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The Use of the Nonprofit "Defense" Under Section 7 of the Clayton Act

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I. INTRODUCTION

Since the early 1980s, for-profit and nonprofit hospitals have undergone an unprecedented number of mergers,[1] reflecting the dramatic changes in the health care industry.[2] The Federal Trade Commission ("FTC") and Department of Justice ("DOJ") have challenged mergers of both types of hospitals.[3] Recently, however, a hand-

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1. *See* ABA Antitrust Section, ANNUAL REVIEW OF 1992 ANTITRUST LAW DEVELOPMENTS, 301-311 (1993). Between 1981 to 1991, there were 195 mergers. *See* Howard J. Anderson, *AHA Lists Hospital Merger Activity for 12-Year Period*, HOSPITALS, June 20, 1992, at 62. The increase in mergers has continued into the 1990s. There were 735 mergers in 1995 compared to 18 in 1993. *See* Michael S. Jacobs, *Presumptions, Damn Presumptions and Economic Theory: The Role of Empirical Evidence in Hospital Merger Analysis*, 31 IND. L. REV. 125, 127 (1998). The mergers discussed in this Note are horizontal mergers between nonprofit private hospitals.

2. During the last decade, significant changes have occurred in the hospital industry. The switch from a cost-based to a fixed price system of reimbursement has contributed to excess capacity. After World War II, the government passed the Hill-Burton Act, which subsidized hospital construction and thus encouraged rapid growth. *See* James E. Magleby, *Hospital Mergers and Antitrust Policy: Arguments Against a Modification of Current Antitrust Law*, 41 ANTITRUST BULL. 137, 138 (1996). In addition, the creation of Medicare/Medicaid gave hospitals little incentive to reduce spending. *See id.* The government's cost-based payment method further contributed to the creation of additional services and facilities. *See id.* at 138-39. Unlike the cost-based payment system, the current prospective payment system (PPS) sets the price that the government will pay for a particular diagnosis regardless of the actual cost to the hospital, making the hospital responsible for any costs that exceed the fixed amount. *See* 42 U.S.C. § 1395ww(d)(5) (1994). Private insurers have established similar payment plans. *See* Magleby, *supra*, at 139. Cost-containment measures have contributed to a decline in hospital admissions, resulting in excess capacity and declining revenue. *See Federal Antitrust Policy in the Health Care Marketplace: Hearing Before the Committee on the Judiciary of the U.S. Senate*, 105th Cong. 71, 73 (1997) (statement of Joe Sims, partner, Jones, Day, Reavis & Pogue) [hereinafter Sims Testimony]. Further, improved medical technology allows many procedures to be performed on an out-patient basis and thus contributes to a reduction in inpatient services. *See* Magelby, *supra*, at 139-40.

3. Organizational form usually does not matter under antitrust law. *See* 1A PHILLIP AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND

ful of nonprofit hospitals have offered nonprofit status as a "defense" to federal challenges to nonprofit hospital mergers.[4] Although not a complete defense—nonprofit status alone does not remove the entity from antitrust scrutiny—a limited "defense" has evolved as nonprofit hospitals claim that a nonprofit merger is less likely to have anti-competitive effects than an equivalent for-profit merger.[5]

THEIR APPLICATION ¶ 261a, at 260-61 (1997). However, state-owned hospitals are not subject to federal antitrust law because of the state-action doctrine. *See* FTC v. Hospital Bd. of Dirs., 38 F.3d 1184, 1187-88 (11th Cir. 1994).

4. *See, e.g.*, United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 145-46 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1296-97 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam); FTC v. Freeman Hosp., 911 F. Supp. 1213, 1222-23 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995); United States v. Carilion Health Sys. 707 F. Supp 840, 849 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

5. *See* Mary Lou Steptoe & Francis M. Fryscak, *Review of Traditional Defenses, Noerr-Pennington, Efficiencies, and Not-For-Profit Status*, American Health Lawyers Association Annual Antitrust in the Health Care Field Meeting, 1, 3 (Feb. 1998) [on file with the author].

Both courts and commentators have debated the significance of nonprofit status under federal antitrust law. Some commentators contend that nonprofit status may prevent anti-competitive behavior. They argue that because nonprofit hospitals are not organized to distribute profits, these entities lack incentive to maximize revenue, *see generally* William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTITRUST BULL. 363 (1994) [hereinafter Lynk, *Property Rights*], and when in possession of market power will not engage in anti-competitive behavior. *See* William G. Kopit & Robert W. McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 J. HEALTH POL., POL'Y & L. 635, 643-44 (1988). Specifically, a board of directors composed of local community leaders and employers has no incentive to raise prices, which virtually guarantees that the entity will not engage in anti-competitive behavior. *See* William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 440-42 (1995) [hereinafter Lynk, *Nonprofit Hospital Mergers*]; *see also* William G. Kopit & Tanya B. Vanderhilt, *Unique Issues in the Analysis of Non-Profit Hospital Mergers*, 35 WASHBURN L.J. 254, 269-70 (1996). These commentators claim that nonprofit hospitals respond differently to highly concentrated markets, and because a nonprofit entity has different incentives than a for-profit one, courts and federal antitrust agencies should consider nonprofit status in evaluating a proposed merger's effect. *See* Fredric J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107, 123-26 (1994); *see generally* William G. Kopit & Neil N. Rosenbaum, *Rethinking the Significance of Merging Hospitals*, America Health Lawyers Association Annual Antitrust in the Health Care Field Meeting (Feb. 1998) (on file with author). *See also* Lynk, *Nonprofit Hospital Mergers*, *supra*, at 438-49, 458-59.

In response to these arguments, the federal antitrust agencies along with numerous antitrust scholars emphasize the lack of evidence demonstrating that nonprofits act differently than for-profits and warrant different treatment under the antitrust laws. They argue that nonprofit entities will exercise market power and should be treated like for-profits for the purposes of antitrust analysis. According to Robert Bloch, former chief of the Department of Justice's Antitrust Division that had responsibility for the health care industry, "[b]oth common sense and economic theory demonstrate that competitive behavior and financial performance of non-profit hospitals—including the incentive to raise prices when faced with less competition—will not differ materially from investor-owned hospitals." *See* Lynk, *Property Rights*, *supra*, at 363. Similarly, commentators have suggested that the antitrust laws appropriately apply to nonprofits because these entities share incentives to act anti-competitively and often compete with for-profits. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261a, at 261-62. For a discussion of how federal courts have analyzed this issue, see *infra* notes 123-43 and accompanying text.

Under Section 7 of the Clayton Act, the FTC and DOJ review proposed mergers to determine whether the merger will have any significant anti-competitive effects.[6] Congressional policy underlying these statutes seeks to protect consumer welfare by preserving competition in the market.[7] Consumers benefit from competition because it encourages producers to offer the best quality at the lowest price.[8]

Although the Supreme Court has established that the nonprofit sector is subject to the antitrust laws[9] and numerous appellate courts have held that nonprofit status alone cannot rebut a presumption of illegality,[10] courts are split on the extent to which nonprofit status can be considered in predicting the competitive effects of a merger. Four district courts have recently determined that nonprofit status deserves consideration when evaluating whether a proposed merger will lessen competition.[11] In contrast, other courts, including the Seventh and Eleventh Circuits, have rejected the view that nonprofits are less likely to act anti-competively and have refused to treat nonprofits differently when determining the potential merger's anti-competitive effects.[12]

Federal Trade Commission v. Butterworth Health Corp., which involved the proposed merger of two nonprofit hospitals in Grand Rapids, Michigan, dramatically increased the significance of nonprofit status to antitrust analysis.[13] Although the district court agreed that the FTC had shown that the proposed merger would result in a significant concentration of power in the relevant markets and give the

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6. 15 U.S.C. § 18 (1994).

7. *See* David L. Meyer & Charles F. (Rick) Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 176-82 (1994).

8. *See id.* at 178.

9. *See generally* NCAA v. Board of Regents, 468 U.S. 85 (1984) (holding the NCAA is subject to antitrust laws); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975) (bolding that the Sherman Act applied to an attorney association, a nonprofit entity).

10. *See* United States v. Brown Univ., 5 F.3d 658, 665 (3d Cir. 1993); FTC v. University Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991); United States v. Reckford Memorial Corp., 898 F.2d 1278, 1285 (7th Cir. 1990); Hospital Corp. of America v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986).

11. *See* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 145-46 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1296-97 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam); FTC v. Freeman Hosp., 911 F. Supp. 1213, 1222-23 (W.D. Mo. 1995) *aff'd*, 69 F.3d 260 (8th Cir. 1995); United States v. Carilion Health Sys. 707 F. Supp 840, 849 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

12. *See, e.g.*, *University Health*, 938 F.2d at 1224; *Rockford*, 898 F.2d at 1285; *Hospital Corp. of America*, 807 F.2d at 1390.

13. Federal Trade Commission v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd* 121 F.3d 708 (6th Cir. 1997) (per curiam).

merged entity an "undue percentage share" of those markets,[14] the *Butterworth* court allowed the merger to proceed.[15] Previous courts have given some weight to nonprofit status, but the district court decision in *Butterworth* marks the first time a court has embraced the notion that nonprofit hospitals act differently in the marketplace and therefore require different treatment under the antitrust laws.[16]

The FTC appealed the district court decision to the Sixth Circuit which issued a per curiam opinion holding that the district court decision was "not legally erroneous."[17] Although the circuit court only summarized the district court's opinion and provided little of its own analysis, it did not challenge the district court's reliance on nonprofit status in determining that the merger would not have anti-competitive effects.[18] This affirmance by the circuit court marks the first time an appellate court has permitted consideration of nonprofit status.[19]

This Note uses the *Butterworth* case to consider how nonprofits should be treated in determining whether a merger is likely to have anti-competitive effects. It challenges the factors recognized by the *Butterworth* court, examines the arguments regarding whether non-profits behave differently than for-profits, and analyzes whether non-profits should enjoy different treatment under the antitrust laws. The Note suggests that the market behavior of nonprofit hospitals is materially similar to that of for-profits, and that, therefore, a less stringent application of the antitrust laws is not justified.

Part II discusses the organizational differences between the nonprofit and for-profit sector generally and then surveys the empirical studies on the behavior of nonprofit and for-profit hospitals. Part III outlines the analysis of a merger under Section 7 of the Clayton Act, reviews the legal treatment of nonprofit status itself as well as of nonprofit hospitals specifically, and discusses the important role of competition in the health care industry. Part IV compares case law

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14. *Butterworth*, 946 F. Supp. at 1294. The court accepted the agency's market definition and concentration figures. *See id.* The court then concluded that the FTC had established its prima facie case showing that the proposed merger would violate Section 7. *See id.*

15. *See id.* at 1302.

16. *See* Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191, 212 (1997) (stating that the *Butterworth* opinion is the "most revolutionary hospital merger decision yet issued").

17. *Butterworth*, No. 96-2440, 1997 WL 420543, at *3 (6th Cir. 1997) (per curiam).

18. *See id.* at *2.

19. Although the district court opinions in *Freeman* and *Carilion* were also affirmed by appellate courts, these courts did not address the nonprofit issue. *See, e.g.*, FTC v. Freeman Hosp., 69 F.3d 260 (8th Cir. 1995) (affirming without published opinion); United States v. Carilion Health Sys., 892 F.2d 1042 (4th Cir. 1989).

treatment of nonprofit status. Part V critiques the district court opinion in *Butterworth* and advocates that traditional antitrust analysis should be applied regardless of ownership status because competition is the best guarantor of consumer welfare. In Part VI, the Note suggests that emphasis on nonprofit status, especially confidence in the good motives of a nonprofit entity in light of competitive harm, does not fit within the legal framework of antitrust law. In conclusion, Part VII summarizes why courts should not rely on nonprofit status in evaluating whether a merger will have anti-competitive effects.

II. DISCUSSION OF THE NONPROFIT SECTOR AND EMPIRICAL STUDIES OF THE BEHAVIOR OF NONPROFIT HOSPITALS

When considering whether nonprofits should be treated differently than for-profits, it is important to first look at whether nonprofits in fact act differently and whether any differences that exist justify different treatment under the antitrust laws.

There are legal and economic differences in the organizational structure of the two sectors. Nonprofits are prohibited from distributing surplus revenue to individuals;[20] are generally exempt from federal and state corporate income tax, property tax, and sales tax;[21] do not have access to equity capital;[22] and often receive donations and grants.[23] Nonprofit organizations, moreover, are frequently directed by a volunteer board of directors.[24]

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20. *See* Henry Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 838 (1981). A nonprofit can generate surplus revenue, but the organization must keep net earnings or use the amount for activities consistent with the organization's purpose. *See* DENNIS R. YOUNG, IF NOT FOR PROFIT, FOR WHAT? 11 (1983). Henry Hansmann has coined the term "nondistribution constraint" te refer to this limitation. *See* Hansmann, *supra*, at 838. Although dividends are distributed differently under the nonprofit form, profit can also be seen in "salaries and perquisites." *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261a, at 261.

21. *See* Henry Hansmann, *Economic Theories of Nonprofit Organization*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 27, 40 (Walter W. Powell ed., 1987) [hereinafter Hansmann, *Economic Theories*]; *see also* David C. Hammack & Dennis R. Young, *Perspectives on Nonprofits in the Marketplace*, *in* NONPROFIT ORGANIZATIONS IN A MARKET ECONOMY 1, 5 (David C. Hammacb & Dennis R. Young, eds., 1993). Section 501(c)(3) of the Internal Revenue Code offers a tax exemption for nonprofits provided, for instance, that the entity serve a charitable purpose and not distribute any part of earnings te an individual. I.R.C. § 501(c)(3) (1994).

22. *See* Richard Steinberg, *Nonprofit Organizations and the Market*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 118, 123 (Walter W. Powell ed., 1987).

23. *See id.* This source of funding is particularly important for donative nonprofits. *See* YOUNG, *supra* note 20, at 12. Hospitals are usually considered commercial nonprofits as they rely on the sale of services for profit. *See id.*

24. *See* Evelyn Brody, *Agents Witheut Principals: The Economic Convergence of the Nonprofit and For-Profit Organizational Forms*, 40 N.Y.L. SCH. L. REV. 457, 466-67 (1996).

Whether nonprofit hospitals behave differently than for-profits has been the subject of debate and study. Results of these studies are in conflict regarding costs,[25] efficiency,[26] prices charged,[27] and profits.[28] Despite the inconsistency of these findings, experts agree that any differences between nonprofits and for-profits are disappearing as competition from third-party payers increases.[29] As the market becomes

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25. *See* Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1417, 1455 (1980) (discussing studies that have concluded for-profits have lower costs than nonprofits); *see also* Stuart H. Altman & David Shactman, *Should We Worry About Hospitals' High Administrative Costs?*, 336 NEW ENG. J. MED. 798 (1997) (stating that one study has found for-profits have lower costs per patient); Steinberg, *supra* note 22, at 129-30 (noting that there is little difference in costs between hospitals in general, but that for-profit chain hospitals are much less costly). *But see*, Bradford H. Gray & Walter J. McNerney, *For-Profit Enterprise in Health Care*, 314 NEW ENG. J. MED. 1523, 1524 (1986) (stating that studies show that for-profit hospitals are not less costly than nonprofits). One 1996 study showed that for-profits have higher total costs per patient. *See* Steffie Woolhandler & David U. Himmelstein, *Costs of Care and Administration at For-Profit and Other Hospitals in the United States*, 336 NEW ENG. J. MED. 769, 772 (1997). This study found that for-profits have higher administrative costs than nonprofits. *See id.* However, it may be difficult to compare the administrative costs of the two sectors because for example, these costs may be reported differently for tax purposes. *See Study Says For Profit Hospitals Have Higher Administrative Costs*, MED. & HEALTH, Mar. 17, 1997, *available in* 1997 WL 8689004.

26. *See* Rogina E. Herzlinger & William S. Krasker, *Who Profits From Nonprofits?*, HARV. BUS. REV., Jan.-Feb. 1987, at 93, 103 (stating that for-profits use labor more efficiently and generato more patient days per bed than nonprofits); *see also* Clark, *supra* note 25, at 1462. One study stated that the efficiency of for-profits and nonprofits appears similar. *See* Edmund R. Becker & Frank A. Sloan, *Hospital Ownership and Performanee*, 23 ECON. INQUIRY 21, 31 (1985). *But see* PAUL FELDSTEIN, HEALTH CARE ECONOMICS 247 (1988) (arguing that for-profits are more profitable because of higher prices not because of greater efficiency); Robert V. Pattison & Hallie M. Katz, *Investor-Owned And Not-For-Profit Hospitals*, 309 NEW ENG. J. MED. 347, 353 (1983) (stating that data does not support the proposition that a for-profit chain is more efficient than a nonprofit one).

27. Some studies have not found any pricing differences between the nonprofits and for-profits. *See* Herzlinger & Krasker, *supra* note 26, at 93. Those studies that have found higher prices associated with for-profit hospitals may be explained by their location, as many for-profits locate in areas where they can charge higher prices. *See* Mark V. Pauly, *Nonprofit Firms in Medical Markets*, 77 AM. ECON. REV. 257, 261 (1987). Some studies have shown nonprofit hospitals charge lower prices than for-profit ones. *See* Lynk, *Nonprofit Hospital Mergers*, *supra* note 5, at 439. One study reports that for-profits charge higher prices for ancillary services. *See* Pattison & Katz, *supra* note 26, at 349.

28. *See* Herzlinger & Krasker, *supra* note 26, at 101 (discussing that for-profits do not have higher returns than nonprofits); *see also* Frank A. Sloan & Robert A. Vraciu, *Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues*, 2 HEALTH AFF. 25, 31 (1983) (stating that their study "showed no statistically significant difference" between the after tax profit of nonprofits and for-profits). *But see* Thomas J. Hoerger, *'Profit' Variability in For-Profit and Not-for-Profit Hospitals*, 10 J. HEALTH ECON. 259, 260, 286-87 (1991) (stating that private nonprofit hospitals experience less variation in their profits than for-profits, which suggests the two operate differently); Pattison & Katz, *supra* note 26, at 349 (stating that for-profits earn higher profits from ancillary services than nonprofits). Noto that nonprofits cannot technically earn a profit but can use surplus te benefit the entity. *See* I.R.C. § 501(c)(3) (1994); see *also supra* note 20 and accompanying text.

29. *See* David S. Salkever & Richard G. Frank, *Health Services*, *in* WHO BENEFITS FROM THE NONPROFIT SECTOR?, 24, 35-39 (Charles T. Clotfelter ed., 1992); *see also* Sims Testimony,

more competitive, the prices charged by both types of hospitals will likely be closer to marginal costs.[30]

Furthermore, studies show numerous similarities in the behavior of for-profit and nonprofit hospitals.[31] First, despite different organizational structures, the management of both sectors are concerned about costs and recognize that profits (or surplus revenues) are essential for operation.[32] Nonprofits have responded to competition by establishing for-profit subsidiaries, selling services to for-profits, and participating in joint ventures with for-profit hospitals.[33] Both for-profits and nonprofits advertise and market themselves in efforts to increase patient flow,[34] and both have been accused of abusing the Medicare system.[35] Due to these similarities, consumers may have difficulty distingnishing between the two sectors.[36] These examples

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supra note 2, at 73, 74 (discussing that managed care has forced nonprofits to compete on price by providing services historically provided only by hospitals, contributing to a wide-scale consolidation in the hospital industry).

30. *See* David Dranove, *Pricing By Non-Profit Institutions: The Case of Hospital Cost-Shifting*, 7 J. HEALTH ECON. 47, 56 (1988).

31. Ownership differences matter very little in market behavior. *See* Pauly, *supra* note 27, at 261-62 ; *see also* Becker & Sloan, *supra* note 26, at 31 (noting that the two ownership forms operato very similarly); Theodore R. Marmor et al., *Nonprofit Organizations and Health Care*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 221, 234-36 (Waltor W. Powell, ed., 1987) (stating that today, few differences exist between nonprofit and for-profit hospitals); Sloan & Vraciu, *supra* note 28, at 34.

32. *See* Erwin A. Blackstene & Joseph P. Fuhr, Jr., *An Antitrust Analysis of Non-Profit Hospital Mergers*, 8 REV. OF INDUS. ORG. 473, 474 (1992) (stating that both for-profits and nonprofits are under greator pressure to reduce costs); *see also* David B. Starkweather, *Profit Making by Nonprofit Hospitals*, *in* NONPROFIT ORGANIZATIONS IN A MARKET ECONOMY 105, 108 (David C. Hammond & Dennis R. Young eds., 1993) (noting that nonprofits make a profit in order to continue operations). For both hospital types, "business acumen [and] coordination" are required for success. *See* Woolhandler & Himmelstein, *supra* note 25, at 773-74. Furthermore, nonprofits must compete for financial capital. *See* Cyril F. Chang & Howard P. Tuckman, *The Profits of Not-For-Profit Hospitals*, 13 J. HEALTH POL., POL'Y & L. 547, 549 (1988). Nonprofit managers, like their for-profit counterparts, dislike increased competition. *See* Lynk, *Nonprofit Hospital Mergers*, *supra* note 5, at 458.

33. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 436-38 (1982) (noting that many nonprofit hospitals have established for-profit subsidiaries and have entored into joint ventures with for-profit entities); *see also* Marmor *et al.*, *supra* note 31, at 229.

34. *See* Nancy Ann Jeffrey, *Hospitals Use TV Spots to Boost Business*, WALL ST.J., Sept. 26, 1996, at B10; *see also* Richard L. O'Brien & Michael J. Haller, *Investor-Owned or Nonprofit? Issues and Implications for Academic and Ethical Values in a Catholic Teaching Hospital*, 313 NEW. ENG. J. MED. 198, 199 (1985) *quoted in* Mark Krause, Comment, *"First Do No Harm": An Analysis of the Nonprofit Hospital Sales Act*, 45 UCLA L. REV. 503, 511 (1997).

35. *See* George Anders, *Pricey Operation: A Plan to Cut Back on Medicare Expenses Goes Awry; Costs Soar*, WALL ST.J., Oct. 3, 1996, at A1.

36. *See* Susan Rose-Ackerman, *Altruism, Nonprofits, and Economic Theory*, 34 J. ECON. LIT. 701, 718 (1996) (noting that for-profits operate in most of the same areas as nonprofits). Changes in health care industry have resultod in "blurred" lines between the conduct of nonprofit and for-profit hospitals. *See* Starkweather, *supra* note 32, at 107. Nonprofit hospitals account for the majority of all hospitals as about 85 percent of hospitals are nonprofits. *See*

indicate that despite differences in financing and dividend distribution, nonprofit and for-profit hospitals share many of the same incentives to act anti-competitively.[37]

Second, studies have found that ownership status does not determine the type of patient treated.[38] Nonprofit and for-profit hospitals provide care for the same types of patients.[39] Third, both types of hospitals are equally accessible to the uninsured and indigent, and both screen patients based on their ability to pay.[40]

Demise of the Not-for-Profit Has Been Greatly Exaggerated, MOD. HEALTHCARE, Dec. 23, 1996, at 33.

37. *See* United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1285 (N.D. Ill. 1989) *aff'd*, 898 F.2d 1278 (7th Cir. 1990) (stating that when a nonprofit's objectives are inconsistent with "the objectives of a competitive market place, the not-for-profit hospital has incentive to act anti-competitively"); *see also* Herzlinger & Krasker, *supra* note 26, at 94 (suggesting that nonprofits have the same motives to act anti-competitively as for-profits by stating that nonprofit managers are just as likely to use funds to pay for "larger salaries, organizational perquisites, and excessively large staffs"); Lynk, *Property Rights*, *supra* note 5, at 377 (recognizing that nonprofits have the same motives as for-profits to act anti-competitively).

38. Ownership status may not determine the type of patient served. *See* Herzlinger & Krasker, *supra* note 26, at 103; *see also* Henry Hansmann, *The Changing Roles of Public, Private, and Nonprofit Enterprise in Education, Health Care, and Other Human Services*, *in* INDIVIDUAL AND SOCIAL RESPONSIBILITY: CHILD CARE, EDUCATION, MEDICAL CARE, AND LONG-TERM CARE IN AMERICA 245, 254 (Victor R. Fuchs ed., 1996); Sloan & Vraciu, *supra* note 28, at 33 (discussing a study of Florida hospitals finding little difference in the type of patient treated).

39. *See* Salkever & Frank, *supra* note 29, at 38-39 (stating that studies have found payer mixes of nonprofits and for-profits are similar with both treating charity or self-paying patients and Medicaid patients). Studies have found that *public* hospitals do care for more uninsured and poor patients than private nonprofits and for-profits. *See id.* at 39. One study of Virginia hospitals found that for-profit hospitals provided more of their operating expenses to charity care than nonprofits. *See* David Burda, *For-Profits, Not-For-Profits Reignite Battle*, MOD. HEALTHCARE, May 8, 1995, at 28. *But see* Barbara Arrington & Cynthia Haddock, *Who Really Profits from Not-For-Profits?*, 25 HEALTH SERV. RES. 291, 300-02 (1990) (finding that nonprofits treat more poor patients than for-profits). Whether studies of charity care should include taxes paid by for-profits is the subject of debate as the use of this data may change a study's results. *See* Burda, *supra*.

Although some studies have found nonprofits provide slightly more care to indigents, locational differences may account for these results. *See* Richard G. Frank & David S. Salkever, *Nonprofit Organizations in the Health Sector*, J. ECON. PERSP., Fall 1994, at 129, 138. Location and selection of medical staff are better predictors of a hospital's patient mix than ownership. *See* Pattison & Katz, *supra* note 26, at 350-51.

40. *See* Krause, *supra* note 34, at 510 (stating that "there is evidence to suggest the two organizational forms provide the same access to care"); *see also* Herzinger & Krasker, *supra* note 26, at 103 (finding that for-profit hospitals provide slightly more access to uninsured than nonprofits). For-profit and nonprofit hospitals are concerned with patients' ability to pay. *See* Maria O'Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 BYU L. REV. 971, 975 (noting that private hospitals have a tradition of avoiding economically undesirable patients); *see also* Marmor et al., *supra* note 31, at 230 (discussing evidence that private nonprofits also carefully screen patients for ability to pay).

Fourth, nonprofits and for-profits now provide similar services since many nonprofits have eliminated unprofitable services.[41] In addition, for-profit and nonprofit hospitals also generally provide the same quality of care to their patients.[42] The competence of staff physicians and post-operative mortality rates are comparable for the two types of hospitals.[43] Both types of hospitals also have to meet the same licensing and accreditation requirements.[44]

Strong evidence suggests that nonprofit and for-profit hospitals operate similarly in important competitive dimensions. In general, an entity's organizational structure does not affect the basic motivations of "stable growth, autonomy, and control."[45] Regardless of ownership structure, an organization seeks to maintain its existence and meet its goals.[46] The forces of competition and government regulation are "paramount" for the functioning of both nonprofit and for-profit hospitals.[47] Given evidence that nonprofits have the same incentives as for-profits to act anti-competitively, it should not be inferred that nonprofit hospitals are less likely to exercise market

41. *See* David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, J. CORP. L. 741, 747 (1998) (noting that for-profits offer the same "range and quality of services" as nonprofits); Starkweather, *supra* note 32, at 112 (stating that many have noted that there is little distinction between the two types of hospitals). *But see* Arrington & Haddock, *supra* note 39, at 300 (stating that nonprofits are more accessible to these types of patients). In addition, a 1990 GAO report found that many service activities of nonprofit and for-profit hospitals are the same. *See* Starkweather, *supra* note 32, at 130. This finding suggests that the service activities of the two forms are becoming increasingly similar. *See id.*

42. *See* Marmor et al., *supra* note 31, at 235 (noting that there are not "appreciable differences" in the care provided te most patients by nonprofit and for-profit hospitals); *see also* Clark, *supra* note 25, at 1455; Gray & McNerney, *supra* note 25, at 1526 (stating that there is no clear difference between for-profits and nonprofits in the quality of care provided). *But see* Salkever & Frank, *supra* note 29, at 37 (noting that one study found the expected length stay for charity patients was shortest at for-profit hospitals, however for Medicaid patients there was less of a differential). According to some experts, the growth of monitoring quality in the health care system by managed care organizations as well as increasing information provided te consumers will diminish any differences in quality that presently exist. *See* Frank & Salkever, *supra* note 39, at 132-34.

43. *See* Frank & Salkever, *Nonprofit Organizations*, *supra* note 39, at 131.

44. *See* Krause, *supra* note 34, at 508 & n.34.

45. Brody, *supra* note 24, at 505. Brody quotes Barry Bozeman who stated that these motivations are "only minimally affected by . . . profit motive." *Id.* (quoting BARRY BOZEMAN, ALL ORGANIZATIONS ARE PUBLIC: BRIDGING PUBLIC AND PRIVATE ORGANIZATIONAL THEORIES 149 (1987)). *See also* Pauly, *supra* note 27, at 262 (discussing that organizational form is much less significant in behavior than economic incentive).

46. *See* Brody, *supra* note 24, at 468. These similarities have prompted debate about whether nonprofits should continue te receive federal tax exemption. *See id.* at 457; *see generally* Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Warranted?*, 26 URB. LAW. 143 (1994).

47. Steinberg, *supra* note 22, at 134. Evidence exists that nonprofits respond to competition in the same manner as for-profits. *See* Blackstone & Fuhr, *supra* note 32, at 437.

power. The same antitrust concerns arise for nonprofit mergers as for equivalent for-profits and thus, less stringent antitrust standards are not justified.

III. LEGAL FRAMEWORK OF ANTITRUST ANALYSIS OF MERGERS

A. Mechanics of Merger Analysis

Section 7 of the Clayton Act prohibits mergers in which the effect "may be substantially to lessen competition."[48] Under the Merger Guidelines and the case law, this statute prevents mergers that create or enhance market power or facilitate its exercise.[49] Market power is usually defined as the ability to maintain prices over a competitive level for an extended period of time.[50] Congress enacted Section 7 to prevent transactions that are likely to substantially reduce competition.[51]

The FTC and DOJ use the Merger Guidelines to analyze the competitive effects of proposed mergers.[52] The steps outlined in the Merger Guidelines are: defining the relevant product and geographic market; identifying actual and potential participants in the market; and determining how the merger will affect market concentration, which includes assessing the likely competitive effects of the merger based on characteristics of the market and its participants, particularly ease of entry and market conditions.[53] These factors are evaluated on a case by case basis.[54]

The Guidelines, like the case law, consider a significant increase in concentration within a relevant market as the primary indi-

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48. 15 U.S.C. § 18 (1994). Section 7 only requires a reasonable probability that the merger will substantially lessen competition. *See* FTC v. Elders Grain, Inc., 868 F.2d 901, 906 (7th Cir. 1989); *see also* Hospital Corp. of America v. FTC, 807 F.2d 1381, 1389 (7th Cir. 1986).

49. *See* U.S. DEPT. OF JUSTICE & FTC, HORIZONTAL MERGER GUIDELINES § 1.0. (1992) [hereinafter MERGER GUIDELINES].

50. *See* 2A PHILLIP E. AREEDA ET AL., ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 501, at 85 (1995). Market power is the ability to raise prices above the competitive level without "losing so much business to other suppliers" as to make the supracompetitive price unprofitable. Unitod States v. Rockford Memorial Corp., 898 F.2d 1278, 1283 (7th Cir. 1990).

51. *See Rockford*, 898 F.2d at 1283.

52. Horizontal Merger Guidelines of the Department of Justice and Federal Trade Commission, 57 Fed. Rog. 41,552, *reprinted in* 4 Trade Rog. Rep. (CCH) ¶ 13,104 (April 7, 1992) (amended May 5, 1992 and April 8, 1997).

53. *See* MERGER GUIDELINES, *supra* note 49, § 0.2.

54. *See id.* § 0.

cator of anti-competitive impact of a proposed merger.[55] The Guidelines conduct the concentration inquiry in terms of the Herfindahl-Hirschman Index ("HHI"),[56] which has been widely adopted by courts.[57] The significance of this data can be discounted or enhanced by considerations of market characteristics such as entry conditions and efficiencies.[58]

Under the case law, a significant increase in market concentration and an "undue percentage share" of the relevant market establishes a prima facie case.[59] Courts have determined that once a prima facie case is created, a presumption of illegality[60] arises and the burden of production shifts to the merging party.[61] To successfully rebut a prima facie case, the challenged party must show that market share and concentration statistics inaccurately predict the effect on competition in the relevant market.[62] If the party effectively challenges the predictive value of the market share and concentration evidence, the FTC must provide additional evidence of the merger's anti-competitive effects.[63] The burden of persuasion remains with the government at all times.[64]

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55. *See e.g., id.* § 1.0; *Rockford* at 1282-83.

56. *See* MERGER GUIDELINES, *supra* note 49, § 1.5. The HHI index squares the market shares of each participant in the relevant market. The antitrust agency must show that a significant increase in concentration would allow a firm to raise prices to an anti-competitive level. The DOJ/ FTC Merger Guidelines state that a post-merger HHI above 1800 is evidence of a high market concentration, and if the HHI exceeds 1800 an increase in the HHI of over 100 points is deemed likely to create or enhance market power or facilitate its exercise. *See id.* § 1.51.

57. *See, e.g.*, FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1294 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam); FTC v. University Health, Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991).

58. *See* MERGER GUIDELINES, *supra* note 49, § 3.0. (entry) & 4.0. (efficiencies). Courts have adopted similar analyses. *See, e.g., Butterworth*, 946 F. Supp. at 1289; *University Health*, 938 F.2d at 1218.

59. United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 363-64 (1963).

60. *See* Steven C. Sunshine, *Non-Profits Use Intent as Defense*, NAT'L. L.J., Mar. 31, 1997, at C1, C15. The premise behind the presumption of illegality is increases in market concentration will likely increase market power, giving firms the ability to raise prices farther above a competitive level than they could before the merger. *See id.*

61. *See University Health*, 938 F.2d at 1218. Note that the Guidelines presumption focuses on high levels of concentration and a large increase in concentration rather than burden shifting. *See* MERGER GUIDELINES, *supra* note 49, § 1.5.

62. *See University Health*, at 1218-19 (quoting United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 363 (1963)); *see also* United States v. General Dynamics Corp., 415 U.S. 486 (1974) (allowing the defendant to rebut the presumption of illegality using evidence other than market share data); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1288-89 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam).

63. *See* United States v. Baker Hughes Inc., 908 F.2d 981, 982-83 (D.C. Cir. 1990).

64. *See id.* at 983.

B. Discussion of Countervailing Factors and Affirmative Defenses Recognized by the Merger Guidelines and Case Law

The Merger Guidelines and the case law analyze elements that suggest that market share and concentration statistics do not accurately predict the merger's effect on competition. These factors, including ease of entry, the imminent exit of a failing firm from the market, and efficiencies,[65] show that a proposed merger will not lessen competition.

As stated in the Merger Guidelines, the DOJ and FTC must consider the entry conditions of the market.[66] When entry into the market would be "timely, likely, and sufficient in its magnitude, character and scope" te prevent any attempt to increase prices significantly above the competitive level, the merger will pose little antitrust concern.[67] New competitors deter the merged entity from abusing market power by making anti-competitive practices unprofitable.[68]

Under the Guidelines, the failing-firm defense can negate an inference of lessened competition. The Guidelines require a showing that absent the merger, the assets of the firm will leave the market.[69] Therefore, the merger does not raise antitrust concern because the proposed merger will not decrease competition in the market.[70]

Efficiencies are also considered under the Merger Guidelines because efficiencies are likely to result in lower costs and higher quality for the consumer. If there are "cognizable efficiencies" that would not be accomplished absent the merger, the federal agencies may decide not to challenge the proposed merger.[71]

Courts also consider the above factors. Because market power is the ability to charge supra-competitive prices unchecked by new entrants or other mitigating factors,[72] courts have allowed defendants to offer evidence of ease of market entry to show that competitors

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65. Both the failing firm and efficiencies defenses are "strictly construed." Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, LAW & CONTEMP. PROBS., Spring 1988, at 93, 161-63. The Merger Guidelines Section 1.2, which evaluates the likely competitive effects of the merger, is analytically equivalent to these facters. *See* MERGER GUIDELINES, supra note 49, § 1.2.

66. *See* MERGER GUIDELINES, *supra* note 49, at § 3.0.

67. *Id.*

68. *See* 2A AREEDA ET AL., *supra* note 50, ¶ 420A, at 56.

69. *See* MERGER GUIDELINES, *supra* note 49, at § 5.0.

70. *See id.*

71. *Id.* § 4.0 (Revised Apr. 8, 1997).

72. *See* 2A AREEDA ET AL., *supra* note 50, ¶ 501, at 85-86.

could prevent the merger's potential anti-competitive effects.[73] A defendant may use ease of entry to rebut a presumption of illegality.[74] Courts have accepted evidence of efficiencies as rebuttal evidence[75] or as an affirmative defense.[76] Finally, courts have considered evidence of a failing firm as an affirmative defense.[77]

C. Application of the Antitrust Laws to the Nonprofit Sector

Congress has ordained competition as the guiding principle for antitrust analysis.[78] Competition will produce "the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress."[79] Following this rationale, the Court in *United States v. Philadelphia National Bank*[80] emphasized that a court can only consider competitive factors when determining whether a merger will have anti-competitive effects[81]—that is, a court cannot determine that a noncompetitive solution would be more beneficial to society than the competitive one,[82] or that special characteristics of an industry makes it unsuited to strict application of the antitrust laws.[83]

Neither the Clayton Act nor the Sherman Act include a statutory exemption for nonprofits.[84] The Supreme Court has held that

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73. *See e.g.*, FTC v. University Health, Inc., 938 F.2d 1206, 1218 (11th Cir. 1991); *see* Baker, *supra* note 65, at 152 (noting that examination of entry conditions and other factors indicating an ability te collude may be enough to rebut an inference of the anti-competitive result of a high level of concentration).

74. *See* FTC v. University Health, Inc., 938 F.2d 1206, 1218 (11th Cir. 1991); *see also* Ball Memorial Hosp. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1336 (7th Cir. 1986) (discussing the significance of ease of entry in merger analysis).

75. *See, e.g., University Health*, 938 F.2d at 1222; FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1300 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam).

76. *See, e.g.*, United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995) *vacated by* 107 F.3d 632, 634 (8th Cir. 1997) (vacating for mootness because the merger at issue was abandoned).

77. *See, e.g.*, E. THOMAS SULLIVAN & HERBERT HOVENKAMP, ANTITRUST LAW, POLICY, & PROCEDURE 868-69 (1994).

78. *See* 15 U.S.C. § 18 (1994).

79. Northern Pacific Ry. Co. v. United States, 356 U.S. 1, 4 (1958).

80. United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963).

81. *See id.* at 371 (stating that "[w]e are clear . . . that a merger the effect of which may be te substantially lessen competition, is not saved because, on some ultimate reckoning of social and economic debts or credits, it may be deemed beneficial").

82. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 693-95 (1978). That Court held that antitrust law does not permit a challenge to competition itself. *See id.* at 695. *See also* Catherine C. Eckel & Richard Steinberg, *Competition, Performance, and Public Policy Toward Nonprofits*, *in* NONPROFIT ORGANIZATIONS IN A MARKET ECONOMY 57, 58 (David C. Hammack & Dennis R. Young eds., 1993).

83. *See Professional Eng'rs*, 435 U.S. at 689.

84. *See* 15 U.S.C. § 1 (1994); 15 U.S.C. § 18 (1994).

nonprofit organizations must comply with the antitrust laws.[85] In *NCAA v. Board of Regents of the University of Oklahoma*,[86] the Court rejected the idea that an implicit exemption exists for nonprofits.[87] Similarly, in *Goldfarb v. Virginia State Bar*, the Court held that the Sherman Act applied to nonprofit entities.[88] The antitrust laws apply to the nonprofit sector because the inability to earn a profit does not ensure that an entity will act in the consumer's best interests.[89] In particular, it is difficult to prevent nonprofit organizations from violating the nondistribution constraint by distributing surplus to those in control.[90] Also, personal financial gain is not the sole motivator for anti-competitive conduct.[91]

In the health care context, courts have also recognized that nonprofit status alone will not rebut a presumption of illegality created by the government's prima facie case. In *Hospital Corporation of America v. FTC*, the Seventh Circuit emphasized that nonprofit structure "does not change human nature."[92] The court explained that most enterprises dislike competition,[93] and suggested that the rift between nonprofit and for-profit hospitals might encourage the nonprofit to engage in anti-competitive behavior.[94] Specifically, nonprofit ideological objectives may offer additional incentives to reduce competition.[95] Following the rationale of the *HCA* decision, the *Rockford* court stressed that nonprofit status did not remove the risk that an

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85. *See* American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp., 456 U.S. 556, 576 (1982) (stating that "it is beyond debate that nonprofit organizations can be held liable under antitrust laws.").

86. NCAA v. Board of Regents, 468 U.S. 85 (1984).

87. *See id.* at 100 n.22. The Court suggests that a nonprofit entity must follow the antitrust laws absent a legislative exemption in stating that "[t]here is no doubt that the sweeping language of § 1 applies to nonprofit entities. . . .").

88. Goldfarb v. Virginia State Bar, 421 U.S. 773, 786-87 (1975).

89. *See* United States v. Brown Univ., 5 F.3d 658, 665 (3d Cir. 1993); *see also* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261a, at 260-61.

90. *See* Richard Steinberg, *How Should Antitrust Laws Apply to Nonprofit Organizations? in* GOVERNING, LEADING, AND MANAGING NONPROFIT ORGANIZATIONS 279, 287 (Dennis R. Young et al. eds., 1993) (arguing that managers and board members could obtain private benefits through excessive salaries and managerial perks and that better enforcement of the nondistribution constraint would be difficult).

91. *See id.* Rather, for-profits and nonprofit managers share incentives te act anti-competitively. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261a, at 261. *See also supra* note 47 and accompanying text.

92. Hospital Corp. of America v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986).

93. *See id.* at 1391.

94. *See id.* (discussing the "antipathy" toward for-profit hospitals because of some nonprofits' view that for-profits take the most affluent patients reducing greatly the nonprofits' ability to cost-shift in order to defray the costs of charitable care).

95. *See id.* The court suggested that a nonprofit hospital may collude in order to obtain higher profits that can fund charity care. *See id.*

entity would exploit market power.[96] Similarly, the court in *University Health* noted that once a nonprofit has market power, no checks exist to prevent it from acting anti-competively.[97]

State legislation also does not provide an exemption for nonprofits. Because of federalism, the state action doctrine permits states to use regulation in place of federal antitrust laws.[98] For an activity to qualify for state action immunity, a state must satisfy a two part test: the state must clearly articulate its policy and actively supervise the policy's implementation.[99] Under this doctrine, some states have enacted statutes that protect health care mergers and joint ventures from federal enforcement of the antitrust laws. Notably, these exemptions do not distinguish between nonprofits and for-profits.[100]

In sum, nonprofits are not exempted from antitrust provisions. Courts have reasoned that the nonprofit form does not justify less stringent application of the antitrust laws. Thus, mergers between nonprofit hospitals must be analyzed in the same way as for-profit hospitals, with the preservation of competition guiding judicial decision making regarding the merger's likely effects.

D. Application of Traditional Antitrust Analysis to the Hospital Industry

Antitrust law is based on the premise that competition benefits consumers by offering the best quality at the lowest price.[101] The application of antitrust doctrine to the health care industry has been debated.[102] For instance, it has been suggested that the traditional presumption that high market concentration yields higher prices is inapplicable to the hospital industry. According to some health care experts, the traditional model does not apply because, unlike other in-

96. *See* United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

97. *See* FTC v. University Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991).

98. *See* Parker v. Brown, 317 U.S. 341, 350-51 (1943). Federalism concerns are behind allowing state regulation to displace federal antitrust laws. *See id.* at 350-52.

99. *See* FTC v. Ticor Title Ins. Co., 504 U.S. 621, 631 (1992); *see also* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

100. *See* Meyer & Rule, *supra* note 7, at 208-10. The DOJ/FTC "Statements of Antitrust Enforcement Policy in Health Care" also do not differentiate between nonprofit and for-profit hospitals in the "safety zones" created for some types of hospital mergers. *See* DOJ/FTC *"Statements of Antitrust Enforcement Policy in Health Care", reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Sept. 5, 1996).

101. *See* Meyer & Rule, *supra* note 7, at 181.

102. *See id.* at 180-81.

dustries, hospital competition is not price-driven,[103] and competition for physician and patients based on quality, services, and other amenities has resulted in duplication of hospital services.[104] These commentators argue that hospital mergers achieve efficiencies by eliminating duplication created by the "medical arms race" and thus result in hospitals located in less concentrated markets charging lower prices.[105]

Numerous studies indicate, however, that the traditional paradigm of lower prices in more competitive markets applies to the health care industry.[106] A review of changes in the health care industry help explain why hospital competition benefits consumers. Prior to health care cost-containment measures, traditional insurers retroactively reimbursed hospitals for most costs.[107] Hospitals competed for patients based on quality of care, facilities, and services,[108] and patients and their physicians selected hospitals based on these same factors.[109] Under this paradigm, insured patients are not concerned

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103. *See* Entin et al., *supra* note 5, at 122-25 (arguing hospitals do not follow this competitive paradigm and that instead, prices increase as competition increases); *see also* Gloria J. Bazzoli et al., *Federal Antitrust Merger Enforcement Standards: A Good Fit for the Hospital Industry?*, 20 J. HEALTH POL., POL'Y & L., 137, 142 (1995) (stating that consumer-driven competition still exists in many areas making the traditional economic theories inapplicable to health care markets). According to Bazzoli and her colleagues, patients do not chose a hospital based on price because insurance covers the majority of patient expenses. *See id.* at 142-44; *see also* Kopit & Vanderbilt, *supra* note 5, at 254-56 (discussing that the traditional model does not apply because competition about price is less important in the health care industry).

104. *See* Entin et al., *supra* note 5, at 124-25; *see also* Kopit & Vanderbilt, *supra* note 5, at 257-58.

105. Some commentators believe that there is an absence of price-concentration correlation in the hospital industry because of the "medical arms race." *See* Entin et al., *supra* note 5, at 123-25. *See also* James C. Robinson & Harold S. Luft, *The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care*, 4 J. HEALTH ECON. 333, 353-54 (1985) (arguing that competition may increase price by affecting the quality of services provided and efficiency of the delivery of these services). For example, hospitals buy expensive equipment in an effort to attract patients. *See* Entin et al., *supra* note 5, at 124. Mergers may avoid duplication and reduce prices. *See id.* at 125. *But see* David Dranove et al., *Is Hospital Competition Wasteful?*, 23 RAND J. ECON. 247, 261 (1992) (challenging the argument that competition in the hospital industry is "inefficient").

106. *See infra* notes 112-14 and accompanying text.

107. *See* Magleby, *supra* note 2, at 138-39.

108. *See* Jack Zwanziger & Glenn A. Melnick, *Effects of Competition on the Hospital Industry: Evidence From California*, *in* COMPETITIVE APPROACHES TO HEALTH CARE REFORM 111, 113-114 (Richard J. Arnould et al. eds., 1993) (outlining the differences between this type of competition and price-driven competition). The authors also note that payer-driven competition is a result of the growth of managed care. *See id.* at 111-12, 114. *See also* United States v. Mercy Health Services, 902 F. Supp. 973-74 (N.D. Iowa 1995), *vacated by* 107 F.3d 632, 634 (8th Cir. 1997) (noting that traditionally hospitals competed based on "perceptions of quality" and amenities).

109. *See* David Dranove et al., *Price and Concentration in Hospital Markets: The Switch From Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 182-83 (1993).

about prices and they lack incentive to obtain information about their care.[110]

Studies show, however, that the hospital market has shifted from competition based upon services and amenities to competition based on price,[111] such that the standard economic assumption that competition yields lower prices applies.[112] The growth of third-party payers who selectively contract to obtain discounted prices has in part motivated this trend.[113] For example, studies of the California health care industry, an area with a high level of managed care penetration, have found that managed care contributes to payer-driven competition.[114] Managed care encourages this type of competition because through selective contracting, managed care organizations

110. *See* David Dranove, *The Case for Competitive Reform in Health Care*, *in* COMPETITIVE APPROACHES TO HEALTH CARE REFORM 67, 71 (Richard J. Arnould et al. eds., 1993).

111. *See* Dranove et al., *supra* note 109, at 179-83 (discussing "patient-driven" and "payer-driven" competition and explaining that patient-driven competition existed when hospitals competed for patients who selected hospitals based on quality and amenities while payer-driven competition is based upon price spurred by the current use of selective contracting).

112. *See id.* at 201; *see also* Dranove, *supra* note 110, at 73-74 (stating that in a payer-driven system, lower prices result from increased competition and earlier studies with contrary results used a measure of price that is irrelevant under payer-driven competition). Today, price plays a "significant role" in hospital competition and market concentration affects pricing behavior. Emmitt B. Keeler *et al.*, *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69, 71, 82-83 (1999). Further, nonprofit hospitals in areas with fewer competitors charged higher prices than those in more competitive areas. *See id.* at 71.

113. *See* Zwanziger & Melnick, *supra* note 108, at 112-14 (emphasizing that these payers differ from patients because they have incentive to obtain pricing discounts and information about price and quality). The prospective payment system also used by some third party payers has contributed to price competition. *See id.* at 114; *see also* Sims Testimony, *supra* note 2, at 73-74.

114. Numerous studies of the health care industry have concluded that third-party payers provide incentives for hospitals to compete on price. *See* Dranove et al., *supra* note 109, at 201; *see also* Jonathan Gruber, *The Effect of Competitive Pressure on Charity: Hospital Responses to Price Shopping in California*, 13 J. HEALTH. ECON. 183, 204 (1994); Glenn A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217, 231-32 (1992); James C. Robinson, *Decline in Hospital Utilization and Cost Inflation Under Managed Care in California*, J. AM. MED. ASS'N, 1060, 1062-63 (Oct. 2, 1996) (reporting that a study of California hospitals found that managed care penetration is associated with lower costs); Jack Zwanziger & Glenn A. Melnick, *The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California*, 7 J. HEALTH ECON. 301, 317 (1988) (finding that selective contracting affects hospital behavior and that hospitals are competing on price). Managed care growth has had similar effects in other areas of the country. *See generally* Michael Staten et al., *Market Share/Market Power Revisited: A New Test for an Old Theory*, 7 J. HEALTH ECON. 73 (1988) (looking at the effect of managed care payers in Indiana). *But see* Bazzoli et al., *supra* note 103, at 144 (discussing studies concluding that patient-driven competition still exists in many health care markets without a high level of managed care penetration and even with the growth of managed care, hospitals continue te compete based on quality); Entin et al., *supra* note 5, at 128-30 (arguing that managed care penetration will not necessarily result in competition based on price).

are able to obtain lower prices and thus allow consumers to pay lower prices for health care.[115]

Price-based competition benefits consumers. Although such competition does not necessarily generate the lowest costs,[116] it produces the best quality product at the lowest price.[117] Because third-party payers create incentives for the hospital industry to compete on price and these payers can only operate when alternative providers exist,[118] a competitive market shonld be maintained.[119] Even if a particular market has not yet shifted to price competition, mergers may inhibit entry of managed care organizations and therefore deprive consumers of future price reductions.[120]

In the hospital industry, price-based competition has benefited consumers by lowering prices and increasing efficiency.[121] Competitive markets protect consumer choice while optimizing quality and price.[122] Therefore, preserving competition in the health care industry is as important as in other industries.

IV. CASE LAW TREATMENT OF MERGING HOSPITALS' NONPROFIT STATUS

Prior to *Butterworth*, numerous courts discussed the importance of nonprofit status in antitrust analysis. Although nonprofit status itself does not immunize an entity from antitrust scrutiny, a few courts have considered nonprofit status relevant in

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115. *See* Zwanziger & Melnick, *supra* note 108, at 131-32.

116. *See* Meyer & Rule, *supra* note 7, at 181.

117. *See id.*

118. *See* Zwanziger & Melnick, *supra* note 108, at 132; *see also* Sunshine, *supra* note 60, at C16; Post-Trial Brief of Plaintiff Federal Trade Commission in Support of Motion for Preliminary Injunction Public Version (Confidential Material Deleted) at 86-87, FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996) (No. 1:96-CV-49) [hereinafter FTC Post-Trial Brief]; Proof Brief for Plaintiff-Appellant Federal Trade Commission at 9-10, FTC v. Butterworth Health Corp., 121 F.3d 708 (6th Cir. 1997) (per curiam) (No. 96-2440) [hereinafter FTC Proof Brief] (stating that without the market power created by the merger, the hospitals would not be able to reduce the discounts offered to managed care organizations because the purchasers could always choose the other hospital).

119. *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, 107 (1998); *see also* Meyer & Rule, *supra* note 7, at 177 (stating that "[c]ompetition belongs in the healthcare field").

120. *See* Dranove et al., *supra* note 109, at 202 (stating that mergers may discourage managed care penetration and therefore may prevent price reductions for the consumer).

121. *See* Meyer & Rule, *supra* note 7, at 177-78 (noting that competition adapts to the field in which it operates and has adapted to health care as it has with other industries).

122. *See id.*

evaluating the likelihood of a merger causing competitive harm. These courts have questioned whether nonprofit hospitals will exercise market power since they are not motivated by monetary goals. Even these courts, however, have not relied solely on this factor for holding that a merger will not have anti-competitive effects.

Other courts have refused to consider nonprofit status in the analysis of a merger's likely effects on competition. These courts have determined that nonprofit entities have the same incentives to act anti-competitively as for-profits.

Not surprisingly, courts have responded differently to issues such as: whether the membership of a nonprofit hospital's board of directors ensures that the merged hospital will not exploit market power; whether the merging hospitals' previous public service suggests that the merged hospital will not act anti-competitively in the future; and whether the hospital's nonprofit status ensures that any efficiencies from the proposed merger will be passed on to the consumers.

A. Composition of the Board of Directors

According to the district courts in *United States v. Carilion Health System*[123] and *FTC v. Freeman Hospital,*[124] the membership of a nonprofit's board of directors may indicate that a nonprofit merger is less likely to raise antitrust concern than an equivalent for-profit merger. These courts found that the composition of the nonprofit hospitals' board of directors weighed in favor of finding the merger reasonable.[125] Each stated that a board's membership is a factor when determining whether to enjoin a merger, yet these courts ultimately concluded that the merger was not anti-competitive on other grounds.[126] According to the *Freeman* and *Carilion* courts, a board

123. United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

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

125. *See Carilion*, 707 F. Supp. at 849 (stating that the community board consisting of numerous local business leaders has an incentive to keep prices low). *See also Freeman*, 911 F. Supp. at 1222-23. The Seventh Circuit rejected the analysis of the *Carilion* court. *See* United States v. Rockford Memorial Corp., 898 F.2d 1278, 1286 (7th Cir. 1990). Post-*Butterworth*, the court in *Long Island Jewish Medical Center* noted that the hospital trustees are volunteers, who are community and business leaders. *See* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 126 (E.D.N.Y. 1997). In addition, the hospitals offer a large amount of free care. These factors suggest that "community service not profit maximization, is the hospitals' mission." *Id.* at 145-46.

126. In *Freeman*, the court held that the government had not established the geographic market. *See Freeman*, 911 F. Supp. at 1226-27. Likewise, in *Carilion*, the court found that the

consisting of community leaders prevents anti-competitive behavior and ensures that a merger's benefits are passed on to consumers.[127] These courts reasoned that even if an entity has market power, business and community leaders do not have an incentive to raise prices above a competitive level.[128] Indeed, the *Freeman* court accepted the theory that nonprofit hospitals act like a consumer cooperative when the board of directors has a stake as consumers in the hospital's operations.[129] Therefore, in both *Freeman* and *Carilion* the notion that nonprofits operate differently than for-profits because of their unique concern for the community and its needs underlies the courts' confidence in the community boards.[130]

Numerous courts have questioned the assumption that nonprofit hospitals lack economic incentives to act anti-competitively and

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actual geographic market was much broader than the definition offered by DOJ. *See Carilion*, 707 F. Supp. at 847-48. Therefore, the government did not establish that the hospitals would have market power in the geographic market. *See id.* The court in *Carilion* only briefly discussed the significance of nonprofit status, stating only that nonprofit status "militates in favor of finding their combination reasonable." *Id.* at 849. Similarly, while the post-*Butterworth* decision of the *Long Island Jewish Medical Center* court agreed that board composition suggests that profit maximization may not be the hospital's primary motivator, it still made clear that not-for-profit status should receive "only limited and non-determinative effect." *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 146. Instead, the decision relied on analysis of the merger's competitive impact. *See id.* at 149; *see also* Blumstein, *supra* note 119, at 117. Unlike *Butterworth*, the *Long Island Jewish Medical Center* court determined that the merger would not result in the hospital having an undue share of the market as at least one existing hospital could constrain the merged hospital's ability to raise prices above a competitive level. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 145.

127. *See Carilion*, 707 F. Supp at 846; *see also Freeman*, 911 F. Supp. at 1222-23.

128. *See Carilion*, 707 F. Supp. at 849; *see also Freeman*, 911 F. Supp. at 1222-23 (emphasizing that business and community leaders served on the board of directors).

129. The court in *Freeman* determined that community boards operate like a consumer cooperative and cited both Lynk and Hansmann. *Freeman*, 911 F. Supp. at 1222-23; *see* Lynk, *Nonprofit Hospital Mergers*, *supra* note 5, at 458 (stating that a board of directors that effectively represents the community likely operates more like a cooperative); *see also* Lynk, *Property Rights*, *supra* note 5, at 377 (noting that in cases involving nonprofit hospitals governed by a board of directors the "property rights" of the hospital "turn it essentially into a consumer cooperative"); Hansmann, *supra* note 20, at 889 (discussing that when owners of an organization have a stake in it as consumers, it is unlikely that prices will be raised above a normal competitive level). Outside of the hospital industry, the district court in *Fuchs v. Rural Electric Convenience Cooperative, Inc.* accepted this argument. *See* Fuchs v. Rural Elec. Convenience Cooperative, Inc., 672 F. Supp. 1111, 1114 (C.D. Ill. 1987).

130. *See Freeman*, 911 F. Supp. at 1222-23; *see also* FTC v. Freeman Hospital, 69 F.3d 260, 263 (8th Cir. 1995) (quoting the district court judge during a temporary restraining order hearing: "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."). There is a perception that the governance of a hospital is a local issue and the federal antitrust laws should not apply. *See* Entin et al., *supra* note 5, at 127-28. *But see* William J. Baer, Director of Bureau of Competition, *Antitrust and Health Care: New Approaches and Challenges*, Address Before the American Bar Association (Oct. 24, 1996), *available in* 1996 WL 613763 (F.T.C.) at *8-10 [hereinafter Baer Speech].

have rejected reliance on a board's ability to prevent anti-competitive behavior. In *HCA*, the court emphasized that nonprofit hospitals possess incentives to collude, noting fear of competition from for-profits and cost-containment policies of third-party payers.[131] Similarly, in *FTC v. University Health, Inc.*, the court was unconvinced that nonprofit status indicated that the merger would not have anti-competitive effects.[132] The court in *United States v. Rockford Memorial Corp.*[133] rejected the defendant's argument that a decisionmaker only acts anti-competitively when motivated by personal gain.[134] Instead, the court reasoned that other motivations, such as a higher salary, a better office or title, or new equipment may spur anti-competitive behavior.[135] In *Rockford*, the district court was skeptical that a community-oriented board could prevent the hospital from engaging in anti-competitive conduct.[136] The district court in *United States v. Mercy Health Services*[137] emphasized that "there is nothing inherent in the structure of the corporate board or the nonprofit status of the hospitals which would operate to stop any anti-competitive behavior."[138] Even if the current board intends to act in the public interest, this provides no assurance that its membership will not change and raise prices to an anti-competitive level.[139]

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131. *See* Hospital Corp. of America v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986); *see also* Magleby, *supra* note 2, at 168-69 (discussing that courts such as *HCA* and *Rockford* did not accept the argument that nonprofit hospital mergers are anti-competitive).

132. FTC v. University Health, Inc., 938 F.2d 1206, 1223 (11th Cir. 1991).

133. United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989) *aff'd*, 898 F.2d 1278 (11th Cir. 1990).

134. *See Rockford*, 717 F. Supp. at 1284.

135. *See id.* at 1284. On appeal, the circuit court stated that nonprofit hospitals were just as likely to act anti-competitively as for-profit hospitals. *See* United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

136. *See Rockford*, 717 F. Supp. at 1286-87 (stating that the board's composition and nonprofit status had not prevented anti-competitive behavior).

137. United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995).

138. *Id.* at 989. Notably, the court in *Mercy Health* concluded that the merger was not anti-competitive, however, it did not accept nonprofit status as a consideration. *See id.*

139. *See id.* (emphasizing that although the court believed the current board members did not intend to raise prices, if the board was replaced there remains potential for anti-competitive behavior unchecked by the structure of a nonprofit). In the most recent challenge to a merger of nonprofit hospitals, the court in *Long Island Jewish Medical Center* stated that it gave limited effect to the structure of the board for purposes of antitrust analysis and quoted *Mercy Health* for this proposition. United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 146 (E.D.N.Y. 1997).

B. Past Behavior of Merging Hospitals

In addition to the board's composition, the past behavior of the merging hospitals has also factored into the analysis of some of the courts that have considered nonprofit status. Specifically, these courts have looked at whether the merging parties have previously acted anti-competitively or whether the entities have acted in the community's best interests.[140] In *Freeman*, the court looked at the hospitals' past behavior and found collusion was unlikely to result from the merger.[141] In *University Health*, however, the court found the merger would have anti-competitive effects despite evidence of past public service.[142] The court explained that a well-intentioned board of directors, which had previously acted for the community's benefit, could always change its behavior.[143]

C. Consideration of Efficiencies

Prior to *Butterworth*, the two district courts that had considered nonprofit status relevant stressed that the claimed efficiencies produced by a merger would benefit consumers.[144] The district court in *Carilion* accepted the defendant's argument that the efficiencies would be realized by the merger and passed on to consumers.[145] The court believed that the nonprofit hospital's board of directors would ensure that consumers benefited from these savings.[146]

In contrast, the district court in *Rockford*[147] and the circuit court in *University Health*[148] were unconvinced that the respective mergers would produce efficiencies that would benefit the consumer. These courts made clear that efficiencies must be adequately proven and specific.[149] Significantly, these courts required a high level of

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140. *See* United States v. Carilion Health Sys., 707 F. Supp. 840, 842 (W.D. Va. 1989) *aff'd*, 892 F.2d 1042 (4th Cir. 1989); *see also* United States v. Freeman Hosp., 911 F. Supp. 213, 1224 (W.D. Mo. 1995) *aff'd*, 69 F.3d 260 (8th Cir. 1995).

141. *See Freeman*, 911 F. Supp. at 1224.

142. *See* FTC v. University Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991).

143 *See id.* at 1225-26.

144. *See e.g., Freeman*, 911 F. Supp. at 1224; *Carilion* 707 F. Supp. at 846.

145. *See Carilion*, 707 F. Supp. at 845-46.

146. *See id.* at 846.

147. *See* United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1291-92 (N.D. Ill. 1989) *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

148. *See University Health*, 938 F.2d at 1223 (stating that a defendant must show the efficiencies will benefit consumers).

149. *See id.* at 1223; *Rockford*, 717 F. Supp. at 1291.

evidence to find that efficiencies outweigh anti-competitive effects.[150] The savings achieved must outweigh the risks of a highly concentrated market.[151] Ultimately, these opinions emphasize that the effect of the efficiencies on competition is a significant consideration in antitrust analysis.[152]

V. ANALYSIS OF *BUTTERWORTH* AND THE ISSUES IT RAISES

A. District Court Decision

The district court in *Butterworth* refused to enjoin the merger between Blodgett and Butterworth, although it acknowledged that the merger would create high market concentration and bestow an undue market share on the merged entity.[153] The court emphasized that nonprofit status should be taken into consideration in evaluating the anti-competitive effects of the merger.[154]

The district court relied on a number of factors relating to nonprofit status in determining that the merger was unlikely to have anti-competitive effects. Although a few courts have given some weight to board composition and efficiencies, these courts paid much less attention to these factors than the *Butterworth* court.

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150. *See University Health*, 938 F.2d at 1222-23; *see also Rockford*, 717 F. Supp. at 1291 (requiring clear and convincing evidence).

151. *See Rockford*, 717 F. Supp. at 1291.

152. *See University Health*, 938 F.2d at 1222; *see also id.* at 1224; Baer Speech, *supra* note 130, at *10.

153. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1293-94 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam). In *Butterworth*, the HHI calculations made by the FTC's expert established that the relevant markets would be highly concentrated after the merger. *See Butterworth*, 946 F. Supp. at 1294. The merged entity would have 47 to 65 percent share of the market for general acute care inpatient hospital services. *See id.* As a result, the post-merger HHI in this market would be 2767 to 4521, an increase of 1064 to 1889 points. *See id.* Further, the merged facility would control between 65 to 70 percent of the primary care inpatient hospital services market, resulting in a HHI of between 4506 and 5079, an increase of 1675 to 2001 points. *See id.* The court also accepted the government's product and geographic market definitions and its entry analysis—that high barriers to entry existed. *See id.* at 1294, 1297-98. It is also notable that more evidence of competitive restraint existed in this case than in others that enjoined the proposed merger. *See University Health*, 938 F.2d at 1218-19; *see also* United States v. Rockford Memorial Corp., 898 F.2d 1278, 1283-84 (7th Cir. 1990).

154. *See Butterworth*, 946 F. Supp. at 1302; *see also* William McD. Miller, III, *Is There a Nonprofit Defense for Antitrust Health Care Mergers and Other Cases?*, 11 THE CHRON. 2, 7 (1997).

First, according to the district court, the defense expert's findings demonstrated that nonprofits act differently than for-profits.[155] In the court's view, this evidence suggested that the market share and concentration statistics did not accurately predict the merger's competitive effects.[156] The court accepted the defendant's argument that the traditional correlation between high prices and high concentration did not apply to nonprofits.[157] At least one expert, however, has suggested that the *Butterworth* decision was based more on the benevolent nature of the nonprofit board than a reasoned economic analysis.[158]

Second, the district court accepted the composition of the merging hospitals' boards as assurance that the merger would benefit the community.[159] Here, the court cited testimony of the chairmen of the Butterworth and Blodgett boards to demonstrate the boards' good intentions.[160] The court believed that the boards' structures, coupled with evidence that the price-concentration correlation did not apply to nonprofit hospitals, demonstrated that nonprofit hospitals do not share the incentive to maximize profits.[161]

According to the FTC, the merged hospital was just as likely to exercise its market power as a for-profit one. Both of the hospitals had previously attempted to reduce competition,[162] and one of the

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155. *See Butterworth*, 946 F. Supp. at 1295 (stating that Dr. Lynk first studied the California hospital industry and then used the same methods to look at the industry in Michigan). The court in *Butterworth* stated that Dr. Lynk's findings were "undisputed," citing to Dr. Lynk's law review article. *Id.* at 1297.

156. *See id.* at 1295-96. The defendants claimed to offer the type of empirical evidence discussed in *Rockford*. *See id.* at 1295. In that case, Judge Posner noted that evidence of price-concentration correlation for the hospital industry would be helpful in evaluating competitive effects. *See* United States v. Rockford Memorial Corp., 898 F.2d 1278, 1286 (7th Cir. 1990).

157. *See Butterworth*, 946 F. Supp. at 1295-96. But evidence indicates that the hospitals competed in the same manner as for-profits prior to the merger. *See* FTC Proof Brief, *supra* note 118, at 28-31 (discussing evidence that the two hospitals competed with each other on price which suggests that the traditional correlation applies and competition results in lower prices for managed care organizations and more efficient operations).

158. *See* Blumstein, *supra* note 119, at 110-11.

159. Other courts have explicitly rejected this argument. See *supra* notes 136-39 and accompanying text.

160. The Chairmen of the Blodgett and Butterworth boards testified that the two had decided to merge because of "a common desire to lower health care costs and improve the quality of care." *Butterworth*, 946 F. Supp. at 1297. The court mentioned the board chairmen by name. *See id.* One commentator has suggested the district court in *Butterworth* pointod out these individuals in an effort te hold them accountable for the future decisions of the merged hospital. *See* Miller, *supra* note 154, at 7-8.

161. *See Butterworth*, 946 F. Supp. at 1296-97.

162. *See* FTC Post-Trial Brief, *supra* note 118, at 71-72 The FTC stated the hospital had refused to give discounts te managed care organizations in services in which either institution had a monopoly. *See id.* at 71. According to the FTC, the two parties intended to merge so the

hospitals had achieved double digit profit margins.[163] Absent the merger, Blodgett planned to spend $200 million on a replacement facility although this amount was considered excessive.[164] The hospitals' actions suggested that the boards of directors, however well-intentioned, had little influence over hospital administrators and operations. Alternatively, the hospital boards may have aligned themselves with the institution, potentially preventing them from acting in the community's best interests.[165]

Third, the district court credited the Community Commitment as additional evidence of the merging hospitals' good intentions and that the merged hospital would not act anti-competitively in the future.[166] According to the district court, the Commitment "corroborates other evidence that nonprofit hospitals may be treated differently under the antitrust laws," and further suggests that the FTC's prima facie case inaccurately predicts the future conduct of the merged entity.[167] This decision appears to be the first time a federal court has accepted this type of price promise.[168]

In *Butterworth*, the Community Commitment had five parts in which the merged entity promised: (1) to freeze hospital charges for three years; (2) to freeze prices to managed care orgamizations; (3) to

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merged facility could exercise market power over managed care organizations. *See* FTC Proof Brief, *supra* note 118, at 29; FTC Post-Trial Brief, *supra* note 118, at 73.

163. *See* FTC Post-Trial Brief, *supra* note 118, at 72. The FTC also noted that the above-average profits achieved by both hospitals suggests that the boards of directers was not acting in the consumers' interests. *See Butterworth*, 946 F. Supp. at 1297. A local paper reported that Butterworth's profit margins had reached the double digits, suggesting that the hospital was more focused on the success of the institution than community interests. *See Another Look at Hospital Plan: FTC Should Appeal Judge's OK of Butterworth-Blodgett Merger*, THE GRAND RAPIDS PRESS, Oct. 3, 1996, at A16 [hereinafter *Another Look at Hospital Plan*]. The court in *Butterworth*, however, found these profits acceptable. *See Butterworth*, 946 F. Supp. at 1297. In addition, prior te the merger, Blodgett raised its prices. *See* Mary Chris Jaklevic, *Price Hikes to HMOs Preceded Merger of Michigan Hospitals*, MOD. HEALTHCARE, Nov. 10, 1997, at 2. Thus, the merged facility could then freeze prices to tbe HMOs at a higher price. *See id.*

164. *See* FTC Post-Trial Brief, *supra* note 118, at 95-96. A commission of community leaders had determined that Blodgett did not need to spend this amount to remain competitive. *See id.* at 96. Further, Blodgett intended to construct a replacement facility if the merger failed. *See Butterworth*, 946 F. Supp. at 1301; *see also Another Look at Hospital Plan, supra* note 163, at A16 (noting that the two hospitals had previously been more concerned with competing witb one another than acting in the community's interest).

165. *See infra* Part VI.B.1. The *Butterworth* court also noted the significant role of fiduciary duty to tbe hospital by stating that because of their duty to tbe hospital, absent the merger the Blodgett Board of Directors would continue with plans for a new facility. *See Butterworth*, 946 F. Supp. at 1301.

166. *See Butterworth*, 946 F. Supp. at 1298.

167. *Id.*

168. *See* Miller, *supra* note 154, at 8; *see also* Sunshine, *supra* note 60, at C16. For criticism of the use of this type of agreement, see *infra* Part V.C.

limit profit margins; (4) to serve the medically needy; and, (5) to govern the merged entity in the best interests of the community.[169]

The FTC challenged the Community Commitment on numerous grounds.[170] The FTC argued that the prices resulting from a freeze on charges would likely be higher than those in a competitive market.[171] It also expressed concern about the hospital equalizing rates to managed care because this practice limited these purchasers' ability to compete among themselves to obtain lower prices from the hospitals.[172] The FTC further argued that the profit margin commitment would permit the merged hospital to earn above what it would in a competitive market in which operating margins are expected to decline because of managed care and other third-party payers.[173] Moreover, it noted that an entity can get around the price limitations by reducing the quality of care provided.[174] Finally, the FTC noted that even though the parties agreed to make the Commitment legally binding,[175] it is unclear how this agreement will be enforced.[176]

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169. *See Butterworth*, 946 F. Supp. at 1298. The FTC only challenged the first three factors. *See id.*

170. *See id.* While the federal antitrust enforcement agencies have not accepted price promises, some state attorneys general have permittod mergers that have offered price commitments. *See* David Burda & Mary Chris Jaklevic, *Promises, Promises: Hospitals Are Using Price-Control Pledges to Win Antitrust Clearance from States, But the Feds Are Wary.* MOD. HEALTHCARE, Feb. 19, 1996, at 26, 27-32.

171. *See Butterworth*, 946 F. Supp. at 1298 (noting the FTC challenged the "charge commitment" as illusory because hospital price increases have been decelerating and prices might decrease); *see also* Baer Speech, *supra* note 130, at *9-*10.

172. *See Butterworth*, 946 F. Supp. at 1298 (stating the FTC claims this part of the Commitment is "deliberately anticompetitive"). If the merged hospital equalized prices for the managed care organizations this would raise the prices charged to some organizations and as a result, eliminate discounts. *See* FTC Post-Trial Brief, *supra* note 118, at 62. The district court in *Butterworth* believed that discounts to managed care organizations did not benefit consumers as a whole and were "hardly the sort of benefit the antitrust laws are designed to protect." *Butterworth*, 946 F. Supp. at 1299.

173. *See* FTC Post-Trial Brief, *supra* note 118, at 74-75.

174. *See* Baer Speech, *supra* note 130, at *10. Nothing in the Commitnent requires a certain level of quality. *See Butterworth*, 946 F. Supp. at 1298.

175. *See Butterworth*, 946 F. Supp. at 1298 (stating that the defendants were willing to enter into a consent decree making the Community Commitment legally binding).

176. *See id.* (stating that the FTC challenges the plan in part because it is unenforceable). The FTC did not agree to the consent decree, leaving the district court judge te enforce it. The FTC does not have resources to regulate this type of written assurance. *See* Burda & Jaklevic, *supra* note 170, at 28. The district judge, however, did not agree to have jurisdiction over enforcement of the Community Commitment. *See* Deanna Bellandi, *Being Not-For-Profit Helps: In Antitrust Cases, Judges Have Been Giving Hospitals Credit for Tax-Exempt Status,* MOD. HEALTHCARE, Nov. 10, 1997, at 17.

Finally, the district court was convinced that the merger would result in substantial efficiencies.[177] This decision appears to be based, in part, on the court's belief that competition in the hospital industry does not result in lower costs.[178] According to the hospitals' expert, the efficiencies achieved by a merger between two nonprofit hospitals may, in part, explain the absence of price-concentration correlation in nonprofits.[179] Because of the parties' nonprofit status and Community Commitment, the district court concluded that these savings would be passed on to consumers.[180]

B. Critique of District Court Decision

The district court in *Butterworth* accepted the defendant's argument that nonprofit hospitals operate differently than for-profits, and found that the merger would not have anti-competitive effects. In so doing, *Butterworth* departed from traditional antitrust analysis and prior case law. Contrary to antitrust doctrine, the court allowed goveruance by the board of directors and the Community Commitment to replace competition. Consideration of the hospital's nonprofit status does not fit into the antitrust framework because it does not justify lessened concern about the merger's anti-competitive effects. Furthermore, the previous cases that considered nonprofit status a relevant factor in their evaluation of the proposed merger ultimately allowed the merger to proceed based on other grounds. In contrast, the *Butterworth* court relied on the merging hospitals' nonprofit structure to ensure that the merged entity would not act anti-competitively in the future.

1. Departure from Traditional Antitrust Policy

Butterworth departs from prevailing antitrust doctrine by finding tlıat a merger among nonprofit hospitals requires different treatment tlıan one among for-profits. The Clayton Act is intended to prevent mergers whose effect "may be substantially to lessen competi-

177. *See Butterworth*, 946 F. Supp. at 1300-01. The court, however, did not adequately evaluate the claimed efficiencies especially in light of the fact that it considered efficiencies as part of the defendant's rebuttal evidence. See Greaney, *supra* note 16, at 219.

178. *See Butterworth*, 946 F. Supp. at 1301 (stating that absent the merger, the "medical arms race" will continue).

179. *See Butterworth*, 946 F. Supp. at 1295 (quoting Lynk, *Nonprofit Hospital Mergers*, *supra* note 5, at 458).

180. *See Butterworth*, 946 F. Supp. at 1301.

tion,"[181] because undue increases in market power will allow an entity to raise prices above a competitive level and thus injure consumers.[182] Since Congress has determined that reduced competition hurts consumers, a court should only determine whether competition is lessened.[183] Once a court determines that the merger will cause competitive harm, specific characteristics of an industry,[184] motives,[185] or organizational structure[186] become irrelevant. A court may not replace competition with another method of allocating goods and services.[187]

The district court declined to enjoin the merger, even though it recognized that the merged hospital would have substantial market power, unchallenged by the remaining hospitals or potential entrants.[188] The court made its own determination about how the merger would affect the community and relied on the alleged good motives of the merging hospitals to find that the merger would not have anti-competitive effects. In its view, the governing body of the merged hospital would act in the best interests of the community. Even if the board of the merged entity was well-intentioned, the court's decision was contrary to antitrust doctrine because it allowed the board to make decisions about allocation, rather than allowing market forces to operate.[189]

a. Consideration of Motive

In both *Philadelphia National Bank* and *NCAA*, the Supreme Court held that good motives cannot validate a practice which violates the antitrust laws.[190] These decisions establish that when market power is abused, good intentions are irrelevant to antitrust analy-

181. 15 U.S.C. § 18 (1994).

182. *See* Hospital Corp. of America v. FTC, 807 F.2d 1381, 1386 (7th Cir. 1986); *see also* NCAA v. Board of Regents, 468 U.S. 85, 104 (1984).

183. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978).

184. *See id.* at 689.

185. *See NCAA*, 468 U.S. at 101 n.23 (stating that "good motives will not validate an otherwise anticompetitive practice.").

186. See *supra* notes 84-88 and accompanying text.

187. A court may not determine if another method is better than competition. *See* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 371 (1963).

188. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1294 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam). The court acknowledged that the two remaining hospitals would not challenge the merged hospital's market power. *See id.*

189. *See* Sunshine, *supra* note 60, at C16.

190. *See Philadelphia Nat'l Bank*, 374 U.S. at 371; *see also NCAA*, 468 U.S. at 100 n.23.

sis.[191] Thus, if a merger is potentially anti-competitive, a court cannot rely on the claimed good intentions of a board of directors to rebut the presumption of illegality. Appellate courts have also rejected the argument that good motives can validate a merger that otherwise violates the antitrust laws.[192] Abuse of market power, even if motivated by good intentions, still causes consumer injury and violates the antitrust laws.[193]

b. The District Court Allowed Community Governance to Replace Competition

Moreover, through the federal antitrust statutes, Congress has mandated that competition is the best guarantor of consumer welfare.[194] The Supreme Court has stated that a court may not substitute another method of allocating goods and services for competition.[195] In *Professional Engineers*, the Court made clear that defendants may not question the benefits of competition. The Court held that if unique characteristics of an industry suggest competition is inapplicable, only Congress can exempt the industry from antitrust scrutiny.[196] In *Butterworth*, however, the court did not rely on competitive forces, finding instead that a board of directors consisting of community leaders and the Community Commitment sufficiently protected consumers.[197] The court allowed these factors to replace competition.

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191. Although motive is irrelevant for anti-competitive conduct, the actors' subjective intent can help a court evaluate the anti-competitive potential of the conduct. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 265-66.

192. *See* FTC v. University Health, Inc., 938 F.2d 1206, 1213 (11th Cir. 1991) (rejecting the argument that a merged hospital will not act anti-competitively because of its nonprofit structure); *see also* United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

193. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 267. Nonprofits must still make decisions about the allocation of profits, and if a nonprofit entity is using market power to charge anti-competitive prices this violates the antitrust laws. *See id.* Further, even if a board has good intentions, the consumer coop analogy will not work if the hospital is part of a chain or if the board only represents a limited segment of the community. *See* Lynk, *Property Rights*, *supra* note 5, at 377.

194. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978).

195. In *Professional Engineers*, the Court rejected the association's argument that competition in its industry was detrimental to consumer welfare. *See id.* at 689-90; *see also* FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411, 423-24 (1990).

196. *See Professional Eng'rs*, 435 U.S. at 689-90 (stating that a court cannot determine if competition is good or bad for a particular industry because this choice must be addressed by the legislature). Congress has determined that certain industries, such as agricultural cooperatives and insurance, are exempt from all Sherman Act requirements. *See id.* at 690 n.14.

197. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam) (stating that "the interests of consumers are . . . likely to be advanced rather than hurt" by the merger). Compare the type of regulation the court allows here te the strict requirements for regulation by the state as discussed *supra* notes 98-99 and accompanying text.

In short, instead of accepting the value of competitive markets as required by Supreme Court precedent, the court made its own determination about what method best protects consumer welfare in the nonprofit hospital industry.

2. Contrary to Prior Case Law

The *Butterworth* district court claimed to follow previous case law by stating that it did not rely on nonprofit status itself. It also argued that earlier cases suggested that status, along with other evidence demonstrating that the merger will not have anti-competitive effects, can be relevant when determining whether to enjoin a merger.[198]

Although the court stated nonprofit status was not a "dispositive consideration,"[199] all of the evidence relied upon by the district court suggests the hospitals' status was indeed dispositive. Arguably, this case is inconsistent with prior case law, which holds that a court cannot consider nonprofit status alone to rebut the presumption of illegality.[200]

Even if the court treated nonprofit status as a "material" factor,[201] the *Butterworth* case marks a significant shift from prior case law.[202] In the hospital context, the Seventh and Eleventh Circuits[203] and one district court[204] have held that nonprofit mergers in concentrated markets raise the same antitrust concerns as equivalent for-profit mergers. In contrast, the district court in *Butterworth* presumed that a nonprofit merger was less likely than a for-profit one to have anti-competitive effects. The court made this determination absent evidence that justified lessened concern and instead relied on the claimed good intentions of the merging hospitals to prevent anti-competitive behavior. Although two other district courts had considered nonprofit status relevant, these courts ultimately permitted the

198. *See id.* at 1297.

199. *See id.*

200. *See* Hospital Corp. of America v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986); *see also* FTC v. University Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991); United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

201. *See Butterworth*, 946 F. Supp at 1297.

202. *See* Greaney, *supra* note 16, at 211-12 (stating that *Butterworth* is in "stark contrast" to the holding of *Freeman* which is consistent with prior case law).

203. *See, e.g., University Health*, 938 F.2d at 1224; *Rockford*, 898 F.2d at 1285; *Hospital Corp. of America*, 807 F.2d at 1390-91.

204. *See* United States v. Mercy Health Services, 902 F. Supp. 968, 989 (N.D. Iowa 1995) *vacated by* 107 F.3d 632, 634 (8th Cir. 1997).

mergers for other reasons and placed much less significance on nonprofit status.[205]

3. *General Dynamics* Merger Inquiry

Market share and concentration data may not always indicate market power will result from the merger. At first glance, the district court's reliance on nonprofit status is consistent with the Supreme Court's decision in *United States v. General Dynamics*. There the Court held that a court can consider evidence that indicates the proposed merger is unlikely to have anti-competitive effects despite statistical evidence te the contrary.[206] In *General Dynamics*, one of the merging firms had experienced severe reductions in its coal reserves and was unable to compete in the future.[207] The one party's reduction in resources and its limited ability to compete prospectively prevented the market share data from adequately predicting the defendant's future competitive strength.[208]

In contrast, in *Butterworth*, evidence indicated that the defendants had competed in the past.[209] The parties simply claimed that the merged facility would not take advantage of its market power because of its nonprofit status,[210] an argument that differs from the one accepted by the Court in *General Dynamics*.[211] First, in *Butterworth*, the court recognized that the merger would lessen competition in the marketplace.[212] Unlike *General Dynamics*, the merged hospital would maintain competitive strength. Second, because Butterworth and Blodgett competed like for-profits in the market prior to the merger, they could not argue that the merged entity would cease to act like a for-profit and exploit its market power. Therefore, the market share

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205. Note that post-*Butterworth*, the *Long Island Jewish Medical Center* court considered nonprofit status a factor in its overall analysis but ultimately determined that the government had not proved that the merger would have anti-competitive effects, finding, unlike *Butterworth*, that the merged entity would not have an undue market share in the relevant markets and remaining hospitals could constrain prices. *See supra* note 139 and accompanying text.

206. United States v. General Dynamics Corp., 415 U.S. 486, 497-98 (1974).

207. *See id.* at 493.

208. *See id.* at 501. Because current merger analysis looks at how much the merger will reduce competition, the consideration of this type of evidence is consistent with the Merger Guidelines. *See* MERGER GUIDELINES, *supra* note 49, § 0.2, 2.2.

209. *See* FTC Post-Trial Brief, *supra* note 118, at 94; *see also Another Look at the Hospital Plan*, *supra* note 163, at A6.

210. *See Butterworth*, 946 F. Supp. at 1294-97.

211. *But see* Greaney, *supra* note 16, at 215-16 (arguing that the *Butterworth* decision adhered to the *General Dynamics* framework).

212. *See Butterworth*, 946 F. Supp. at 1294.

statistics painted an accurate picture of the merged entity's market power and raised antitrust concerns. Third, while the Court in *General Dynamics* relied on objective economic data to adjust the economic model's predictions of how much a profit-maximizing firm can influence the market, the *Butterworth* court predicted behavior based on subjective intent that led the court to reject the basic postulate of the economic model underlying antitrust law: that firms operate to maximize profits. The court made a determination about what the entity *would* do with market power rather than focusing on what the entity was *capable* of doing with this power.

In sum, the *General Dynamics* Court held that the government did not prove its prima facie case that the merger would produce anti-competitive effects. Because the proposed merger would not lessen future competition, no antitrust concern resulted.[213] Although the FTC proved its prima facie case in *Butterworth*, the court concluded nonprofit status would prevent anti-competitive results and consumers would not be harmed.[214]

C. Competition Guarantees Consumer Welfare

The *Butterworth* decision raises some interesting issues regarding merger analysis. The court held that "even though competition may be lessened, the interests of consumers are . . . likely to be advanced rather than hurt."[215] Congress, however, intended to protect consumers by maintaining competition[216] and the Supreme Court has stated that Congress has mandated competition as the guiding principle for judicial decision making.[217] The antitrust laws protect the competitive process, as competition produces the optimum outcome for consumers.[218]

Community governance is not an adequate replacement for competition for several reasons. First, competition is a more reliable safeguard of an efficient market and consumer welfare than commu-

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213. *See* United States v. General Dynamics Corp., 415 U.S. 486, 503-04 (1974).

214. *See Butterworth*, 946 F. Supp. at 1294.

215. *See id.* at 1301.

216. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978). As recognized in current case law, Section 7 proscribes mergers that are likely to "hurt consumers, as by making it easier for the firms in the market to collude . . . and thereby force price above or farther above the competitive level." Hospital Corp. of America v. FTC, 807 F.2d 1381, 1386 (7th Cir. 1986); *see also* United Statos v. Rockford Memorial Corp., 898 F.2d 1278, 1282-83 (7th Cir. 1990) (quoting *Hospital Corp. of America*, 807 F.2d at 1386).

217. *See Professional Eng'rs*, 435 U.S. at 695.

218. *See* Meyer & Rule, *supra* note 7, at 181. *See also* Blumstein, *supra* note 119, at 111.

nity governance.[219] Competition encourages producers to offer the best quality at the lowest price.[220] It is also the most efficient method of allocating goods and services, and the best indicator of consumer demand.[221] Antitrust law, moreover, focuses on whether the merged entity will be able to exercise market power without restraint. The law seeks to protect the competitive process rather than mandate a particular outcome.[222]

Studies indicate that regulation has not effectively reduced hospital costs or promoted efficient behavior.[223] A number of states that have regulated hospital prices are eliminating this practice and replacing regulation with a competitive market.[224] In other industries, courts have also recognized that regulation is not an adequato substitute for competitive free markets.[225]

Second, competition provides incentives for entities to provide information to consumers, allowing consumers to make choices about quality and price.[226] The subjective judgment of a board of directors or the court removes the consumers' freedom to choose. Furthermore, because Congress has determined that competition ensures consumer welfare by providing incentives for optimal quality at the lowest price, regulation may only replace competition if a federal or state immunity exists.[227]

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219. *See* Meyer & Rule, *supra* note 7, at 171 (stating the competition is the hest method for ensuring consumer welfare); *see also* Baer Speech, *supra* note 130, at *9. In addition, nonprofit hospitals that do not face competition will provide unnecessary resources and equipment to their staff physicians. *See* John Simpson & Richard Shin, Do Nonprofit Hospitals Exercise Market Power? 2-3 (unpublished manuscript, on file with author). Competition serves an important role in preventing inefficient expenditures "for which good intentions are rarely a sufficient substitute." *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 267.

220. *See Professional Eng'rs*, 435 U.S. at 695 (explaining that the Sherman Act indicates a judgment by the legislature that competition produces lower prices and better goods and services).

221. See ELBERT V. BOWDEN, ECONOMICS: THE SCIENCE OF COMMON SENSE 138-39 (1974). The failure of central planning in the USSR demonstrates the superiority of competitive free markets. *See* FTC Proof Brief, *supra* note 118, at 22; *see also*, LEONARD SILK & MARK SILK, MAKING CAPITALISM WORK 12, 15 (1996).

222. *See* Blumstein, *supra* note 119, at 111.

223. *See* Baer Speech, *supra* note 130, at *9.

224. *See id.*

225. *See* FTC v. Alliant Techsystoms Inc., 808 F. Supp. 9, 16 (1992) (responding to defendants claim the Department of Defense's cost monitoring and auditing would prevent the exercise of market power). The court statod, "[t]here is persuasive opinion in the record that Army oversight, while effective, is an imperfect substitute for the action of the competitive market." *Id.*

226. *See* Simpson & Shin, *supra* noto 219, at 24 (finding that nonprofits exercise market power against privatoly insured patients).

227. *See* Meyer & Rule, *supra* noto 7, at 175; *see also* NCAA v. Board of Regents, 468 U.S. 104 n.27 (1984) (suggesting that with the passage of the Sherman Act, Congress intended to pro-

Analysis of the factors accepted by the *Butterworth* court demonstrates that enforcement by a community board or a price commitment is an inadequate substitute for a competitive market. First, the evidence accepted by the *Butterworth* court does not provide permanent assurance that the entity will not act anti-competitively.[228] For example, even if the board of directors is community-minded, the risk of change in membership of community board exists. Second, there is no guarantee that a nonprofit board will act in the best interests of the community or have adequate control over management to prevent the merged entity from raising prices above a competitive level.[229] The danger is exacerbated by the fact that reduced competition flowing from the merger would give the board nearly unfettered discretion te behave anti-competitively.[230] Third, even assuming the hospital believes it is acting in the consumers' best interests, it is unlikely to produce the same efficient results of a competitive market.[231] For instance, prices might fall if the market was left to operate. No matter how well-intentioned, externally-imposed protections are inherently inferior to market outcomes.[232] Market pressures create incentives for the entity to benefit consumers through innovation, reduction of costs or improved quality.[233]

The price promises accepted in *Butterworth*, like community goverance, are similarly less efficient than the free market in allocating goods and services. The protection provided by the Community Commitment is also questionable. As acknowledged by the *Butterworth* court, this type of commitment does not "provide failsafe assurances to the community."[234] Even if the commitment does protect consumers, a price assurance is a temporary safeguard.[235]

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mote a policy of competition and free trade which would only be replaced in specific circumstances).

228. *See NCAA*, 468 U.S. at 101 n.23 (stating that good intentions do not provide adequate protection for consumers); *see also* FTC v. University Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991).

229. *See infra* Part VI.B.1.

230. *See* Blackstone & Fuhr, *supra* note 32, at 474.

231. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 267.

232. *See* Blumstein, *supra* note 119, at 110-11.

233. *See* Meyer & Rule, *supra* note 7, at 171.

234. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1298 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam).

235. The Community Commitment only limits hospital charges for three years and profit margins for four years. *See id.*; *see also* Burda & Jaklevic, *Promises, Promises*, *supra* note 170, at 30 (explaining that term lengths are a negotiating point in these types of agreements).

VI. NONPROFIT STATUS IS NOT AN ACCURATE PREDICTOR OF A MERGER'S ANTI-COMPETITIVE EFFECTS

Nonprofit status is distinguishable from characteristics that may challenge the accuracy of the analysis of the merger's competitive harm. Moreover, concerns exist about the ability or desire of a nonprofit hospital board to guarantee that the nonprofit entity does not exploit market power. These issues, along with evidence that price-concentration applies to nonprofits because nonprofits and for-profits operate similarly in highly concentrated markets, indicate that a court should not consider nonprofit status as equivalent to those factors that may successfully rebut a prima facie case.

A. Application of the Antitrust Framework to Nonprofit Status

As discussed above, courts have considered factors such as ease of entry, the imminent exit of a firm from the market, and efficiencies as evidence that a proposed merger will not lessen competition despite market share and concentration statistics that suggest otherwise. First, if entry into a market is "easy," the anti-competitive effects that normally flow from high market share and concentration will not result.[236] If other competitors can easily enter the market and challenge the existing entities' ability to reduce output and raise prices, the existing firms will not be able to exercise market power.[237] Unlike ease of entry, nonprofit status does not ensure that the entity will not abuse market power. Instead, a court which allows nonprofit status to rebut the presumption of illegality assumes that nonprofits will refrain from exploiting market power because of good motives and thus depends on the future benevolence of the merged firm, rather than market analysis. The amount of power a firm possesses becomes irrelevant because the court trusts the entity to use it wisely. In contrast to nonprofit status, ease of entry speaks directly to the merged entity's ability to exercise market power.

If a firm will fail absent the proposed merger and that firm's assets will leave the relevant market, the merger will not create or enhance market power.[238] Nonprofit status, however, does not indi-

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236. *See* Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc., 784 F.2d 1325, 1336 (7th Cir. 1986). Analysis of entry conditions is a fact-intensive inquiry that looks at whether the merged entity will be able to exercise market power. *See* MERGER GUIDELINES, *supra* note 49, § 3.0-3.4. The most reliable evidence of ease of entry is past entry in a context similar to the current one. *See* 2A AREEDA ET AL., *supra* note 50, ¶ 420b, at 58.

237. *See Ball Memorial*, 784 F.2d at 1335.

238. *See* MERGER GUIDELINES, *supra* note 49, § 5.0.

cate that the same level of competition will exist post-merger.[239] Furthermore, courts have rejected the argument that a nonprofit hospital's past behavior ensures anti-competitive conduct will not occur in the future.[240]

Efficiencies that generate increased competition or more effective competition benefit consumers.[241] In some cases, efficiencies outweigh the risk of increased market concentration.[242] Unlike the pro-competitive benefits of efficiencies, which counterbalance the risks of increased concentration, nonprofit status does not advance competition and is not an inherently pro-competitive factor.

In sum, current evidence regarding nonprofit status does not suggest that it is equivalent to those factors which show that the statistical market share and concentration data presents an inaccurate picture of a merger's competitive effects.[243] Reliance on nonprofit status negates the economic analysis underlying antitrust law. A court which allows nonprofit status to rebut the presumption of ille-

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239. Arguably, if the nonprofit parties can show that they did not compete like for-profits prior to the merger and, therefore, that the merger would not lessen competition, the parties could establish something akin to the failing firm defense. This scenario is, at best, unlikely, given the studies which suggest nonprofit hospitals behave like for-profits.

240. *See supra* notes 142-43 and accompanying text.

241. *See* Baer Speech, *supra* note 130, at *10; *see also* MERGER GUIDELINES, *supra* note 49, § 4 (Revised Apr. 8, 1997).

242. The Merger Guidelines explains that efficiencies must be substantial "to reverse the merger's potential to harm consumers in the relevant market." *See* MERGER GUIDELINES, *supra* note 49, § 4.0 (Revised, Apr. 8, 1997). The higher the concentration resulting from the merger, the more substantial efficiencies the defendant must show. *See id.* Courts weigh the efficiencies evidence against the risk of a highly concentrated market. *See* FTC v. University Health, Inc., 938 F.2d 1206, 1222-23 (11th Cir. 1991); *see also* United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1291 (N.D. Ill. 1989) *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

243. The illegitimacy of reliance on nonprofit status in antitrust analysis is evidenced by the possibilities it creates. First, a conversion of a hospital from nonprofit status to for-profit status could be challenged despite no increase in concentration. Because conversion of nonprofit hospitals has become increasingly common, it is not unlikely that a nonprofit will be purchased by a for-profit hospital. *See* Krause, *supra* note 34, at 506. If a court relied on nonprofit status to prevent anti-competitive behavior, a conversion to for-profit form removes any existing restraints on the exercise of market power. An integral part of antitrust doctrine, however, is consideration of the merger's effect on market concentration in order to challenge a merger. If a federal antitrust enforcement agency challenged this type of merger it would conflict with traditional antitrust doctrine which requires increased concentration and does not consider ownership status relevant to antitrust analysis.

On the other hand, if ownership was transferred from a nonprofit to a for-profit and the merger was not challenged, a for-profit would achieve market power. Traditional antitrust doctrine assumes that a for-profit will abuse this power and thus injure consumers. The economic analysis underlying antitrust law is based on a profit-maximizing model. *See* MERGER GUIDELINES, *supra* note 49, § 1.0.

Another possibility is that a nonprofit hospital outsources some of its health care services to a for-profit. Even assuming the nonprofit governance does not possess the economic incentives to act anti-competitively, whether a nonprofit board would be able to prevent a for-profit from exercising market pewer is questionable at best.

gality assumes that the public can rely on a firm's self-restraint. This assumption makes market analysis irrelevant; the court does not focus on the amount of market power possessed because the court trusts the firm to use it benevolently.

B. Concerns Which Further Demonstrate Nonprofit Status is Unlike the Factors That Fall Within the Antitrust Framework

1. Board of Directors

Courts that have given any consideration to nonprofit status have concluded that a nonprofit hospital board ensures that the merged entity will not exercise market power.[244] These courts assume that a nonprofit board has good motives and will benefit consumers. This confidence may be misplaced because arguably a board consisting of community members is not analogous to a consumer cooperative, thus removing any incentive to refrain from anti-competitive behavior.[245] Even a well-intentioned board may not act competitively or be able to prevent hospital management from acting anti-competitively.[246] First, the board members have a fiduciary duty of care and loyalty to the nonprofit hospital and will likely align with the institution.[247] These duties to the hospital may prevent the board from acting in the community's best interests.[248] Second, the board

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244. This confidence is based, in part, on the theory that a community board does not have the incentive to act anti-competitively. *See* Entin et al., *supra* note 5, at 127-28.

245. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 266 (discussing the divided loyalty of a member to the public and the entity that appointed him); Bozeman, *supra* note 45, at 149. Note that Lynk states that the consumer cooperative analogy does not work if the hospital board is subject to pressure from interests outside of the patient population or if the board only represents the interests of a limited group of patients. *See* Lynk, *Nonprofit Hospital Mergers*, *supra* note 5, at 458.

246. The federal antitrust agencies reject consideration of the board's makeup. *See* Baer Speech, *supra* note 130, at *9. Some antitrust scholars maintain that reliance on a nonprofit hospital's board does not guarantee that the community will not be harmed. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 266. The FTC used *University Health*, *Rockford* and *Mercy Health Services* to reject the defendant's argument in *Butterworth*. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1296 (W.D. Mich. 1996) *aff'd*, 121 F.3d 708 (6th Cir. 1997) (per curiam).

247. *See* FTC Post-Trial Brief, *supra* note 118, at 96-98. The FTC also notes that alignment with the institution is a result of fiduciary duty. Trustees may also want to promote the status of the institution because it reflects well on them. Thus they may be less concerned about controlling health care costs. *See id.*

246. In *Butterworth*, the FTC argued that board members may develop institutional loyalty that could overcome the board's community interests. *See Butterworth*, 946 F. Supp. at 1297. For example, low consumer prices may in some cases be contrary to a director's fiduciary duty te the institution. *See* Greaney, *supra* note 16, at 217. The duty to the community may also not guarantee that the board acts in the public interest. *See* 1A AREEDA & HOVENKAMP, *supra* note

may not act on behalf of consumers if its members have conflicts of interest[249] or if the board is not representative of the community as a whole.[250] Furthermore, because directors are not responsible for the day-to-day operations of the hospital, they may have limited information about pricing practices and often rubber-stamp the decisions of management.[251] Studies indicate that the board members depend on management for information and follow their instructions.[252] Board members also often do not have technical expertise in the nonprofit's operations.[253] Therefore, the board is also likely to have inadequate oversight over the management's decisions.[254] Thus it seems that even the most well-intentioned board will not act as efficiently as it would if subject to competitive forces.[255]

3, ¶ 261c, at 266 (questioning reliance on a board to act in public interest); *see also* Steinberg, *supra* note 90, at 291 (stating that the board's fiduciary duty to the community may not prevent anti-competitive conduct by the board because violations of this duty are rarely enforced).

249. *See* Joseph Berger, *Hospital is Haunted by History of Deals with Board Members*, N.Y. TIMES, Mar. 14, 1999, at 37.

250. *See Another Look at the Hospital Plan*, *supra* note 163 (stating that the community had no assurance post-merger that community interests would be represented on the board); *see also* Lynk, *Nonprofit Hospital Mergers*, *supra* note 5, at 440-41, 448; Karla Schuster, *Boca Raton Residents Don't Trust Trustees*, SUN-SENTINEL, Sept. 26, 1997, at 1B, *available in* 1997 WL 11404090.

251. *See* Deborah A. DeMott, *Self-Dealing Transactions in Nonprofit Corporations*, 59 BROOK. L. REV. 131, 140 (1993) (stating that nonprofit boards may rely on management for information); Greaney, *supra* note 16, at 217 (explaining that outside members of boards of nonprofit corporations rarely involve themselves in everyday business decisions); *Ceding Local Control Is the Price To Be Paid For System Advantages*, MOD. HEALTHCARE, June 5, 1995, at 36 (stating that local boards often feel that they are rubber-stamping decisions).

252. *See* Melissa Middleton, *Nonprofit Boards of Directors: Beyond the Governance Function*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 141, 143, 152 (Walter W. Powell ed., 1987) (concluding that studies show board members acquire most information from management and follow instructions of management).

253. *See* Brody, *supra* note 24, at 467, 500-01 (stating that nonprofit directors usually lack technical expertise in the nonprofit hospitals' operations).

254. *See* Monica Langley, *Trauma Center: A Nonprofit Hospital Finds Its Executives Were Making the Profit*, WALL ST. J., Nov. 20, 1996, at A1 (quoting numerous sources stating that nonprofit hospital boards lack supervision over hospital management); *see also* Brody, *supra* note 24, at 499 (discussing that nonprofit outside directors often lack the time and expertise to have control over management); Sally Covington, *Who Governs The Non-Profit Sector?*, FUND RAISING MGMT., July 1, 1994, at 33, *available in* 1994 WL 2810915; Gilbert, *supra* note 46, at 155 (1994) (noting that the IRS is concerned about a nonprofit board's lack of oversight).

255. *See supra* notes 228-33 and accompanying text; *see also* Baer Speech, *supra* note 130, at *9.

2. Evidence Suggesting the Traditional Price-Concentration Correlation Applies to Nonprofit Hospitals

The district court in *Butterworth* relied on one empirical study conducted by the hospital's expert in determining that the traditional presumption does not apply to nonprofit hospitals. According to numerous economists, however, this expert failed to control significant variables that would affect his study's conclusion.[256] Moreover, many experts have found that the traditional correlation between high market concentration and high prices applies to nonprofit hospitals.[257] These studies support the argument that antitrust agencies should challenge nonprofit mergers in concentrated markets because these mergers are just as likely to raise antitrust concerns as similar for-profit mergers.[258]

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256. Lynk's methods and conclusions have been criticized. *See* Mary Chris Jaklevic, *Ownership and Pricing: Economists Knock Key Study in Grand Rapids Case* MOD. HEALTHCARE, Oct. 6, 1997, at 2; *see, e.g.,* David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87, 88 (1999) (listing two methodical choices that generate bias)); Keeler et al., *supra* note 112, at 83; Simpson & Shin, *supra* note 219, at 22; FTC Proof Brief, *supra* note 118, at 32 (arguing that Dr. Lynk's study does not account for numerous significant factors such as cost which may be lower in rural areas where the hospital market is more concentrated). In addition, Lynk used list prices instead of the transaction prices. *See* FTC Post-Trial Brief, *supra* note 118, at 72. The use of list prices may affect a study's conclusion regarding traditional assumptions about high market concentration. *See* Dranove et al., *supra* note 109, at 181, 188. Absent from the study relied upon by the *Butterworth* court is a discussion of the quality of care provided. *See* Sunshine, *supra* note 60, at C15-C16. Looking only at price does not take into account the quality of care given. *See* Paul A. Pautler & Michael G. Vita, *Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?* 10 J. CONTEMP. HEALTH L. & POL'Y 117, 133, 140 (1994). Note that Lynk has responded to these challenges. *See generally* William J. Lynk & Lynette R. Neuman, *Price and Profit*, 18 J. HEALTH ECON. 99 (1999).

257. *See* Dranove & Ludwick, *supra* note 256, at 97 (rejecting Lynk's finding that nonprofit mergers are associated with lower prices); Keeler et al., *supra* note 112, at 83 (finding that nonprofit mergers lead to higher prices). Nonprofit hospitals set higher prices when they have market power. *See* Simpson & Shin, supra note 219, at 24. The need to cross- subsidize may be a motive for a nonprofit hospital to use market power. *See* 1A AREEDA & HOVENKAMP, *supra* note 3, ¶ 261c, at 267. In fact, William Lynk, notes this in his own article. *See* William J. Lynk, *Antitrust Analysis and Hospital Certificate-of-Need Policy*, 32 ANTITRUST BULL. 61, 68-69 (1987) (explaining why the process of "cross-subsidizations" is economically inefficient).

258. *See* Dranove & Ludwick, *supra* note 256, at 19; *see also* Gruber, *supra* note 114, at 208 (suggesting that nonprofit hospitals exploit market power to fund indigent care); *see also* Simpson & Shin, *supra* note 219, at 24. Evidence exists that nonprofits exercise market power. *See id.* at 18 (finding nonprofits exercise market power against private insurers).

VII. CONCLUSION

The district court in *Butterworth* held, and the Sixth Circuit affirmed, that a merger between two nonprofit hospitals would not have anti-competitive effects. Although the FTC's prima facie case demonstrated that the merger would reduce competition, the district court presumed that the nonprofit nature of the merged hospital would ensure the merger would not harm consumers.

Reliance on the good intentions of a nonprofit board in evaluating whether a merger will have anti-competitive effects, however, departs from traditional antitrust analysis and prior case law. Congress has determined that preserving competition, instead of relying on regulation and monitoring, is the best way to protect consumers. Congress can make a legislative judgment that competition is not effective in a specific industry, and states can nse the state-action doctrine to replace competition. The role of the courts in antitrust cases, however, is to focus on the merger's likely competitive effects. Nonprofit status is distinguishable from the factors which demonstrate that market share and concentration statistics inaccurately predict the merger's effects. These factors fit within traditional antitrust analysis because they demonstrate that a proposed merger will not lessen competition. In contrast, nonprofit status does not indicate that the proposed merger will not have anti-competitive effects. Thus, reliance on the future benevolence of the merged entity does not fit into the legal framework of merger analysis.

A merger among nonprofit hospitals in a concentrated market raises the same antitrust concerns as a merger among for-profit hospitals in similar circumstances. Studies have found that nonprofit and for-profit hospitals share critical similarities in their conduct, and that the price-concentration correlation does apply to nonprofit hospitals. Furthermore, because market power allows an entity to raise prices and restrict output, confidence in the benevolence of nonprofits is likely to backfire, leaving communities across the country with a large profitable hospital that acts contrary to the best interests of consumers. Because most hospitals in the United States are

organized as nonprofits, if this decision's treatment of nonprofit status is followed by future courts, the consumer may be harmed.

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