸⁴ The tax code does not, however, prohibit nonprofits from exacting positive margins on certain services, and (as discussed above) nonprofits display a strong inclination to charge whatever prices the market will bear.⁸⁵ To accommodate the nondistribution constraint, nonprofits have been shown to adjust discretionary spending in other health care activities (rather than reducing prices) such that their net earnings approximate zero.⁸⁶

Thus, any surplus gained by nonprofit hospitals must remain within the health care system, causing those institutions to plow their excess earnings back into the health care enterprise.⁸⁷ These rents proceed to fund the many activities that the hospital's leaders deem worthy, such as uncompensated and undercharged care for indigent and low-income patients (including adjustments for underpayments by Medicare and Medicaid) as well as 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.⁸⁸ In short, nonprofit hospitals create their own intricate

⁸⁴ I.R.C. § 501(c)(3) (2000) (limiting nonprofit status to entities "no part of the net earnings of which inure[] to the benefit of any private shareholder or individual").

⁸⁵ See *supra* notes 48 & 54-55 and accompanying text.

⁸⁶ See, e.g., Andrew J. Leone & R. Lawrence Van Horn, *How Do Nonprofit Hospitals Manage Earnings?*, 24 J. HEALTH ECON. 815, 835 (2005). The nondistribution constraint and resulting cross-subsidies also suggest that even if one accepts the FTC's conclusion that "nonprofits exploit market power when given the opportunity to do so," A DOSE OF COMPETITION, *supra* note 12, ch. 4, at 33, a nonprofit's supracompetitive prices for some services will by necessity translate into reductions in prices for others. In other words, nonprofit hospitals and for-profits do, in fact, price slightly differently from each other, even if those pricing differences do not mitigate the harms imposed by nonprofit power.

⁸⁷ There is also substantial evidence for the converse, that as competition increases and nonprofit hospitals are forced to charge competitive prices, nonprofits reduce their expenditures on uncompensated care. See Jonathan Gruber, *The Effect of Competitive Pressure on Charity: Hospital Responses to Price Shopping in California*, 38 J. HEALTH ECON. 183, 208 (1994). However, at least one study has concluded that charity care does not increase even as competition is reduced, thus offering "no support to the claim made by some that hospital mergers lead to benefits for uninsured patients through cross-subsidization from insured patients." Christopher Garmon, *Hospital Competition and Charity Care* 6 (FTC Bureau of Econ., Working Paper No. 285, 2006), available at <http://www.ftc.gov/be/workpapers/wp285.pdf>.

⁸⁸ Havighurst & Richman, *supra* note 65, at 22-23.

world of cross-subsidies, in which the excess earnings from some services finance activities that the market would not otherwise support.⁸⁹

Though a nonprofit's inflation of some prices while reducing others can itself be objectionable under antitrust principles if it facilitates inefficient consumption,⁹⁰ pervasive cross-subsidies invite an additional antitrust concern. Unlike for-profit monopolies, which can channel their rents into efficient, market-driven uses, nonprofits are restrained to expend their monopoly rents within the health care system regardless of how efficient or inefficient such investments might be. This system of cross-subsidies has always been a cornerstone of the operation of nonprofit hospitals. Several studies indicate that nonprofit hospitals are more likely than for-profits to pursue new expensive technologies with uncertain returns.⁹¹ Moreover, a former prominent health care policymaker, conceding that "[h]ospitals in the United States have engaged in internal cross-subsidization throughout their history," warned that subjecting hospitals to increased competition would endanger their ability to provide the community services that governments have traditionally avoided paying for themselves.⁹² A sympathetic observer might characterize these cross-subsidies as the channeling of excess revenues into admirable, socially beneficial health care activities. A proper antitrust perspective, however, recognizes that these fund transfers support activities that are not demanded by the market, are unsustainable absent gen-

⁸⁹ It is entirely possible that the surplus from supracompetitive prices is whittled away by inflated salaries, administrative inefficiencies, or undesired quality improvements. See *id.* ("[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.* at 18-19. Also, there is some (contested) evidence suggesting that nonprofit hospitals have lower costs and larger efficiencies than for-profits. See Pauline Vaillancourt Rosenau, *Performance Evaluations of For-Profit and Nonprofit U.S. Hospitals Since 1980*, 13 NONPROFIT MGMT. & LEADERSHIP 401, 407 (2003).

⁹⁰ See *supra* Part II.B.

⁹¹ See Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139, 175 (2007) (finding that nonprofit hospitals provide services that are unlikely to be offered by for-profits); Mark Schlesinger & Bradford H. Gray, *Why Nonprofits Matter in American Medicine: A Policy Brief* 10-11 (The Aspen Inst., Nonprofit Sector Research Fund Working Paper Series, 2005), available at http://www.nonprofitresearch.org/nsr_doc/Healthcare.pdf (praising nonprofit hospitals for serving "as the incubator for entirely new services . . . for which payment systems have not been regularized" and for being "slower [than for-profits] to react to changing conditions").

⁹² Bruce C. Vladeck, *Paying for Hospitals' Community Service*, 25 HEALTH AFF. 34, 34 (2006).

erous subsidies, and are therefore not efficient market-driven uses for valuable resources. If any of these activities are deemed socially desirable public goods and worthy of public support—and many undoubtedly are—then they should be supported by public institutions following a transparent and accountable public debate, not through carved-out exceptions to the antitrust laws that entrust paternalistic power to a few private actors.⁹³

Cross-subsidies have not escaped the notice of courts, which have correctly understood that nonprofit hospitals gather surplus through supracompetitive pricing and spend it on excess health care. However, these practices have served as reasons to approve a merger, not reasons to reject one. In some recent merger cases, courts have even made explicit allowances for, and imposed implicit requirements on, nonprofit hospitals to engage in cross-subsidies. For example, in permitting two nonprofit hospitals to merge in 1997, the Eastern District of New York explained that

both 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.⁹⁴

Thus, the hospitals' cross-subsidies helped defend a merger, rather than serving as a troubling indication that the hospitals enjoyed market power. But this allowance is a departure from the central economic goals of antitrust law. 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,⁹⁵

⁹³ Another reason for objecting to financing hospital activities through cross-subsidies is their regressive impact on working-class individuals. Privately financed health care is predominantly supported through health insurance premiums, which fall equally upon all insured individuals, regardless of income, akin to a head tax. Public financing for socially desirable health care spending would be supported through a far more progressive system of taxation. See Havighurst & Richman, *supra* note 65, at 28-29.

⁹⁴ *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 146 (E.D.N.Y. 1997).

⁹⁵ *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

and arguments by nonprofit hospitals to justify their monopoly rents should be met with similar skepticism. If courts were to evaluate proposed mergers with a focus on allocative efficiency, antitrust law could play a constructive role in ending the misallocation of significant social resources and encouraging a transparent debate over how to finance public needs.

Of course, disassembling the health care industry's system of cross-subsidies would be a daunting task. The system is deeply rooted in 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. Even the earliest IRS revenue rulings determining whether hospitals were exempt from paying taxes hinged upon the maintenance of a healthy system of cross-subsidies. For example, in commenting on the seminal Revenue Ruling 56-185,⁹⁶ which provided a list of "requirements" for the exemption of a nonprofit hospital, one noted expert on tax-exempt organizations observed:

to balance properly the asserted public interest benefits against the resulting harms to competition so long as they receive direct financial advantages.”)

⁹⁶ Rev. Rul. 56-185, 1956-1 C.B. 202 (interpreting § 501(c)(3) of the Internal Revenue Code and listing requirements for hospitals to qualify for tax-exempt status). Battles over the interpretation of § 501(c)(3) and the granting of tax-exempt status to hospitals have been the source of heated and sustained litigation. Part of the problem is that the section and its associated revenue rulings impose vague and unspecific standards, but the granting of tax-exempt status also involves big dollars and emotional politics. For example, when the 1956 ruling required nonprofits to provide uncompensated care “to the extent of its financial ability,” the industry protested and earned in 1969 the less demanding requirement to provide a “benefit to the community.” Rev. Rul. 69-545, 1969-2 C.B. 117; see also David M. Studdert et al., *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 NEW ENG. J. MED. 625, 626 (2007). Relatedly, “[m]ore than 100 lawsuits have been filed accusing [nonprofit hospitals] of shirking their charitable commitments by charging uninsured patients high fees and then pursuing these ‘debts.’” *Id.* at 625. The topic’s political salience has made it a favorite subject for politicians, and both Congress and the executive branch are considering alternatives to the community benefit standard in order to extract more uncompensated care from nonprofits. See, e.g., *Sen. Grassley Questions Tax Status of Nonprofit Hospitals, May Seek Legislation*, 15 Health L. Rep. (BNA) 1048, 1048 (Sept. 14, 2006) (recounting a senator’s “stinging rebuke to the nation’s nonprofit hospitals” for “in some cases do[ing] less than for-profit institutions in providing charity care”); *IRS Interim Report Should Address Community Benefit, Treasury IG Says*, 16 Health L. Rep. (BNA) 491, 492 (Apr. 19, 2007) (quoting one observer as saying that “exempt hospitals remain the focus of congressional, IRS, and other federal governmental concern and scrutiny”).

[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.⁹⁷

Cross-subsidies continue to remain at the heart of nonprofit status in the health care sector—but again as something the law requires, not as something deemed undesirable. For example, when a group of health maintenance organizations sought nonprofit status, they encountered hostility when they suggested that they deserved the tax exemption because they could provide care at more competitive costs.⁹⁸ Instead, the IRS and a recent Tenth Circuit ruling demanded “some additional ‘plus.’”⁹⁹ One commentator explained 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.”¹⁰⁰

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, has largely been lost on the courts. Whether applying antitrust law or tax law, courts have largely deemed market power of this sort to be admirable, and a reason to protect nonprofit hospitals from standard antitrust scrutiny. A proper application of antitrust law would instead understand that extensive cross-subsidies are reasons to subject nonprofits to *additional* scrutiny.

CONCLUSION

This Article issues a plea to courts to apply the most basic antitrust principles when reviewing challenges to proposed mergers of nonprofit hospitals. Unpacking the complex web of health care financing reveals many inefficiencies that are exacerbated by nonprofit market

⁹⁷ Schmalbeck, *supra* note 22, at 124 (citation omitted).

⁹⁸ *IHC Health Plans, Inc. v. Comm’r.*, 325 F.3d 1188, 1200 (10th Cir. 2003).

⁹⁹ *Id.* at 1197 (citing Rev. Rul. 69-545). The court also required that a nonprofit “make its services available to all in the community.” *Id.* at 1198.

¹⁰⁰ Schmalbeck, *supra* note 22, at 128 (citing *IHC Health Plans*, 325 F.3d at 1197).

power, and a renewed emphasis on foundational antitrust principles—competitive prices, optimal output, and allocative efficiency—would both challenge many predispositions toward nonprofit health care providers and lead to a far less permissive merger policy.

Conveniently, this Article's lessons translate into easily applied legal rules. It argues that merger law has been both muddled and weakened when courts give inappropriate weight to factors such as a hospital's nonprofit status, pledges to expand output, and promises for generous below-cost services financed by cross-subsidies. A proper application of antitrust law would prevent courts from considering these factors and require them to proceed instead with a standard antitrust analysis. This return to antitrust basics, in addition to simplifying the court's duties, complements the many other compelling reasons for judges and juries to pay greater heed to the FTC's merger challenges.

It is possible that the FTC's persistence might soon pay off and its record on hospital mergers could turn around. Another chapter is now being written by *In re Evanston Northwestern Healthcare Corp.*, in which the FTC is challenging a merger of an academic hospital and a community hospital that since 2000 have been operated by a nonprofit corporation, Evanston Northwestern Healthcare (ENH).¹⁰¹ On August 7, 2007, the FTC Commissioners unanimously ruled that the merged entity created a highly concentrated market, increased hospital prices, harmed consumers, and thereby violated section 7 of the Clayton Act.¹⁰² Of great significance was the ruling's rejection of the defendant's proffered justifications for leniency from antitrust scrutiny. In a repudiation of the *Carilion-Freeman-Butterworth* trilogy, the Commission tersely concluded that "ENH's non-profit status did not affect its efforts to raise prices after the merger, and . . . does not suffice to rebut complaint counsel's evidence of anticompetitive effects."¹⁰³ Perhaps more significantly, the Commission dismissed ENH's assertion that its merger was procompetitive because it spent

¹⁰¹ See *In re Evanston Nw. Healthcare Corp.*, No. 9315, at 5-7 (FTC Oct. 20, 2005) (initial decision of the Administrative Law Judge), available at <http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf>.

¹⁰² *In re Evanston Nw. Healthcare Corp.*, No. 9315, at 78 (FTC Aug. 6, 2007) (opinion of the Commission), available at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>. Section 7 of the Clayton Act prohibits the acquisition of assets "in any line of commerce or in any activity affecting commerce in any section of the country, [where] the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18 (2000).

¹⁰³ *In re Evanston Nw. Healthcare Corp.* (opinion of the Commission) at 85.

over \$120 million post-merger to make improvements and expand health care services, noting instead that quality improvements must result from cost-saving efficiencies to squarely warrant a justification.¹⁰⁴ It was an admirable recognition that enhanced output and the temptation of cross subsidies do not outweigh the harm from (and are in fact products of) provider market power.

The FTC's decision to challenge the ENH merger retroactively has been described as "a renewed commitment to hospital merger enforcement."¹⁰⁵ Moreover,

given how much the FTC has invested in this case in terms of time, resources and reputation, [and] 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 this case will continue to be hard-fought and is likely to become a bellwether of future government antitrust enforcement in hospital mergers.¹⁰⁶

But the FTC does not enjoy the final say, and if ENH decides to appeal the Commission's ruling, the case will fall into the hands of the judiciary. How the courts will handle the case, and how they will address the defendant's justifications, might significantly shape merger law. Hopefully, the courts will seize upon the opportunity to bring an end to the mistaken *Carilion-Freeman-Butterworth* trilogy, recognize the dangers of nonprofit market power, and restore foundational antitrust analysis in the market for hospital services.

¹⁰⁴ *Id.* at 81-82.

¹⁰⁵ Barak D. Richman, *The Corrosive Combination of Nonprofit Monopolies and U.S.-Style Health Insurance: Implications for Antitrust and Merger Policy*, LAW & CONTEMP. PROBS., Autumn 2006, at 139, 146 (quoting 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).

¹⁰⁶ *Id.* at 146-47 (quoting Bissegger, *supra* note 105).