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Antitrust & Hospital Mergers: Does the Nonprofit Form Affect Competitive Substance?

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Abstract Following a string of government losses in cases challenging hospital mergers in federal court, the Federal Trade Commission and the Department of Justice issued their report on competition in health care seeking to set the record straight on a number of issues that underlie the judiciary's resolution of these cases. One such issue is the import of nonprofit status for applying antitrust law. This essay describes antitrust's role in addressing the consolidation in the hospital sector and the subtle influence that the social function of the nonprofit hospital has had in merger litigation. Noting that the political and social context in which these institutions operate is never far from the surface, it takes issue with the proposal to cabin merger doctrine so as to deny the significance of nonprofit status in merger analysis. Given the dynamic change in the regulatory climate and heterogeneity of local health care markets, it advises courts not to accept the FTC's preemptive standard regarding the significance of hospitals' nonprofit status and keep open the possibility of fashioning new presumptive rules tailored to more complete economic accounts of nonprofit firm behavior.

Part social institution, part profit-driven enterprise, the private nonprofit hospital has long served a central and multifaceted role in the delivery of health care services. Nonprofits have facilitated capital accumulation enabling local access to technologically advanced medicine while simultaneously serving as a principal provider of primary and secondary health services to the indigent. While benefits accruing from tax-exempt status, government funding, and community support helped finance these functions, nonprofits have also relied on cross subsidies from paying patients

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and funds channeled from various government sources to help redistribute health resources.

The emergence of price competition and managed care contracting made this hybrid function more difficult to sustain. During the 1990s, nonprofit hospitals undertook a variety of strategies including joint ventures with physicians and for-profit organizations, formation of multihospital systems, and horizontal consolidations with rivals. Merger activity peaked in 1996–1997 when 349 hospital mergers occurred; contrary to some perceptions, nonprofit hospitals acquired 77 percent of the bed capacity that was transferred by merger at that time (Melnick , Keeler, and Zwanziger. 1999).

For policy makers, this vast structural transformation initially seemed to be a sensible rationalization of hospital delivery despite the questions it raised about whether the nonprofit hospital could survive without becoming indistinguishable from its for-profit counterparts and whether its social service functions would be lost. With the budgetary crisis facing state and federal government in recent years, the focus has shifted back to the nonprofit sector, with legislators, regulators, and class-action lawyers questioning whether the nonprofit sector is doing its part in providing charity care.

This essay describes the role of antitrust law in addressing the consolidation in the hospital sector and the subtle influence that the social function of the nonprofit hospital has had in merger litigation. It suggests that the political and social context in which these institutions operate is never far from the surface in antitrust cases, even though antitrust legal doctrine seeks to strictly compartmentalize its inquiry. Against this background, this essay takes issue with the proposal by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) to cabin merger doctrine so as to deny the significance of nonprofit status in merger analysis.

The Government's Setbacks in Court

After prevailing in almost all of their challenges to hospital mergers in federal court in the 1980s and early 1990s, state and federal antitrust enforcers lost seven consecutive litigated cases during the period from 1994 to 2001. The legal precedents established by these decisions and the tenor of the courts' opinions cast a pall over enforcement efforts, as federal authorities did not initiate a single challenge to a hospital merger from 1997 until 2004, when the FTC initiated its *Evanston Northwestern* case—a proceeding seeking to unwind a merger that it had allowed to go

forward four years previously (Greaney 2004; *In the Matter of Evanston Northwestern Healthcare Corporation*, FTC No. 9315 [Initial Decision, Oct. 20, 2005]). By some accounts, the failure of the government's antitrust enforcement agenda in federal court and its lackluster efforts to challenge hospital affiliations more vigorously have had deleterious consequences for consumers. Empirical studies suggest that increasing concentration among acute-care hospitals has contributed to health insurance premium increases without offsetting benefits in quality, efficiency, or charity care (Cuellar and Gertler 2005; Strunk, Ginsburg, and Gabel 2001).

It is no coincidence that this judicial roadblock to antitrust hospital merger cases was erected at the same time that legal norms were tilting against managed care and policy makers were expressing concerns that nonprofit hospitals were being squeezed by competitive pressures to neglect their mission to provide charity care. As discussed later, the backlash against managed care was marked by passage of over a thousand state laws regulating contracting practices and a 180-degree turnabout by the Supreme Court that permitted such regulations to survive preemption challenges under the Employee Retirement Income Security Act (ERISA). Likewise, tax and state fiduciary law enforcers permitted nonprofit hospitals to undertake joint ventures with physician groups and for-profit entities and reluctantly acceded to conversions under terms that preserved assets to serve eleemosynary purposes in the hopes of retaining some charitable presence in the increasingly competitive hospital marketplace. Against this background, judicial tolerance of hospital mergers that strengthened the hand of local and religious groups to direct the path of health services in their communities was not a cause for alarm in most circles.

For the FTC and advocates of competition policy for health care, however, it was. The FTC/DOJ (2004) report, *Improving Health Care: A Dose of Competition*, seeks to set the record straight on a number of issues that, in the government's view, underlie the courts' mishandling of hospital merger cases. The 360-page report, which touches on virtually every aspect of antitrust law affecting health care financing and delivery, offers an array of economic analysis and advice on the topic of mergers. It also speaks on broad policy issues, warning legislatures against adopting or maintaining certain competition-suppressing statutes and urging that government grant direct subsidies to the needy rather than rely on cross subsidies by providers to fund indigent health care. The FTC also undertook a retrospective examination of a number of mergers that had been permitted to go forward during its quiescent period. One of these reviews resulted in an administrative challenge to a consummated merger, which

the FTC chair stated was intended to revitalize the commission's merger enforcement program (*In re* Evanston Northwestern Healthcare Corp., FTC No. 9315 [initial decision, Oct. 20, 2005]).

Antitrust and Mergers of Nonprofit Hospitals

The significant hospital consolidation movement that began in the 1980s saw large proprietary chains acquiring government and private nonprofit hospitals in many markets while many nonprofit hospitals also pursued aggressive acquisition strategies. During this period of consolidation, the nation's antitrust enforcement agencies (the Department of Justice, the Federal Trade Commission, and, to a lesser extent, state attorneys general) recognized that mergers of rival hospitals held the prospect of having both pro-competitive and anticompetitive impacts. On the one hand, an increasingly competitive marketplace spurred by managed care was insisting that hospitals not only deliver services at lower cost but also in groups or bundles that enabled intermediaries to offer "preferred provider" hospitals that could adequately serve the needs of an entire geographic area. Mergers of once-rival hospitals seemed a logical path toward rationalizing an industry regarded as wasteful—engaged in what was termed the "medical arms race" (Conner, Feldman, and Dowd 1998)—and more solicitous of doctors' interests than community service or cost-effective patient care (Pauly and Redisch 1973). At the same time, the agencies confronted mergers that threatened to undermine the entire premise of a competition-based policy in health care, as the number of choices in some communities were reduced to three, two, and sometimes one hospital system. Under these conditions—facing dominant or oligopolistic sellers of hospital services—managed care could hardly be expected to fulfill its promise that competitive contracting would rationalize care delivery and lower costs.

Federal antitrust authorities under the Carter, Reagan, and Bush administrations and several state attorneys general responded with lawsuits challenging a number of hospital acquisitions—the government brought eighteen cases in federal court or in administrative proceedings before the FTC between 1980 and 2001 (Greaney 2004). After a half dozen important litigation victories in the 1980s, including two that produced influential opinions authored by Judge Richard Posner, things went sour for the government in hospital merger litigation. After losing seven consecutive decisions in the federal courts, the government confronted accreting

judicial precedent on a number of issues that were necessary to meet the statutory requirement of proving that a merger "may substantially lessen competition."

First, many cases in which the government was unsuccessful turned on the definition of the market in which the hospitals competed. In almost all of these cases, the court found a geographic market far broader than the local boundaries alleged in their complaints (e.g., *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 [8th Cir. 1998]). A revealing evidentiary finding underlay these conclusions. Courts were unwilling to credit the views of managed care payers and employers about the extent of potential travel for hospital care. Second, several cases relied at least in part on a conclusion that the nonprofit status of the merged hospital (sometimes in conjunction with the composition of its board) tends to rebut the presumption that the hospital will exercise market power achieved or enhanced by the merger (*FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 [W.D. Mich. 1996]; *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 [E.D. N.Y. 1997]). Third, some decisions noted, usually as an additive rather than dispositive factor, that the merger enabled the hospital to realize significant efficiencies not otherwise achievable. For these cost savings to have legal significance, the court also had to conclude that these savings outweighed potential anticompetitive effects and, importantly, that the savings would be passed on to consumers. The latter conclusion sometimes found support in the nonprofit status of the hospital, as courts expressed the belief that local control offered some assurance that savings would be used to benefit the community (*United States v. Long Island Jewish Med. Ctr.*).

Looking behind the highly fact-intensive inquiry that goes into antitrust merger analysis, one finds an interesting subtext in the courts' treatment of these issues. While these decisions have been subject to intense criticism for ignoring market imperfections that shape consumer choices of hospitals (Capps et al. 2001; Greaney 2004), they also betray some a priori judgments regarding managed care and the role of nonprofit organizations. For example, there is a degree of judicial skepticism that nonprofit entities, led by pillars of the community, would exploit their neighbors by exercising market power. Some courts explicitly relied on economic analyses suggesting that nonprofit hospitals did not take advantage of market power to raise prices; others invoked nonprofit status to buttress conclusions that hospitals would pass along savings realized by the merger or abide by commitments not to raise prices. The second background issue found in these decisions concerns the role of managed care in shaping the delivery

of health care services. In the late 1990s, some judges began to share the popular sentiment—styled by commentators as the "managed care backlash"—that the competition model that depended on health maintenance organizations (HMOs) and other entities selectively contracting with providers and rationing care by utilization protocols did not serve consumers well. For example, one merger decision quoted Judge Posner's epigram about HMOs ("The HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible" [*FTC v. Tenet Healthcare Corp.*), while another observed, "In 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.*).

It should not be surprising that shifting sentiments regarding managed care may have played a role in shaping judicial attitudes toward hospital mergers. The Supreme Court itself followed a similar path in its treatment of preemption of state laws regulating managed care under ERISA. As commentators have observed, these shifts in law betray an acute awareness of larger issues of health policy and the impact of legal doctrine on them. For example, in its first series of cases—during the period when managed care was in its heyday—the Court's interpretations of ERISA supported robust preemptive power. It then shifted rather abruptly in 1995—the beginning of the managed care backlash—to give what Gregg Bloche and David Studdert (2004) termed an "all clear signal" to states imposing regulations on managed care. A shift back in the other direction in its most recent ERISA preemption case last year has been interpreted as signaling the Court's unease with its role at the vanguard of health policy (Kesselheim and Brennan 2005).

Treatment of Nonprofit Status in Merger Litigation

Antitrust doctrine has long focused almost exclusively on competitive conditions. Courts are not permitted to weigh or trade off societal benefits accruing from restraints of trade or anticompetitive mergers against their anticompetitive harms. Hence professional restraints of trade, including price fixing, cannot be saved by justifications premised on promoting ethical behavior or even vouchsafing public safety (*National Society of Professional Engineers v. United States*, 435 U.S. 679 [1978]). Likewise, antitrust merger law will not permit consideration of improvements in environmental

conditions or other social objectives; and, while enhancing efficiency may save an otherwise anticompetitive merger, efficiency benefits are narrowly construed (*United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 [1963]). It comes as no surprise then that courts have uniformly rejected the notion that nonprofit status should constitute an *exemption* or otherwise immunize hospitals from antitrust scrutiny. The leading treatise on antitrust law advances prudential and economic grounds for this doctrine: "The absence of profit is no guarantee of eleemosynary intent or practice. . . . [While] nonprofit institutions do not necessarily 'maximize profits' in the sense of equating marginal cost and marginal revenue, [they] may seek monopoly profits and cause competitive injury even when acting for purely eleemosynary purposes" (Areeda and Hovenkamp 2000: 1A:255).

Moving beyond the issue of exemption, a number of cases have examined whether nonprofit hospitals were less likely to exercise market power and to what extent nonprofit status should therefore militate in favor of approving an otherwise anticompetitive merger. A majority of courts have rejected such arguments. Though the holdings of these cases were based on the facts before them, these opinions often expressed skepticism about the underlying logic of such a defense: "Adoption of the nonprofit form does not change human nature"; "No one has shown that it makes the enterprise unwilling to cooperate to reduce competition" (*United States v. Rockford Mem'l Corp.*, 898 F.2d 1278 [7th Cir. 1990]). Observing that even though nonprofit corporations may lack incentives to *maximize* profits because they do not have shareholders and are obliged to pursue charitable ends, these opinions stress that nonprofits still need to generate operating surpluses and thus have an incentive to engage in anticompetitive behavior. In this connection, it is sometimes noted that the antitrust enforcement agencies have on several occasions brought cases against nonprofit hospitals that entered into collusive anticompetitive arrangements with their competitors.

At the same time, other courts have signaled receptiveness to arguments that nonprofit hospitals' propensity to behave differently than for-profits should at least be a factor in gauging the potential competitive impact of a merger (*United States v. Carillion Health Sys.*, 707 F. Supp. 840 [W.D. Va. 1989]; *United States v. Long Island Jewish Med. Ctr.* (Indeed, even the opinions cited earlier rejecting such claims have not explicitly ruled out the possibility that such evidence may yet prove decisive in particular cases.) For most courts, then, the question is largely an empirical one, albeit not yet resolved by reliable economic studies. For example, while rejecting a nonprofit defense on the record before him,

Judge Richard Posner famously lamented the state of learning on this subject: "It is regrettable that antitrust cases are decided on the basis of theoretical guesses as to what particular market-structure characteristics portend for competition. We would like to see more effort put into studying the actual effect of concentration on price in the hospital industry. . . . This is a studiable hypothesis, by modern methods of multivariate statistical analysis" (*United States v. Rockford Memorial Corp.*, 898 F.2d 1278 [7th Cir. 1990]).

One notable—and much criticized—district court decision, *FTC v. Butterworth Health Corp.*, took Judge Posner's "lament" to heart and undertook to apply theoretical and empirical economic evidence to evaluate the competitive risks posed by a merger that placed the nonprofit hospital in a near-monopoly position in its market. The court relied in part on two studies prepared by William Lynk—one examining the postmerger pricing behavior of California hospitals that acquired significant market shares by their mergers (Lynk 1995) and a "replication" of that study using data on Michigan hospitals prepared by Lynk for use in defending the Butterworth-Blodgett merger. It applied the findings of these studies—that "on balance increased nonprofit market share is associated with lower, not higher, prices"—to support the defendant's claim that the surviving nonprofit entity would be unlikely to raise prices collusively or unilaterally (*Butterworth*, 946 F. Supp. at 1297). Also supporting this prediction was theoretical economic evidence offered by Lynk that the governance structure of the merged hospital would operate as a safeguard against the exercise of market power. (The court observed that the hospital board was "comprised of community business leaders who have a direct stake in maintaining high quality, low cost hospital services" [Lynk 1994].) Further support was provided by the court's evaluation of the subjective intentions of the community representative (i.e., the merger was motivated "by a common desire to lower health care costs and improve the quality of care") and a written "Community Commitment" made by the merging hospitals pledging to freeze prices and margins while maintaining certain levels of charity care.

Finally, the court interpreted the peculiarities of health care financing to militate in favor of deference to health care providers. It disparaged managed care as a vehicle for "cost shifting" from one set of consumers to another and thus of dubious benefit, concluding, "Viewing the managed care discounts in light of their impact on the welfare of consumers as a whole exposes them as illusory. Such selective price advantages are hardly

the sort of benefit the antitrust laws are designed to protect" (*Butterworth*, 946 F. Supp. at 1299).

To say the least, commentators have not been kind to the *Butterworth* opinion, finding its evaluations of the empirical record before it suspect, questioning its normative biases, rejecting its assumptions about nonprofit corporate governance, and doubting the wisdom and efficacy of its remedies (Blumstein 1998; Greaney 1997; Jacobs 1998; but see Kopit 1999). The decision is problematic as a legal precedent as well because the court did not explain what weight it afforded to each consideration or state whether one would be sufficient to remove the transaction from condemnation under merger law. Further, as discussed in the next few pages, economic studies point in the opposite direction of the conclusion reached by the court.

Neither the *Butterworth* decision nor its critics have put to rest the question of the role to be afforded nonprofit status in antitrust challenges to hospital mergers. The controversy underscores that judicial resolution of this issue entails a host of considerations: evaluating economic literature and testimony, appraising subjective intentions or propensities of the parties in litigation, and construing the intricate competitive context of health care financing. Moreover, it has served to isolate several distinct issues that antitrust jurisprudence much needs to resolve:

- Shouldorganizational form ever be a factor in assessing the risks of anticompetitive harm from a merger involving nonprofit hospitals?
- Ifso, what kind of proof would suffice to support the prediction in particular cases that a merger is unlikely to cause such harm?
- Shouldcourts impose remedies designed to make more certain that such advantages accrue, and should those remedies also be designed to assure that "non-antitrust" goals (such as charitable mission) are advanced?

The Government's Response

The FTC/DOJ report frames the nonprofit question narrowly and answers it peremptorily. The issue, it states, is "not whether nonprofit hospitals behave in a manner indistinguishable from for-profit institutions, but rather whether they would exploit merger-created market power in ways harmful to consumers." It goes on to report some of the economic literature, recounts hearing testimony summarizing the literature, and concludes that "the best available evidence indicates that nonprofits exploit market power

when given the opportunity" (FTC/DOJ 2004: chap. 4, 33). Its policy prescription is that "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" (ibid.).

The report also takes a dim view of "community commitments." Pursuant to these arrangements, a number of state attorneys general have agreed to settle hospital merger cases by approving the transaction in return for commitment not to use their newly acquired market power to raise prices and to serve the community's medically needy (ibid.: 26 n. 151 [citing cases brought by state attorneys general]). The district court in *Butterworth* also rested its conclusion that the merger would not significantly lessen competition on the parties' pledge to freeze list prices, limit profit margins, serve the medically needy, and ensure community control of the merged hospital's board of directors (*FTC v. Butterworth*, 946 F. Supp. 1304). Branding these settlements as "regulatory," the report rejected employing community commitments to resolve the risks arising from problematic hospital mergers because it viewed them as "an ineffective short term regulatory approach to what is ultimately a problem of competition" (FTC/DOJ 2004: chap. 4, 26).

The conclusion that nonprofits are prone to take advantage of market power is certainly not unwarranted. An impressive amount of economic scholarship strongly suggests that, in the aggregate, voluntary and proprietary hospitals respond when market conditions permit them to raise prices (ibid.: 31–33 [summarizing studies and testimony received at hearings]). Indeed, studies employing essentially the same data used by the study relied upon in *Butterworth* concluded that nonprofit hospital mergers lead to higher prices (Dranove and Ludwick 1999; Keeler, Melnick, and Zwanziger 1999), and various other economic studies using different methods and data, including merger simulations and comparisons of preconversion and postconversion conduct, reached results supporting the proposition that there is either no or little difference between the pricing practices of nonprofit and for-profit hospitals (Capps, Dranove, and Satterthwaite 2003; Conner, Feldman, and Dowd 1998).

It is far from certain, though, that the evidence marshaled by the report warrants the preclusive doctrinal approach it suggests that courts and enforcers take with regard to nonprofit status in hospital merger cases. Looking further into the economic literature, one finds several other themes that strike a more ambiguous chord. Moreover, the changing landscape of legal oversight and director norms commends a more open approach in future cases.

The Economic Learning on Nonprofit Organization and Behavior

Theory posits that nonprofits follow objective functions that differ from those of for-profit firms. Although it is generally conceded that nonprofit corporations seek profits or break-even status, they also pursue other goals that distinguish their performance from that of their for-profit rivals. There is considerable disagreement over what that something else is (e.g., quality, charity or other community benefits, donor preferences, prestige, or the desires of their medical staff) (Needleman 2001). However, legal commands found in tax and corporate fiduciary law and social norms influencing managers and directors support the presumption that nonprofits will tend to be less intensely profit seeking than for-profits (Horwitz 2005). It is important to note here that these legal commands have been weakly enforced: tax law requires only that nonprofit hospitals provide loosely defined "community benefits" (Colombo, in this issue), and fiduciary laws are rarely applied to discipline managers who are lax or opportunistic or who neglect their mission (Greaney and Boozang 2005).

It is of course appropriate to push theory aside where compelling empirical evidence points in the opposite direction. Before empirical evidence can justify the preemptive doctrinal approach that the report commends, however, it must shoulder the burden of establishing not only that, in the aggregate, nonprofits do not behave differently when they obtain market power, but also that no significant variations among these institutions exist that would recommend a more case-specific approach from the courts. For a number of reasons, it is doubtful that the current empirical record can satisfy this test.

The vast literature addressing the question of whether nonprofit hospitals differ from for-profits along policy-relevant dimensions suffers from normative disagreement over what qualifies as a societal benefit and empirical disputes over measurement (Bloche 2003; Claxton et al. 1997). Jack Needleman's (2001) commendable survey of the literature posits differences in quality of care, trustworthy behavior, community benefits (including lower prices or greater provision of charity care or unprofitable services), and commitment to place as appropriate benchmarks. His conclusion is that, though the evidence is "mixed," the literature suggests that these benchmarks validate the case for preferring nonprofits. Although others counsel forbearance from policies broadly favoring nonprofit organizations (Bloche 2003), much of this evidence reveals important distinctions in the conduct of many nonprofit hospitals

and suggests that the underlying empirical issues for antitrust analysis have not yet been resolved.

For example, there is persuasive evidence that nonprofit hospitals exhibit a greater willingness to stay the course than for-profits by continuing to provide needed care in unprofitable services and in underserved geographic markets. Conversely, while nonprofits tend to maintain low reimbursement services, for-profits respond more readily to financial incentives, for example, by closing or restructuring in the face of financial pressure or by investing in profitable postacute services (Horwitz 2003, 2005). Perhaps the most significant finding of this research for antitrust analysis is that hospital behavior and the mix of services offered within the cluster of acute-care services is influenced by the ownership status of their neighbors. Although only limited research exists on this issue, evidence gathered by Jill Horwitz (2005) suggests that both nonprofit and for-profit hospitals are more likely to offer profitable services in markets with a high percentage of for-profit hospitals, and both are less likely to offer an unprofitable service in such markets. Other studies also point to neighborhood effects such as those demonstrating that both for-profit and nonprofit hospitals have a greater likelihood to upcode their reimbursement claims in for-profit markets (Silverman and Skinner 2001) and a greater propensity to exploit loopholes in Medicare billing rules (Cutler and Horwitz 2000).

Further, there is some evidence that market effects may vary according to the control structure of the nonprofit organization; that is, *some* nonprofit hospitals exercise market power more readily than other nonprofits. One study indicates that nonprofits that are part of more geographically diffuse systems (and hence less subject to local control) with market power raise prices significantly more than do those that are part of systems with more localized control (Young, Desai, and Hellinger 2000). Another environmental factor may be the regulatory climate in which nonprofit hospitals compete. States vary considerably in the extent to which they monitor the quantity of indigent care provided by hospitals and police the management decisions, including reallocation of charitable assets, by nonprofit hospitals (Greaney and Boozang 2005).

Ownership form also appears to affect hospital behavior in responding to changing market conditions. Recent studies suggest that for-profit hospitals have higher rates of entry and exit than do nonprofits and that these differences are greater in markets in which both forms are present (Chakravarty et al. 2005; Hansmann, Kessler, and McClellan 2004). A notable example of the capacity of for-profit entities to respond to profit

opportunities is seen in the recent growth in single-specialty hospitals. Physician-owned for-profit hospitals have been able to take advantage of profit opportunities created by administered pricing (principally in Medicare) and regulatory advantages that such facilities enjoy (General Accounting Office 2003).

Moreover, the aforementioned empirical literature showing that nonprofits raise prices in concentrated markets is subject to several caveats. For example, much of the research seems to indicate that price-elevating effects are observable only in markets in which there is selective contracting or other forms of vigorous managed care–induced competition among hospitals. Where the competition is less robust and rivalry is based on nonprice factors, the relationship between nonprofit status and the exercise of market power is not strong or is actually inverse, as the *Butterworth* court found. Given the decline in recent years of the capacity of managed care to exert competitive pressures on providers, one must be wary of interpreting data based on markets in which vigorous selective contracting disciplined hospitals in their pricing practices. Further complicating the picture is that in order for antitrust tribunals to rely on studies showing no difference between the prices charged by profit and nonprofit hospitals with market power, the tribunals must be confident that there are not significant quality differences that differentiate the two sectors; that is, if the *quality-adjusted* price of nonprofit hospitals is lower than that of for-profits, the *Butterworth* court's findings may have some merit. Unfortunately, the empirical literature on this subject is "skimpy and mixed" (Needleman 2001). While not evidencing significant quality differences between for-profit and nonprofit hospitals across the board (Keeler et al. 1992; Sloan 2000 [summarizing studies]), a few studies suggest that significant but difficult-to-observe quality differences may exist (Picone, Chou, and Sloan 2002).

One way of synthesizing this literature is to observe that because nonprofit hospitals are highly heterogeneous in both the internal incentive structures they face and the markets in which they operate, their response to competitive conditions will vary and ownership matters at least in certain circumstances. One strand of evidence points to the fact that hospitals make choices with regard to location and profitable versus nonprofitable services that vary systematically by ownership. Another suggests the chameleon-like character of nonprofit organizations: their performance is strongly influenced by the degree to which they compete with for-profit counterparts and by the regulatory and payment environment in which they operate.

Implications for Antitrust Doctrine: Leeway in Existing Law for Considering Nonprofit Status

The ambiguous state of the evidence regarding the effect of ownership status on hospital performance poses a considerable challenge for antitrust. As a doctrinal matter, it would be unwise for courts to follow the FTC's call for a strong presumptive rule that would confine the relevance of nonprofit status in merger cases. The quest for better data and more reliable information is necessary to establish presumptive rules that give clear but economically sensible guidance. While disagreeing with the findings of the district court in *Butterworth*, Michael Jacobs (1998: 139) summarized well the need for more empirical examination of the dynamic of nonprofit hospital competition: "As new facts help to displace old presumptions, the law may seem rudderless for a while, too particularistic, lacking in guidance or intelligibility. But this is a reasonable price to pay for new, sensible presumptions. As more new facts emerge, new presumptions will form around them; presumptions in general are useful, but no particular presumption has a right to eternal life."

The economic literature suggests that, while much is still to be learned, there are some reasonably clear indications that some systematic differences exist between nonprofit and for-profit hospitals and that differences in market composition, system affiliation, and competitiveness also seem to influence the behavior of firms. Though certainly it appears true that nonprofit hospitals *may* exercise market power when they acquire it, there is sufficient uncertainty about the conditions under which—and the extent to which—individual hospitals would do so as to merit consideration by courts. Just as antitrust tribunals are deemed capable of considering whether prospective new-entry, powerful buyers or a host of other conditions are prone to lessen the likelihood that the merged firm will exercise unilateral or coordinated market power, the incentives inherent in nonprofit hospitals' structure should be fair game. While cautioning against focusing on the nonprofits "stated intentions," the leading treatise on antitrust law endorses an "objective . . . look at the structure and nature of the nonprofit entity before the court" in order to make a sound prediction of its likely postmerger conduct (Areeda and Hovenkamp 2000: 1A:265).

The heterogeneity of hospitals and markets also argues for holding open the question of nonprofit status and treating the issue on a case-specific basis. Nonprofit hospitals vary widely by affiliation, governance structure, board composition, local control, and mission. Likewise, nonprofits serve

communities that differ significantly along economic lines and confront diverse legal and social environments. This characteristic, nonprofit hospital heterogeneity has demonstrable consequences in its performance and responses to regulatory and market conditions as evidenced by considerable variation among nonprofit hospitals in the quantity of charitable care they provide.

It is notable that the first decision issued in a merger case since the publication of the FTC report seems to have taken the more nuanced investigation into the issue recommended here. The opinion of the administrative law judge in the FTC's retrospective challenge to the Evanston Northwestern Healthcare Corporation merger with Highland Park Hospital carefully examined evidence regarding the merged hospital's governance structure, including the role played by community representatives on its board with regard to pricing decisions, and the bonus and other compensation arrangements for management, to determine whether their role supported or refuted the prediction that nonprofit status lessened the risks of anticompetitive harms (*In re* Evanston Northwestern Healthcare Corp.: 192–194). Of course, the Evanston Northwestern case was relatively easy to decide on this issue because the administrative law judge also found that the parties had in fact already exercised market power.

New Approaches

More controversially, antitrust doctrine might be flexible enough to permit in limited circumstances consideration of the distributive consequences of mergers involving nonprofit hospitals. Although the law has not as yet ventured down the path sketched here, the public-private economic character of the modern nonprofit hospital may justify such an approach. A critical problem with antitrust's exclusive focus on narrowly defined competitive effects is that it ignores some real-world effects of competition in markets where those effects are not directly caused by private actors, such as where regulation or government payment policies or market failures have distorting effects. As Peter Hammer and Bill Sage (2003: 88) put it, the "Achilles heel" of antitrust law is "not its indifference to . . . hospitals' charitable impulses, but rather its inability to coherently address the role of government itself as regulator and purchaser." In the hospital merger context, we have seen that courts have been loathe to commit trusted locally based social institutions to the marketplace where valued community benefits would be lost. Hence, to some extent, judicial hostility

to the government's antitrust agenda may be a problem of antitrust's own making. The report recommendation—that policy makers should eschew reliance on cross subsidies from private parties and begin a regimen of direct payments to the needy—is an intellectually sound and coherent position. Unfortunately, it rings hollow in the fiscal world in which we find ourselves today.

Although antitrust law does not permit courts to excuse an anticompetitive merger on the grounds that it will improve social or noneconomic conditions, established legal precedent does compel finders of fact to consider efficiencies that flow from a merger and offset them against anticompetitive harms. In the health care marketplace, hospitals sell their services to government purchasers, private third-party payers, and individuals. The law generally brands the provision of services to individuals who cannot pay as charity rather than a marketplace transaction. Yet the provision of charity care is orchestrated by regulation (federal and state tax law and nonprofit corporate law require community or public benefits) and financed in part by government payments, such as Medicare and Medicaid disproportionate share hospital (DSH) payments, and in part by cross subsidies from private payers. In the black-and-white world of antitrust doctrine, the provision of services in these spheres is seen as a nonmarket transaction and hence, for the most part, is beyond the law's purview. In a very real sense, though, the government is purchasing care at zero or discounted prices for those unable to pay through its mixed financing and regulatory scheme. A plausible argument therefore could be advanced that efficiencies realized in this sector of the hospital's operations—care to the needy, provision of unprofitable services, and so forth—should be regarded as falling within the sphere of the hospital's business operations. It would then seem to follow that *merger-induced* efficiencies in this area should at least count in the balancing of potential harms and benefits.

The foregoing suggestions still leave open the question of how (and by whom) such admittedly fine distinctions should be made. One approach would be to commit to the discretion of antitrust enforcers the task of incorporating these trade-offs. They could do so, as they do on many other accounts in the context of advisory opinions, case selection, and settlement. To a certain extent, some state attorneys general are already doing this, choosing to negotiate consent decrees that permit mergers to go forward subject to conditions preserving some public benefit. As one FTC commissioner recently observed (Harbour 2005), the pragmatic benefits of assuring tangible returns to the community in the face of highly uncertain outcomes in litigation should not be overlooked. Moreover, the dual responsibilities

of state attorneys general—to enforce both antitrust and charitable institution law—mitigate somewhat the aforementioned problems with an antitrust regime that is powerless to consider other policy goals.

Concluding Remarks

Overall, the FTC/DOJ report makes a notable contribution by advancing understanding of the delicate interplay of health market economics and legal doctrine. It may help correct many of the errors that it identifies in recent legal precedents and assuage the misgivings that courts and policy makers have exhibited toward applying antitrust rules in various health care contexts. However, given the dynamic change in the regulatory climate and heterogeneity of local health care markets, courts might be well advised not to accept the FTC's conclusions regarding the nonprofit status of hospitals and keep open the possibility of fashioning new presumptive rules tailored to more complete economic accounts of nonprofit firm behavior.

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