# THE EVOLUTION OF FEDERAL COURTS' HEALTHCARE ANTITRUST ANALYSIS: DOES THE PPACA SPELL THE END TO HOSPITAL MERGERS?

## INTRODUCTION

Since the 1990s, the trend for hospitals in the United States has been to combine resources and merge into larger systems.[1] In 2013, for example, Community Health Systems of Tennessee and Health Management Associates of Florida combined in a $7.6 billion deal.[2] Over 300 hospital acquisitions have occurred between 2007 and 2012, and many, like the merger between Tennessee and Florida hospitals, have been single hospitals forming new systems.[3] Newly formed hospital systems have largely been successful in defending against antitrust challenges.[4] For example, in the late 1990s, the Federal Trade Commission ("FTC") suffered six straight losses in healthcare antitrust cases it filed in federal courts.[5] These cases showed that the FTC struggled to define the relevant markets[6] and judges were reluctant to enforce antitrust principles to nonprofit hospitals.[7] Indeed, courts deferred to merging hospitals in the belief that hospitals achieving economies of scale were in the best interests

1. Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. TIMES (Aug. 12, 2013), http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html.

2. *Id.*

3. FTI CTR. FOR HEALTHCARE ECONS. AND POLICY, HOW HOSPITAL MERGERS AND ACQUISITIONS BENEFIT COMMUNITIES 5 (2013), *available at* http://www.aha.org/content/13/13mergebenefitcommty.pdf.

4. For discussion of the general ambivalence of courts dealing with healthcare markets, see Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497 (2006).

5. U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch. 4, at 1 n.7 (2004), *available at* http://www.justice.gov/atr/public/health_care/ 204694.pdf.

6. Antitrust challenges require the FTC to define the relevant geographic and product markets. *See generally* Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007); *see also* FTC v. Freeman Hosp., 69 F.3d 260, 269 (8th Cir. 1995) (holding that "the FTC failed to produce sufficient evidence on the crucial aspect of the geographic market").

7. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996) ("[N]onprofit hospitals operate differently in highly-concentrated markets than do profit-maximizing firms."). However, not all courts accepted this premise. *See* United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (1990) (regardless of the nonprofit classification, "people do not like to compete, and will seek ways of avoiding competition by agreement tacit or explicit, depending of course on the costs of agreeing").

of the public because, "[i]n the real world, hospitals are in the business of saving lives" and would not abuse market power.[8]

Arguably, these unsuccessful antitrust challenges have given hospitals "a green light to consolidation."[9] The FTC admits that court decisions in this area have led enforcers to stay away from hospital mergers.[10] One problem for the FTC is that courts have struggled to apply antitrust law to the healthcare sector.[11] Making matters worse, it is widely acknowledged that courts analyzing hospital mergers have failed to apply sound economic principles in defining relevant markets.[12]

Regardless of the reasons for consolidation, it has been harmful to the general public.[13] Studies show that hospital market concentration in the 1990s caused inpatient prices to rise at least five percent and more than forty percent when the merging hospitals were in competition with each other.[14] Another study performed in Massachusetts found that pricing for health services was positively correlated with provider market power and uncorrelated with "differences in quality, complexity of services, or other

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

9. *The Patient Protection and Affordable Care Act and the Consequent Impact on Competition in Healthcare: Hearing Before Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. On the Judiciary*, 113th Cong. 4 (2013) [hereinafter *PPACA Hearing*] (prepared statement of Prof. Thomas L. Greaney, Saint Louis University School of Law), http://judiciary.house.gov/_cache/files/565cd9fa-8a86-40a4-9bad-99827e678de2/113-51-82848.pdf.

10. Victoria Stagg Elliott, *FTC, in Turnabout, Takes a Closer Look at Hospital Mergers*, AM. MED. NEWS (Apr. 9, 2012), http://www.amednews.com/article/20120409/business/304099973/7/.

11. *See* Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847 (2011). Other scholars suggest the lack of transparency in medical procedures leads to higher medical bills charged by hospitals. Keith T. Peters, *What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care*, 10 J. HEALTH CARE L. & POL'Y 363, 364–65 (2007).

12. *See, e.g.*, Cory S. Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 8216, 2001), *available at* http://www.nber.org/papers/w8216.

13. *See PPACA Hearing*, *supra* note 9, at 5 (prepared statement of Prof. Thomas L. Greaney); *see also* 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, 772–74 (1997) (claiming that large hospital systems threaten patient care, remove the existence of local control, and become more motivated on the "bottom line"); Judith C. Applebaum & Jill C. Morrison, *Hospital Mergers and the Threat to Women's Reproductive Health Services: Applying the Antitrust Laws*, 26 N.Y.U. REV. L. & SOC. CHANGE 1 (2000) (expressing concern regarding the negative effect of hospital mergers on women's health services); Don Lee, *Closures Put Big Hospital Chains Under Microscope*, L.A. TIMES, Aug. 22, 2002, at A1 (discussing the ramifications of the purchases of small hospitals by larger chains, resulting in concentrated market power).

14. WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 4 (2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

factors the health care market should reward."[15] This means that the higher the market concentration, the higher the cost for the consumer—exactly what antitrust law seeks to avoid.[16]

Recently, however, judges' favorable perspective toward nonprofit hospital mergers has shifted. For example, in 2012, two hospital chains in Illinois were blocked from merging after the FTC challenged the deal.[17] The FTC argued that the combination of the two hospitals would "have anticompetitive effects."[18] The problem for the FTC was that the two hospitals had no agreement in place to maintain current hospital charges for patients.[19] Without that agreement, there was no guarantee that the newly formed system would not increase patient prices.[20] Outside the courts, scholars have become more critical of hospital mergers as well. Similar to the FTC's argument above, they reason that providers are concentrating to enable them to charge higher prices for patients.[21] Making matters worse, it has been suggested that healthcare providers enjoy more freedom in pricing than other monopolies such as the diamond industry and public utilities.[22] One reason for this relaxed approach by federal courts is that hospitals have a redistributive component that provides care to indigent patients.[23]

This Note acknowledges the harm of hospital concentration and will focus on recent governmental efforts to block hospital mergers. Specifically, Part I will explain the structure of hospital antitrust claims. Part II will provide an analysis of recent case law and identify trends in FTC antitrust enforcement. This Part will describe why federal judges shifted their favorable approach to hospital consolidation. Finally, this Note argues that the Patient Protection and Affordable Care Act

15. MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 6D, § 8, at 6 (2010), *available at* http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf.

16. *See* Bus. Elecs. Corp. v. Sharp Elecs. Corp., 485 U.S. 717 (1988).

17. FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1076 (N.D. Ill. 2012).

18. *Id.* at 1076. Measuring market share in terms of the number of patient admissions and the length of patient stays, the court held that the FTC met its burden in demonstrating that the merger would lead to an illegal concentration of firms in the market. *Id.* at 1078.

19. *Id.* at 1082.

20. *Id.*

21. *See* Havighurst & Richman, *supra* note 11, at 848. Generally, higher bargaining leverage for suppliers works to the detriment of consumers. *See id.*

22. *See, e.g.*, *id.*

23. *Id.* at 847.

("PPACA"),[24] combined with new government regulation, will work to ameliorate the monopoly problem in the health care sector.[25]

## I. OVERVIEW OF ANTITRUST PRINCIPLES

### *A. The Clayton Act*

The economic rationale of antitrust law is that, in a freely operating competitive market, consumers are given the widest variety of choices at the lowest prices.[26] The Clayton Act is the statute that governs antitrust merger claims and seeks to eradicate anticompetitive transactions.[27] Specifically, Section 7 of the Clayton Act prohibits acquisitions "where in any line of commerce or in any activity affecting commerce . . . the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[28] Section 7 is designed to protect against "the substantial lessening of competition from the acquisition by one corporation of the whole or any part of the stock of a competing corporation."[29] Thus, antitrust laws seek to remove barriers to healthy and vibrant competition such as an agreement between two firms to raise prices or two firms merging solely to gain market power.[30] Without Section 7, two firms can increase their market power by merging and thereby increase prices for patients.

Once a merger challenge is brought, the court determines the likely anticompetitive effects in the market.[31] To determine whether there is a reasonable probability of a reduction in competition, the courts have focused on whether the transaction has the "potential for creating, enhancing, or facilitating the exercise of market power—the ability of one or more firms to raise prices above competitive levels for a significant period of time."[32] The court's analysis takes two steps. First, the court defines the relevant market that the merger is likely to affect.[33] Second, the

24. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

25. *See* Havighurst & Richman, *supra* note 11, at 851.

26. U.S. FED. TRADE CMM'N & U.S. DEP'T OF JUSTICE, *supra* note 5, ch. 2, at 1.

27. 15 U.S.C. § 18 (2006). The Clayton Act prohibits price discrimination, exclusive dealings, or mergers that either create a monopoly or substantially lessen competition. *Id.* §§ 17–19.

28. *Id.* § 18.

29. United States v. E.I. du Pont de Nemours & Co., 353 U.S. 586, 589 (1957).

30. Brown Shoe Co. v. United States, 370 U.S. 294, 312–13 (1962).

31. United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 136–37 (E.D.N.Y. 1997).

32. United States v. Archer-Daniels-Midland Co., 866 F.2d 242, 246 (8th Cir. 1988).

33. *See id.*

court determines whether the merged entity would have a significant market power in the defined market.[34] For a plaintiff to establish a prima facie case under the Clayton Act, he or she must demonstrate that an entity would control "an undue percentage share of the relevant market, and would result in a significant increase in the concentration of power in that market."[35] The defendants may rebut this prima facie showing by producing evidence that the merger will not create anticompetitive effects.[36] For example, this can be done by showing the merger will create significant efficiencies that would benefit consumers.[37] The court then weighs the competing views and decides whether to block the merger.[38]

### *B. Defining the Relevant Market and Determining if a Merged Entity Has Significant Market Power*

Importantly, the court must define the relevant market that the proposed transaction might impact.[39] Courts have determined that "[a] 'relevant market' consists of two components: a product market, and a geographic market."[40] The product market is determined by "the cross-elasticity of demand between the product itself and substitutes for it."[41] In other words, the product market is defined by the responsiveness of the demand for a good to a change in the price of another good.[42] For example, suppose a grocery store sells 2% milk and whole milk. If the store decides to raise the price of 2% milk, the demand for whole milk might increase because consumers will purchase the substitute. The ability for consumers to substitute goods limits the stores' ability to increase prices. The harder it is for the store to increase the price of milk, the higher the cross-elasticity of demand will be. Thus, the product market (whole

34. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 136–37.
35. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1289 (W.D. Mich. 1996).
36. *Id.*
37. FTC. v. Univ. Health, Inc., 938 F.2d 1206, 1222 (11th Cir. 1991).
38. *See id.*
39. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 136–37. Courts' objective in defining the relevant market for antitrust purposes is to uncover where competition exists. Brown Shoe Co. v. United States, 370 U.S. 294, 326 (1962). Because substitutes, by nature, compete in the same market, substitutability of supply is a central criterion for setting the boundaries of the market. United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 395 (1956) (goods that can be "reasonably interchangeable by consumers" should be seen as in the same market).
40. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 136.
41. *Brown Shoe Co.*, 370 U.S. at 325.
42. *Id.*

milk and 2% milk in the above example) is determined by the range of products that would limit the merged entity's ability to raise prices.[43]

The geographic market is defined by the existence of competitors who are close enough to provide similar products.[44] The ultimate question is whether consumers can practically turn to alternatives.[45] Defining the geographic market is highly fact intensive and can often be determinative of the court's outcome.[46] For example, assume there are two grocery stores in a town that sell milk and one grocery store that is forty miles away that also sells milk. If the two grocery stores in town attempted to merge, a court could define the relevant market as the two stores in town, which would destroy the market for milk in that geographic market. Alternatively, a court could instead decide to include the store that is forty miles away because consumers might travel to that store if prices were too high. Thus, if the geographic market were limited to the two local grocery stores, then the anticompetitive effect of those stores merging would be very high. But if the market included all three grocery stores, then the anticompetitive effect of the two grocery stores merging would be very small. The same problem is prevalent in the hospital merger setting, and how the relevant market is defined typically determines the outcome of the case.[47]

Defining the relevant market in the health care setting can be especially problematic.[48] The Clayton Act prohibits any merger having an

43. United States v. Mercy Health Servs., 902 F. Supp. 968, 975 (N.D. Iowa 1995), *vacated as moot on unrelated grounds*, 107 F.3d 632 (8th Cir. 1997).

44. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1291 (W.D. Mich. 1996).

45. *Mercy Health Servs.*, 902 F. Supp. at 975–76.

46. *See Butterworth*, 946 F. Supp. at 1291.

47. *See* FTC v. ProMedica Health Sys., Inc., No. 3:11-CV-47, 2011 WL 1219281, at *7, *9 (N.D. Ohio Mar. 29, 2011) (granting a preliminary injunction to plaintiffs by defining the relevant market broadly to include tertiary, quaternary, outpatient, and general acute-care services together).

48. *See, e.g.*, *Mercy Health Servs.*, 902 F. Supp. at 979 (considering whether patient loyalty should factor into the determination of the relevant market). Many problems arise in the decision to aggregate different treatments offered by hospitals such as cancer therapy, tertiary services, and heart surgery. *See* Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, 877–79 (2004). Aggregating all treatments may be an overly simplistic way to analyze hospital mergers primarily because services draw from different geographic areas. *Id.* at 883–84. For example, complicated tertiary services may draw patients from all across the state whereas emergency services only draw patients from a limited geographic area. *See id.* Studies demonstrate that combining all inpatient services may conceal the concentration of certain hospital services while separating out services could reveal a strong market power. *See* Seth Sacher & Louis Silvia, *Antitrust Issues in Defining the Product Market for Hospital Services*, 5 INT'L J. ECON. BUS. 181, 183–85 (1998); *see also* Jack Zwanziger et al., *Hospitals and Antitrust: Defining Markets, Setting Standards*, 19 J. HEALTH POL. POL'Y & L. 423, 436–39 (1994) (breaking up hospital inpatient services into distinct categories). Therefore, using clusters can lead to a misleading analysis of the market power possessed over a certain hospital service. Greaney, *supra*, at 882–84.

anticompetitive effect "in any line of commerce . . . in any section of the country,"[49] and forbids any merger that would likely cause a competitive harm in the market for any services that hospitals provide.[50] Proving the likely competitive harm in a market can be challenging because different hospital service lines draw patients from different distances.[51] For example, in *United States v. Long Island Jewish Medical Center*,[52] the court struggled to define the competitive influences of nearby hospitals.[53] The court noted that hospitals offering specialty services, especially teaching and research hospitals, might draw patients from a very broad geographic area.[54] Because patients are drawn from all over the state for these specialty services such as chronic conditions of cancer, identifying the geographic area is difficult.[55] By contrast, emergency services are drawn from a very narrow geographic area.[56] Therefore, combining specialty services with emergency services is problematic because emergency services draw patients from a limited geographic area.[57]

The problem in hospital merger cases is that federal judges need to decide whether to combine hospital service lines or separate them out. On one hand, if a court defines the relevant market as overly broad, the merger's effects will likely appear insignificant and the court will underestimate the anticompetitive effects.[58] On the other hand, a relevant market that is defined too narrowly will overestimate the anticompetitive effects and block an otherwise legitimate merger between two hospitals.[59] Because defining the relevant market can be the deciding factor in many of these antitrust claims, the judge's decision to choose one economist over the other is often dispositive.[60] Therefore, the court must address both the

49. 15 U.S.C. § 18 (2006).

50. *Id.*

51. *See* U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 5, ch. 4, at 21–24.

52. 983 F. Supp. 121 (E.D.N.Y. 1997).

53. *Id.* at 137–42.

54. *Id.* at 125.

55. *Id.* at 141. *See also* Evergreen Presbyterian Ministries Inc. v. Hood, 235 F.3d 908, 1029 (5th Cir. 2000). The georgraphic area is dependent on the type of medical service because "emergcy care must be swift, and hence close, but longer travel times are toleratble when obtaining outpatient care for chronic conditions." *Id*. at 1029.

56. *Id.*

57. *Id.*

58. *See* FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1052–54 (8th Cir. 1999) (examining the relevant market for hospitals in a poorly defined area).

59. *See* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 137–40 (E.D.N.Y. 1997) (analyzing a merger with unclear influences of nearby hospitals).

60. "Without a well-defined relevant market, a merger's effect on competition cannot be properly evaluated." *Id.* at 1051. Moreover, often a monopolization claim "succeeds or fails strictly on the definition of the product or geographic market." *Id.* at 1052; *see also* United States v. Mercy Health

product market and the geographic market to accurately identify the correct relevant market.[61]

### *C. Mitigating Factors Used to Rebut the Government's Prima Facie Showing*

If the FTC makes a prima facie showing of an antitrust violation, courts have established that a defendant may rebut the government's showing in a number of ways.[62] First, a hospital system can produce evidence that the defendant's market-share statistics are inaccurate for the "effects on competition in the relevant market."[63] To meet this burden, a defendant often relies on nonstatistical evidence such as bias that may "cast[] doubt on the persuasive quality of the statistics to predict future anticompetitive consequences."[64] Second, a hospital system can rebut the prima facie showing by offering evidence "that the intended merger would create significant efficiencies in the relevant market"[65] or that the merger "would result in significant economies and that these economies ultimately would benefit the consumers."[66] Such a showing proves that the proposed merger would actually benefit the community because it would "enhance[] rather than hinder[] competition as a result of the gained efficiencies."[67]

The third way that a hospital system can rebut a prima facie showing is by proving the acquired hospital was in a state of financial "weakness."[68]

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Servs., 902 F. Supp. 968, 979 (N.D. Iowa 1995), *vacated as moot on unrelated grounds*, 107 F.3d 632 (8th Cir. 1997) (finding insufficient evidence to extend the relevant market based on patient loyalty).

61. *See id.* at 140. Over time, the relevant product market has come to be defined by the ability to increase prices profitably by a "small but significant" amount for a meaningful period of time. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 4.1.1 (2010) [hereinafter 2010 GUIDELINES], *available at* http://www.justice.gov/atr/public/guidelines/hmg-2010.html.

62. FTC v. Univ. Health, Inc., 938 F.2d 1206, 1220–24 (11th Cir. 1991). Once the relevant market has been defined, courts have employed a burden-shifting approach to determine whether the FTC will likely succeed on the merits of its Section 7 claim. FTC v. H.J. Heinz Co., 246 F.3d 708, 715 (D.C. Cir. 2001). The Supreme Court has articulated that a merger with these characteristics "is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." United States v. Phila. Nat'l Bank, 374 U.S. 321, 363 (1963).

63. *H.J. Heinz Co.*, 246 F.3d at 715 (internal quotation marks omitted).

64. *Id.* at 715 n.7.

65. *Univ. Health*, 938 F.2d at 1222.

66. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 147; *see also Univ. Health*, 938 F.2d at 1223.

67. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 147; *see also* United States v. Country Lake Foods, Inc., 754 F. Supp. 669, 680 (D. Minn. 1990).

68. *Univ. Health*, 938 F.2d at 1221. However, the acquisition of a financially weak company is not automatically immune from Section 7 scrutiny. *Id.* The court in *University Health* stated that such a defense will only be granted in "rare circumstances" and drew a distinction between a financially weak firm and a failing firm. *Id.* The "failing company" defense is only allowed if: (1) the firm being

For example, in *Federal Trade Commission v. Freeman Hospital*,[69] the court explained that the hospital in question had been experiencing financial problems and was struggling to compete in the challenging healthcare market.[70] The hospital's trustees sought to merge with another hospital to remain financially sustainable.[71] Had the court focused primarily on increasing the number of participants in the market, the court would have denied the merger.[72] Instead, the court valued the likelihood that the merged entity would be able to compete in the market.[73] Additionally, in *Long Island Jewish Medical Center*,[74] the court found that the merged entity would decrease equipment costs, increase the ability to share staff and facilities, and create efficiencies in computer services.[75] The court saw these factors as offsetting the anticompetitive risks proved by the FTC.[76] Therefore, the court held that "the proposed merger will result in significant efficiencies in the form of annual operating savings in expenses in the sum of approximately 25 to 30 million dollars per year."[77]

Fourth, federal judges have tolerated mergers between nonprofit hospitals because of expressed commitment to the community.[78] Courts have defined community commitment as a "series of formal assurances . . . to assuage any purchaser concerns and to reiterate [the hospitals'] strong conviction that the purpose and intent of the transaction is to reduce costs."[79] The rationale behind this approach is that nonprofit hospitals differ from conventional monopolists because they do not abuse market power.[80] Under the federal tax code, nonprofit hospitals must use profits for charitable purposes.[81] Therefore, it is argued that the entity's exercise of market power is benign.[82] For example, in *FTC v. Butterworth Health*

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acquired faces a high probability of bankruptcy and (2) the merger is the only means for avoiding failure. *See* Citizen Publ'g Co. v. United States, 394 U.S. 131, 136–39 (1969).

69. 69 F.3d 260 (8th Cir. 1995).
70. *Id.* at 262.
71. *Id.*
72. *See id.* at 270–71.
73. *Id.* at 272.
74. 983 F. Supp. 121 (E.D.N.Y. 1997).
75. *Id.* at 148.
76. *Id.*
77. *Id.*
78. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1298 (W.D. Mich. 1996).
79. *Id.* (alteration in original).
80. *See* Havighurst & Richman, *supra* note 11, at 858.
81. 26 U.S.C. § 501(c)(3) (2012); *see also* Havighurst & Richman, *supra* note 11, at 858.
82. *See* Havighurst & Richman, *supra* note 11, at 858. Courts that adopt this point of view frequently cite a Third Circuit decision, United States v. Brown Univ., 5 F.3d 658 (3d Cir. 1993), allowing a university to violate antitrust principles to fund scholarships for needy students. *Id.* at 678–79; *see also* Gordon v. Lewistown Hosp., 423 F.3d 184, 210 (3d Cir. 2005); Deutscher Tennis Bund v.

*Corp.*,[83] the district judge was certain that the nonprofit hospitals' ultimate goal was to establish "world-class health facilities."[84] Thus, the district judge allowed a merger that would otherwise have violated Section 7.[85] It reasoned that the proposed merger would allow the board of directors the discretion to improve the quality of healthcare and act in the best interests of the public.[86] Because of judges' historical deference to nonprofit hospitals, government agencies have found it difficult to convince courts that these hospitals would use market power to the detriment of the public.[87]

## II. RESURGENCE OF ANTITRUST ENFORCEMENT

Recently, the government antitrust enforcement agencies have increased their efforts to block anticompetitive mergers.[88] In 2007, the FTC challenged a merger, four years after the merger had been consummated, in a case that marked a substantial change in federal courts' antitrust analysis.[89] In the last three years, the FTC has challenged four

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ATP Tour, Inc., 610 F.3d 820, 830 (3d Cir. 2010); Orson, Inc. v. Miramax Film Corp., 79 F.3d 1358, 1367 (3d Cir. 1996). In *Brown University*, the court held that redirecting scholarship funds to low income students might act as a defense to an antitrust claim because of the charitable purpose. *Brown Univ.*, 5 F.3d at 678–79.

83. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1298 (W.D. Mich. 1996).

84. *Id.* at 1302. Some scholars have understood hospital mergers as a way to counteract physician demands for equipment, and greater market concentration would therefore improve matters by reducing expenses in marginally useful equipment and amenities. *See* Peter J. Hammer, *Questioning Traditional Antitrust Presumptions: Price and Non-Price Competition in Hospital Markets*, 32 U. MICH. J.L. REFORM 727, 736 (1999) (citing studies that demonstrate "a strong and consistent negative relationship between measures of hospital cost and levels of economic concentration").

85. *Butterworth*, 946 F. Supp. at 1302–03.

86. *Id.* at 1298. Other courts reviewing hospital mergers took a similar approach. FTC v. Freeman Hosp., 69 F.3d 260, 263 (8th Cir. 1995). In *Freeman*, a Missouri judge said to the federal agency, "I don't think you've got any business being in here. . . . 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." *Id.* at 263 (quoting district court).

87. *Butterworth Health Corp.*, 946 F. Supp. at 1298.

88. *See PPACA Hearing*, *supra* note 9, at 7 (prepared statement of Prof. Thomas L. Greaney).

89. Evanston Nw. Healthcare Corp., No. 9315, 2007 WL 2286195 (F.T.C. Aug. 6, 2007). In addition to the significance of analyzing the case postmerger, the court also rejected a claim that the relevant product market includes hospital-based outpatient services. *Id.* at *46–47. Defendants argued that the relevant product market should consider all purchases made by a customer in determining the relevant product market making it less likely to find an antitrust violation. Evanston Nw. Healthcare Corp., No. 9315, 2005 WL 2845790, at *106 (F.T.C. Oct. 20, 2005) (initial decision), *available at* http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf, *aff'd*, 2007 WL 2286195 (F.T.C. Aug. 6, 2007) (citing United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284 (7th Cir. 1990)). Administrative Law Judge Steven J. McGuire stated that "the Court of Appeals for the Seventh Circuit

hospital mergers.[90] The courts in these cases changed their definition of the relevant markets and "unbundled" hospital service lines in holding for the FTC.[91] Even the Supreme Court has weighed in on a hospital antitrust case. In *FTC v. Phoebe Putney Health Systems*, the Court denied the application of the state-action doctrine and found that the hospital merger was facilitated by hospital executives desire to increase patient charges.[92] The Court held that state-action immunity did not apply because Georgia failed to describe why allowing a hospital to substantially reduce competition would be a benefit to the public.[93] Applied together, these cases demonstrate a strong resurgence of antitrust enforcement in the hospital-merger setting and a rejection of previous holdings giving deference to nonprofit hospital mergers.[94] The next section will describe how courts departed from accepting traditional hospital-merger defenses and began to limit the consolidation of hospitals.

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has explicitly rejected an approach that defined the relevant product market as *all* the services provided by the merging parties and demanded by customers." *Id.*

90. *See* OSF Healthcare Sys., No. 9349, 2012 WL 1355604 (F.T.C. Apr. 13, 2012) (dismissed upon merger abandonment), *available at* http://www.ftc.gov/os/adjpro/d9349/120413rockford order.pdf; ProMedica Health Sys., Inc., No. 9346, 2012 WL 1155392 (F.T.C. Mar. 28, 2012) (petition for review on file with 6th Circuit, No. 12-3104), *available at* http://www.ftc.gov/os/adjpro/ d9346/120328promedicabrillopinion.pdf; Reading Health Sys., No. 9353, 2012 WL 6188557 (F.T.C. Dec. 7, 2012) (dismissed upon acquisition abandonment), *available at* http://www.ftc.gov/os/adjpro/ d9353/121116readingsurgicalcmpt.pdf; FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003 (2013).

91. *ProMedica Health Sys.*, 2012 WL 1155392. "Unbundled" is another way of saying separated out product service lines.

92. *Putney*, 133 S. Ct. at 1006. The Court previously held that States may "use their municipalities to administer state regulatory policies free of the inhibitions of the federal antitrust laws without at the same time permitting purely parochial interests to disrupt the Nation's free-market goals." City of Lafayette v. La. Power & Light Co., 435 U.S. 389, 415–16 (1978). By contrast, in *FTC v. Phoebe Putney Health System*, the issue was whether an otherwise unlawful merger was immunized by the state action doctrine. *Putney*, 133 S. Ct. at 1010–11. Respondents argued that "hospital authorities are granted unique powers and responsibilities to fulfill the State's objective of providing all residents with access to adequate and affordable health and hospital care." *Id.* at 1014. The Supreme Court rejected this argument and held that, to satisfy the state action doctrine, the State "must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals." *Id.* at 1013. The Court reasoned that there was not sufficient evidence to show that the State acknowledged how hospital executives would "displace competition by consolidating hospital ownership." *Id.* at 1011.

93. *Putney*, 133 S. Ct. at 1011. This decision was significant because in the early 1990s, eighteen states enacted programs to "provide an exemption from state antitrust laws and also provide immunity from federal antitrust enforcement under the state action immunity doctrine." U.S. GEN. ACCOUNTING OFFICE, HEALTH CARE: FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY 11 (1994).

94. *See PPACA Hearing*, *supra* note 9, at 7 (prepared statement of Prof. Thomas L. Greaney).

### *A. Relevant Market Definition Altered*

Courts defining the product market when looking at hospital mergers have generally assumed the product to be acute-care services.[95] Until recently, this broad product-market definition was typical.[96] In 2010, however, the Department of Justice released a revised version of the 2010 Horizontal Merger Guidelines ("2010 Guidelines") that attempted to increase transparency of agency evaluations.[97] The 2010 Guidelines clarify the definitions of relevant product markets and explain that when evaluating product market concentration, "the smallest relevant market" is required.[98] For example, in the case of a merger between two motorcycle manufacturers, an agency could not include cars in the same product market.[99] Similar to cars and motorcycles, the 2010 Guidelines would prohibit courts from combining different healthcare services such as knee surgery and hip surgery. This marked a change in the healthcare antitrust

95. For purposes of the Clayton Act, acute care services are services "necessary to meet the medical, surgical, and other needs of inpatients, e.g., operating rooms, anesthesia, intensive care capabilities, 24-hour nursing care, lodging, and pharmaceuticals." FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1290 (W.D. Mich. 1996); *see also* California v. Sutter Health Sys., 130 F. Supp. 2d. 1109, 1119 (N.D. Cal. 2001) (finding product market includes "not only services provided by hospitals that offer the full range of general acute inpatient services, but also those [acute care services] available at 'niche' hospitals").

96. *See Sutter*, 130 F. Supp. 2d at 1119.

97. 2010 GUIDELINES, *supra* note 61.

98. *Id.* § 4.1.1 ("[T]he overarching principle that the purpose of defining the market and measuring market shares is to illuminate the evaluation of the competitive effects."). Hospital merger cases have evolved from a belief that the relevant product market should include inpatient and outpatient services provided by hospitals, *see* Am. Med. Int'l, Inc., 104 F.T.C. 1 (1984), to a consensus that identifies the market as acute care inpatient services, except for tertiary care. *See, e.g.*, United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) (market that consisted of inpatient acute care services); United States v. Mercy Health Servs., 902 F. Supp. 968, 981–83 (N.D. Iowa 1995), *vacated as moot on unrelated grounds*, 107 F.3d 632 (8th Cir. 1997) (eliminating tertiary care services from the product cluster).

99. 2010 GUIDELINES, *supra* note 61, § 4.1.1. Moreover, the 2010 Guidelines explain that antitrust agencies should begin market definition when a product of one merging firm competes with a product of another merging firm. *Id.* § 4.1.3. In other words, a relevant product market should be defined by the potential that two firms will compete in a given service line. *See* Little Rock Cardiology Clinic v. Baptist Health, 573 F. Supp. 2d 1125, 1140–41 (E.D. Ark. 2008). For example, when deciding whether to include tertiary services into the cluster of GAC inpatient hospital services, analyzing the number of competitors in each service is important. *See* ProMedica Health Sys., Inc., No. 9346, 2012 WL 2450574, at *39 (F.T.C. June 25, 2012). Patients are likely to travel for complex treatments typical of tertiary services, making the number of competitors in tertiary services higher than for other GAC services. *Id.* Because, "only relevant service markets with similar competitive conditions" should be grouped together, tertiary and GAC inpatient services should not be aggregated in the same cluster market. *Id.*

area, because courts started to separate out different hospital services that were traditionally combined in the product market analysis.[100]

The Northern District of Ohio illustrated this approach in *FTC v. Promedica*[101] when it addressed whether a merger between one health system that operated three general acute care hospitals and another nonprofit hospital violated Section 7.[102] The court determined that general acute care ("GAC") was the relevant product market to address the effects of the merger.[103] The court noted that "GAC services are a broad 'cluster market' of inpatient surgical, medical, and supporting services."[104] However, when defining the GAC, the court did not include services that all four hospitals did not perform,[105] such as tertiary services.[106] Additionally, services that were offered by other providers in the county including obstetrical ("OB") services were also excluded from the GAC cluster.[107]

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100. *See* FTC v. ProMedica Health Sys., Inc., No. 3:11-CV-47, 2011 WL 1219281, at *72 (N.D. Ohio Mar. 29, 2011). In *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991), the court accepted a broad market definition "for ease of discussion." *Id.* at 1211. *ProMedica* marks a change of approach in antitrust analysis that is inconsistent with courts' analysis of other markets. *See* United States v. Grinnell Corp., 384 U.S. 563, 572 (1966). For instance, in *Grinnell*, the Court found that where fire and burgluary services were generally offered, it would be impractical to "break down the market into various kinds of central station protective services that are available." *Id.* Although some customers use a combination of different protective services, the Court noted that the market should be defined not by the different purchases but instead by the services provided. *Id.* at 573.

101. No. 3:11-CV-47, 2011 WL 1219281 (N.D. Ohio Mar. 29, 2011).

102. *Id.* at *1, *9–10.

103. *Id.* at *68.

104. *Id.*

105. *Id.* at *69. Litigants generally disagree about the appropriate size of the cluster. *See, e.g.*, United States v. Hughes Tool Co., 415 F. Supp. 637, 641 (C.D. Cal. 1976). The side seeking a smaller market cluster is generally the same party seeking individual product definitions. *Id.*

106. *ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *69. Prior cases had determined that tertiary services should be included in a GAC inpatient hospital services market. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1291 (W.D. 1996); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 137, 140 (E.D.N.Y. 1997). In other cases, both sides have agreed to exclude tertiary services from the alleged relevant product market. *See* Answering and Cross-Appeal Brief of Complaint Counsel, at 37, Evanston Nw. Healthcare Corp., No. 9315, 2006 WL 447836 (F.T.C. Feb. 10, 2006), *available at* http://www.ftc.gov/os/adjpro/d9315/060210ccattachmnt pursuantrule.pdf. In *ProMedica*, the court noted that defining the relevant market is fact specific, and it is not surprising that courts differ on its determination of including tertiary services in the product market. *See* ProMedica Health Sys., Inc., No. 9346, 2012 WL 2450574, at *39 (F.T.C. June 25, 2012).

107. *ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *72. The court rejected the argument that separating OB services would be redundant and not proper since there is no judicial precedent for doing so. *ProMedica Health Sys., Inc.*, 2012 WL 2450574, at *41. The court responded that although there is not judicial precedent for specifically separating out OB services from the general product cluster, "there [was] judicial precedent for the underlying rationale." *Id.* It reasoned that case law determined it necessary to separate services "where the group of suppliers for that group of services differs from the suppliers of GAC inpatient hospital services." *Id.*; *see also Butterworth Health Corp.*,

The court held that it would be wrong to include OB services into "the cluster market of GAC services because OB services are offered by a different set of providers . . . and, thus, are subject to different competitive conditions than are GAC services."[108] The practical effect of the FTC separating out certain services is that hospitals can no longer lump all services in the same equation.[109] For example, inpatient services and outpatient services would be separated because outpatient services can be offered by other surgical centers and, therefore, have different competitors.[110] Without the ability to lump all services together, judges can individually scrutinize service lines, making mergers less likely to survive antitrust violations.[111]

### *B. Less Deference to Proposed Efficiencies and Community Involvement*

Federal judges have long held that hospital administrators differ from conventional monopolists because of their nonprofit status and their potential to increase efficiencies.[112] The 2010 Guidelines provide that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete."[113] This, in turn, "may result in lower prices, improved quality, enhanced service, or new products."[114] Further, a merger will not be deemed illegal "if cognizable efficiencies are of a character and

946 F. Supp. at 1291 (separating primary care inpatient services and GAC inpatient services because of the different suppliers of each service).

108. *ProMedica Health Sys., Inc*., 2011 WL 1219281, at *73. The court concluded that OB services "constitute a separate relevant product market" because "[n]o other services are interchangeable with OB services." *ProMedica Health Sys., Inc.*, 2012 WL 2450574, at *40. Moreover, obstetrics is a distinct field of medicine as seen by providers, "the merging hospitals track OB services market shares separately from GAC inpatient services," and there are "competitive alternatives for consumers of OB services" that are different than those for other services in the cluster. *Id.* Therefore, combining OB services with the GAC inpatient hospital service cluster would work against the 2010 Guidelines' goal of analyzing competitive effects. *Id.*

109. *See* Complaint, Reading Health Sys., No. 9353, 2012 WL 5879804 (F.T.C. Nov. 16, 2012), *available at* http://www.ftc.gov/sites/default/files/documents/cases/2012/11/121116readingsurgicalcmpt.pdf.

110. *See id.* at 10.

111. *See id.* at 2.

112. *See* Havighurst & Richman, *supra* note 11, at 857–58. Some scholars suggest that courts' aversion to applying traditional antitrust principles to nonprofit-hospital mergers may be a result of the natural sympathies for those who run the healthcare organizations. *See* Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 614–17 (2002) ("The small, elite club of individuals from which hospitals draw their boards of trustees shares much with the privileged pool from which most federal district court judges emerge.").

113. *See* 2010 GUIDELINES, *supra* note 61, § 10.

114. *See id.*

magnitude such that the merger is not likely to be anticompetitive in any relevant market."[115] The 2010 Guidelines note that the greater market power that a merger would create, "the greater must be the cognizable efficiencies."[116] Lower courts allow this defense to rebut the government's prima facie showing.[117]

A significant change, however, is marked by the 2010 Guidelines note that "[e]fficency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means."[118] Accordingly, courts, following this guidance, have taken a vigorous approach in analyzing proposed efficiencies.[119] In *FTC v. OSF Healthcare System*,[120] the defendant hospitals claimed there would be a $3.2 to $3.6 million annual saving in consolidation of services and eliminating redundancies through their proposed merger.[121] An expert witness for the defense reached this conclusion based on possible cost savings and economic incentives.[122] The redundancies to be eliminated were "on-call physicians, trauma center staff, and helicopter crews."[123] The FTC responded that the hospital had not even started the process of consolidation and did not determine where the consolidated trauma center would be located.[124] Additionally, the hospital's claimed efficiencies through combining service lines were also speculative.[125] The court held that just because "it might make business sense to consolidate trauma services after the merger does not guarantee that the identified efficiencies will be attained."[126] The court reasoned that the 2010 Guidelines do not allow efficiencies supported by "good faith" to be realized.[127] Further, the court noted that this uncertainty does not reach the cognizable efficiencies that the 2010 Guidelines require to rebut the FTC case.[128]

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115. *Id.*
116. *Id.*
117. FTC v. H.J. Heinz Co., 246 F.3d 708, 720 (D.C. Cir. 2001).
118. *See* 2010 GUIDELINES, *supra* note 61, § 10.
119. *See H.J. Heinz Co.*, 246 F.3d at 721 ("[A] rigorous analysis of the kinds of efficiencies being urged by the parties [is] in order to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior.").
120. 852 F. Supp. 2d 1069 (N.D. Ill. 2012).
121. *Id.* at 1090.
122. *Id.*
123. *Id.*
124. *Id.*
125. *Id.* at 1091.
126. *Id.* at 1090.
127. *Id.*; *see also* 2010 GUIDELINES, *supra* note 61, § 10.
128. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1091.

Other courts, applying close scrutiny to alleged efficiencies, have held that when a merger involves a high market concentration courts "generally have found inadequate proof of efficiencies to sustain a rebuttal of the government's case."[129] Most recently in *ProMedica*, the court recognized that "[n]o court in a 13(b) proceeding, or otherwise, has found efficiencies sufficient to rescue an otherwise illegal merger."[130] Therefore, not only has the FTC unbundled certain services provided by the hospital, making it easier to challenge hospital mergers, but courts are also beginning to reject the idea that nonprofit hospitals will create significant efficiencies from consolidation.[131] In actuality, courts have begun seeing hospital systems as no different than other profit-maximizing firms.

### *C. Nonprofit Hospitals Losing Their Charitable Defense*

Courts have traditionally tolerated nonprofit hospital mergers because of the presence of redistributing profits for charitable purposes in hospitals' charters.[132] The idea is that even if a hospital merger causes a large net increase in profits, hospitals will channel those funds back to the poor areas of the community.[133] Critics of hospital system consolidation, however, have been quick to point out that funds are not always used for that assumed purpose.[134] First, nearly 38% of uninsured Americans come from middle class families,[135] and uninsured middle class families are not clearly candidates for charity care provided by a subsidizing hospital.[136] Second, hospitals have maintained their tax-exempt status by spending

129. FTC v. H.J. Heinz Co., 246 F.3d 708, 720 (D.C. Cir. 2001) (citing ABA ANTITRUST SECTION, MERGERS AND ACQUISITIONS: UNDERSTANDING THE ANTITRUST ISSUES 152 (2000)).

130. FTC v. ProMedica Health Sys., Inc., No. 3:11-CV-47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011).

131. *See* United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

132. *See* Havighurst & Richman, *supra* note 11, at 857–58.

133. *Id.* This was supported by a number of hospital pricing studies that indicated that hospitals were able to charge supracompetitive prices regardless of market structure. *See, e.g.*, Monica Noether, *Competition Among Hospitals*, 7 J. HEALTH ECON. 259, 277 (1988) (examining Medicare cost reports from 1977–78, which found higher costs in more competitive markets); James C. Robinson & Harold S. Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 257 JAMA 3241 (1987) (study showing that the more competitive the market structure, the higher the hospital expenses).

134. *See* Havighurst & Richman, *supra* note 11, at 858.

135. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 21 tbl.6 (2007), *available at* http://www.census.gov/prod/2007pubs/p60-233.pdf.

136. *See* Havighurst & Richman, *supra* note 11, at 858–59.

profits on alternative means, departing from true charity care.[137] For instance, nonprofit hospital expenditures include new facilities, medical research, and various healthcare training services.[138]

Following this line of reasoning, courts have now rejected the argument used in *Butterworth* that "nonprofit hospitals operate differently in highly-concentrated markets than do profit-maximizing firms" because of their commitment to charity care.[139] In *FTC v. OSF*, the court stated that nonprofit hospitals *are* seeking to "maximize the reimbursement rates they receive."[140] The court distinguished the *Butterworth* case in one important way.[141] In *Butterworth*, the court relied on the fact that the merging hospitals would freeze prices at both hospitals for three years and curtail prices for the following four.[142] In *FTC v. OSF*, by contrast, there was no agreement to freeze or limit the prices after the merger had been consummated.[143] Thus, the merged entity in *OSF* would not have the legal obligation to curtail prices.[144] The court in *FTC v. OSF* also distinguished two previous cases:[145] *FTC v. Tenet Health Care Corp.*,[146] and *United States v. Long Island Jewish Medical Center*.[147] In *FTC v. Tenet Health Care Corp.*, the court allowed two hospitals to merge in Popular Bluff, Missouri because "the FTC produced insufficient evidence of a well-defined relevant geographic market."[148] Similarly, in *Long Island Jewish*,

137. Scott Allen & Marcella Bombardieri, *Fueled by Profits, a Health Care Giant Takes Aim at Suburbs*, BOS. GLOBE (Dec. 21, 2008), https://www.bostonglobe.com/specials/2008/12/21/fueled-profits-healthcare-giant-takes-aim-suburbs/hVExi2njp1hUFhQIyRUmuO/story.html.

138. *Id.* At least one scholar notes that these state-of-the-art facilities and specialty training services are established through hospital profits and put hospitals in an even stronger power market position. *Id.* Tax authorities have analyzed these expenditures and have considered specialty training an "incidental" benefit to a hospital's goal of promoting healthcare in the community. *Id.* The IRS stated that a specialist receiving advanced training at zero cost through a specialty hospital is not enough to "make the private benefit more than incidental." *Id.*

139. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996); *see also* United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) (rejecting the argument that nonprofit hospitals do not seek to maximize profits through market power); FTC v. Univ. Health, Inc., 938 F.2d 1206, 1213–14 (11th Cir. 1991) (the assumption that the nonprofit hospital "would not act anticompetitively was improper"); FTC v. ProMedica Health Sys., Inc., No. 3:11-CV-47, 2011 WL 1219281, at *22 (N.D. Ohio Mar. 29, 2011) (holding that the nonprofit entity "exercises its bargaining leverage to obtain the most favorable reimbursement rates possible from commercial health plans").

140. FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1081 (N.D. Ill. 2012).

141. *Id.* at 1082.

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

143. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1082.

144. *Id.*

145. *Id.* at 1081–82.

146. 186 F.3d 1045 (8th Cir. 1999).

147. 983 F. Supp. 121 (E.D.N.Y. 1997).

148. *Tenet Health Care Corp.*, 186 F.3d at 1053. The FTC failed "to prove its relevant geographic market [was] fatal to its motion for injunctive relief." *Id.*

the court denied an injunction because the FTC's product market was "unduly restricted to 'anchor' hospitals" and failed to include several other hospitals in the area.[149] By contrast, the court in *FTC v. OSF* found that the product and geographic market were properly defined without dispute.[150] Essentially, the court in *FTC v. OSF* limited the previous holdings to denying injunctive relief only when the product market is properly disputed.[151] Therefore, arguably, the justification for market consolidation because hospitals offer charity care has also been eliminated.

### *D. Challenging Mergers After Consummation*

The final change in the policy towards hospital mergers is that mergers can now be challenged after the deal has gone through. Specifically, the 2010 Guidelines state that consummated mergers can be challenged and that the "issue is not only whether adverse competitive effects have already resulted from the merger, but also whether such effects are likely to arise in the future."[152] The agencies use the same analysis when reviewing a consummated merger as a post merger review because the merged entity may be cognizant of the possibility of a government review and keep prices down.[153]

The 2010 Guidelines' explicitly allowing consummated mergers to be challenged accomplished two things. First, the FTC does not have to seek remedy in federal court for an injunction before the merger is complete.[154] This provides the FTC with a longer timeline to challenge the merger. Second, the FTC in challenging a consummated merger can now prove that nonprofit hospitals were in fact using market power to increase prices.[155] This marked a significant change in antitrust application because allowing courts to analyze only premerger cases limited the agencies to relying on theoretical or speculative anticompetitive effects.[156] Direct proof that hospitals were in fact using market power to increase prices worked against the notion that nonprofit hospitals were in the public interest rather than monopolists.[157]

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149. *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 138.
150. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1081.
151. *Id.*
152. *See* 2010 GUIDELINES, *supra* note 61, § 2.1.1.
153. *Id.*
154. Havighurst & Richman, *supra* note 11, at 855.
155. *Id.*
156. *See id.*
157. *See id.*

In *Evanston Northwestern Healthcare Corp.*,[158] Evanston Northwestern Healthcare Corporation merged with Highland Park Hospital.[159] The FTC challenged the merger four years later, alleging that the merged entity had substantially raised prices for managed-care organizations in violation of Section 7.[160] Because the merger had already been consummated, the FTC was given the opportunity to examine real data and obtain direct proof that abuses were occurring in the pricing practices of nonprofit hospitals.[161] In fact, there was direct evidence in the form of internal documents from hospital executives attributing the ability to raise prices to increased market share.[162] Accordingly, the FTC could finally dismiss any expert testimony provided in previous hospital merger cases suggesting nonprofit hospitals do not abuse pricing practices.[163]

In analyzing this merger, the court in *Evanston Northwestern Healthcare Corp.* first examined minutes from the hospital board's finance committee showing abusive practices.[164] The President of Northwestern Memorial, Mark Neaman, stated that large market share had enabled the hospital to negotiate more favorable managed-care contracts.[165] Neaman wrote a memo that explained the increase in revenue from managed-care renegotiations to the merged entity: "[N]one of this could have been achieved by either Evanston or Highland Park alone."[166] Highland Park officials also testified that an opportunity to raise prices came into existence post merger and that the merger provided the entity with "additional bargaining power."[167] The court held that the merged firm raised prices immediately after the consummation, which was in direct response to the increased bargaining power of the hospital system in relation to the payors.[168]

Second, the FTC was given the opportunity to dismiss economic evidence showing that nonprofit hospitals do not abuse pricing practices.[169] The FTC's expert discredited economic testimony introduced

158. Evanston Nw. Healthcare Corp., 2007 WL 2286195 (F.T.C. Aug. 6, 2007).
159. *Id.* at *2.
160. 15 U.S.C. § 18 (2006).
161. *Evanston Nw. Healthcare Corp.*, 2007 WL 2286195 at *13.
162. *Id.* Postmerger documents showed that the health system's executives understood that the ability to increase prices was attributed to the market power gained through the merger. *Id.*
163. *See id.*
164. *Id.*
165. *Id.*
166. *Id.* (emphasis omitted).
167. *Id.*
168. *Id.*
169. *Id.*

by the defendants that had previously been given in support of the hospital merger at issue in *Butterworth*.[170] That study was performed by William J. Lynk and concluded that nonprofit hospitals had lower prices than for-profit hospitals in concentrated markets.[171] In response, the FTC introduced data found by Deborah Haas-Wilson, an economic expert from the University of California-Berkley,[172] concluding that the merged entity "increased its per day average net prices by 48% for all patients; 46% for the commercial and self-pay patients; and 46% for commercial, self-pay, self-administered, and HMO patients."[173]

The economic facts presented in *Evanston Northwestern Healthcare Corp.*, combined with the internal documents of hospital executives, finally dispelled the notion that nonprofit hospitals should be immune from antitrust analysis.[174] Together, these factors alter the way in which hospital mergers are viewed. First, the relevant market definition is altered because courts are willing to unbundle services causing individual lines to be more closely scrutinized. Second, market efficiencies caused by consolidation of services can no longer be speculative or vague. Third, hospitals' justification for consolidation based on charity care has been narrowed. And finally, the FTC can now challenge a merger postconsolidation that allows for the presentation of real data of market abuse as well as the possibility of uncovering damaging internal documents. Thus, the direct evidence produced against the health system in *Evanston Northwestern Healthcare Corp.* make it difficult for future hospital antitrust defendants to claim that no hospital system would abuse market power.[175]

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170. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1296 (W.D. Mich. 1996).

171. *Id.* at 1296–97. William J. Lynk published two scholarly articles that mirrored his findings. *See* William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 458–59 (1995) [hereinafter Lynk, *Nonprofit Hospital Mergers*]; William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTITRUST BULL. 363, 377 (1994). These studies were discredited by other economic studies. *See* David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87 (1999); Emmett B. Keeler et al., *The Changing Effects of Competition on Non-Profit and for-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69 (1999).

172. *Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *12.

173. *Id.* (emphasis omitted).

174. *See* Havighurst & Richman, *supra* note 11, at 855.

175. *See id.* The ability for antitrust government agencies to challenge already completed mergers as in *Evanston Nw. Healthcare Corp.* is a significant advantage for the FTC. However, there are problems with courts granting a remedy in these situations. *Id.* at 871. The damage may already have been done in the hospital merger context because it seems that the dissolution of a merger is ordered only when the integral parts have not been integrated. *See* United States v. E.I. du Pont de Nemours & Co., 353 U.S. 586 (1957).

## III. PPACA'S EFFECT ON HOSPITAL CONSOLIDATION AND ANTITRUST ANALYSIS

The PPACA substantially altered many areas of the health care industry. For purposes of hospital mergers and antitrust analysis, two parts of the PPACA are important: implementation of Accountable Care Organizations ("ACOs") and Section 9007's requirement of a community health needs assessment relating to charity care. Subpart A will begin with a description of ACOs and how they came to be included in the PPACA. Although ACOs encourage consolidation of services, this section contends that the PPACA will protect against the possibility that ACOs lead to market consolidation. Subpart B will describe the evolution of charity care provided by nonprofit hospitals. This section argues that, through the implementation of Section 9007, the PPACA will require concrete proof of charity care, ultimately eliminating a defense used by hospital systems in antitrust cases.

### *A. Emergence of Accountable Care Organizations*

In the antitrust context, the PPACA's establishment of ACOs has drawn a lot of attention.[176] For purposes of this section, it is important to understand why ACOs were implemented. Traditionally, Medicare doctors were paid through a fee-for-service system.[177] Fee-for-service meant that doctors and hospitals are paid for the number of tests and procedures performed on an individual patient.[178] The problem with the fee-for-service arrangement was that hospitals had an incentive to perform additional, potentially unnecessary, tests and procedures because the federal government was reimbursing all of the costs.[179] This led to a system of fragmented delivery of service and a system where payments rewarded volume and not performance-based service.[180] Because the cost of Medicare was expected to rise exponentially with population trends, Congress wanted to provide a program that might reduce this cost.[181] Instead of continuing a fee-for-service model, ACOs were established to

176. *See PPACA Hearing*, *supra* note 9, at 8 (prepared statement of Prof. Thomas L. Greaney).

177. *See* Jenny Gold, *FAQ on ACOs: Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Apr. 16, 2014), http://kaiserhealthnews.org/news/aco-accountable-care-organization-faq/.

178. *See id.*

179. *Id.* It is worth noting that hospitals are not reimbursed through Medicare payments at full cost. *Id.* Hospitals cover the bills through a system called charity care. *Id.*

180. *Id.*

181. *Id.*

provide financial incentives for doctors and hospitals to keep patients healthy and out of the hospital.[182]

Basically, ACOs organize care for groups of Medicare beneficiaries and consist of networks of doctors and hospitals.[183] An ACO's purpose is to coordinate care, reduce costs, improve quality of patient visits, and expand access for vulnerable populations.[184] It accomplishes this goal by creating incentives for healthcare providers to work, avoid unnecessary tests and procedures, and treat patients together by sharing patient information.[185] The Medicare Shared Savings Program ("MSSP") rewards ACOs that have low costs and meets certain standards of performance in quality of care.[186] Under the PPACA, each ACO is required to manage, at a minimum, 5000 Medicare beneficiaries for at least three years.[187] Accordingly, when a patient goes to a hospital for treatment, the hospital will refer the patient to a specialist in the ACO network.[188] The idea is that combining resources among individual practitioners, hospitals, physicians, and long-term care facilities will lower costs.[189]

Critics of the PPACA and ACO implementation are quick to acknowledge that ACOs, by nature, establish an integrated network of providers that can accelerate hospital mergers and provider consolidation.[190] Theoretically, hospitals and physician practices joining forces can increase market share and lead to higher health care costs and limited patient choice.[191] By some estimates, 488 ACOs are operating in all fifty states.[192] Of these 488, over 250 are currently enrolled in the MSSP.[193] It has been reported that new trends of hospital mergers are

182. *Id.*

183. *Id.*

184. *Id.*; *see also* Tara Adams Ragone, *Structuring Medicaid Acountable Care Organizations to Avoid Antitrust Challenges*, 42 SETON HALL L. REV. 1443, 1469 (2012).

185. Gold, *supra* note 177.

186. *Id.*

187. 42 U.S.C. § 1395jjj(b)(2)(D) (2006); *see also* DEP'T OF HEALTH & HUMAN SERVS., SUMMARY OF FINAL RULE PROVISIONS FOR ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM 5 (2014), *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf.

188. *See* Gold, *supra* note 177.

189. *Id.*

190. *Id.*

191. *See id.*

192. MATTHEW PETERSEN ET AL., LEAVITT PARTNERS, CTR. FOR ACCOUNTABLE CARE INTELLIGENCE, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS: AUGUST 2013 UPDATE 4 (2013), *available at* http://leavittpartners.com/wp-content/uploads/2013/08/Growth-and-Disperson-of-ACOs-August-20131.pdf.

193. *Id.* at 6.

caused by "clinics and doctor groups eager to share costs and savings, and cash in on the [ACO program's] incentives."[194] Others suggest that providers' underlying purpose in vertical integration and forming an ACO may be "to strengthen their market power over purchasers in the private sector."[195]

However, these arguments presuppose that ACOs cannot preserve procompetitive effects.[196] Significantly, federal agencies, including the Department of Justice and FTC, have worked closely with the Center for Medicaid and Medicare Services ("CMS") to establish guidelines for ACOs in a way that protects against hospital systems abusing market share.[197] These agencies have noted that, in some instances, ACOs would not benefit consumers and reduce competition, but rather harm consumers with lower quality of care and higher prices.[198] For that reason, the federal antitrust enforcement agencies developed an Antitrust Enforcement Policy ("Policy") to monitor ACO applicants.[199] Notably, the government plans on protecting "both Medicare beneficiaries and commercially insured patients from potential anticompetitive harm while allowing ACOs the opportunity to achieve significant efficiencies" in a series of ways.[200] First, the Policy allows ACOs a significant amount of flexibility in the organization of networks.[201] ACOs allow providers to contract among themselves but only to the extent that contracting does not limit competition.[202] Second, the Policy establishes exceptions for rural providers that might have special circumstances such as serving a limited number of beneficiaries.[203] Providers that are in more densely populated areas, however, are limited in their ability to engage in competitive contracting.[204] Finally, ACOs are required to submit data to CMS for the purpose of monitoring ACO performance.[205]

The agencies make clear that the Policy will only apply to the collaborations between independent providers and provider groups as

194. Robert Pear, *Consumer Risks Feared as Health Law Spurs Mergers*, N.Y. TIMES (Nov. 20, 2010), http://www.nytimes.com/2010/11/21/health/policy/21health.html?pagewanted=all&_r=0.
195. Havighurst & Richman, *supra* note 11, at 872.
196. *See PPACA Hearing*, *supra* note 9, at 8–9 (prepared statement of Prof. Thomas L. Greaney).
197. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011).
198. *Id.*
199. *Id.*
200. *Id.*
201. *Id.*
202. *Id.*
203. *See PPACA Hearing*, *supra* note 9, at 9 (prepared statement of Prof. Thomas L. Greaney).
204. *See* Statement of Antitrust Enforcement Policy, *supra* note 197.
205. *Id.*

ACO participants.[206] It is not meant to apply to hospital mergers that would be covered under the 2010 Guidelines.[207] Additionally, any sort of price fixing or market-share agreements is illegal under antitrust laws.[208] Therefore, because of the government antitrust agencies' involvement with and oversight of ACOs, it is unlikely that ACOs will contribute significantly to hospital consolidation.[209]

### *B. Nonprofit Hospitals Losing Charitable Giving Defense Under the PPACA*

In an antitrust analysis, the courts have traditionally granted leniency to nonprofit hospital mergers because of the perception that nonprofit hospitals are good for consumers, seek to achieve the best results for the community, and are not in the business to turn a profit.[210] As noted in Part II, this notion has steadily declined because of recent court cases[211] and changes in government policies. Moreover, studies[212] and new developments in tax-exempt analysis have also worked against this notion.[213] In 2005, Senator Charles Grassley, Chairman of the Senate Finance Committee, questioned the monetary value of hospital tax-exemptions compared to the benefit that they provide to the community.[214] Grassley stated, "Too many [hospitals] do little to nothing. Too often, it

206. *Id.* "Collaboration" comprises an agreement or set of agreements, other than merger agreements, among otherwise independent entities jointly to engage in economic activity. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N., ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS § 1.1 (2000), *available at* http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf.

207. Final Statement, *supra* note 197.

208. *See id.*

209. *See PPACA Hearing*, *supra* note 9, at 8–9 (prepared statement of Prof. Thomas L. Greaney).

210. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1297–98 (W.D. Mich. 1996). Historically, the argument that nonprofit hospitals do not have an incentive to raise prices was especially persuasive. *Id.* at 1297; *see also* United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989) (concluding that nonprofit status has a long tradition of free assistance to the underserved and therefore has no incentive to increase prices).

211. *See* Evanston Nw. Healthcare Corp., No. 9315, 2007 WL 2286195, at *53 (F.T.C. Aug. 6, 2007); *see also* United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot on unrelated grounds*, 107 F.3d 632 (8th Cir. 1997) (noting that there is nothing "inherent in the structure of the corporate board or the non-profit status of the hospitals which would operate to stop any anticompetitive behavior").

212. *See, e.g.*, Gary J. Young et al., *Community Control and Pricing Patterns of Nonprofit Hospitals: An Antitrust Analysis*, 25 J. HEALTH POL. POL'Y & L. 1051 (2000) (concluding that nonprofit hospitals exercise market power in the form of raising prices especially when oversight is lacking).

213. *See* Robert Pear, *I.R.S. Checking Compliance by Tax-Exempt Hospitals: Inquiry May Bring Changes in Standards*, N.Y. TIMES, June 19, 2006, at A15.

214. *Id.*

seems that tax-exempt hospitals offer less charitable care and community benefit than for-profit hospitals."[215]

Specifically, the way in which the law addresses tax-exempt status and charitable giving has led to new provisions in the PPACA.[216] The PPACA has changed the requirements for nonprofit hospitals under Section 9007 "Additional Requirements for Charitable Hospitals."[217] Before the PPACA, the IRS required hospitals to engage in "community benefit activities" to receive a federal tax-exemption.[218] Among the advantages of being considered a tax-exempt entity under the Federal Revenue Code were receipt of tax-deductible contributions, federal income tax-exemption, and the ability to issue tax-free bonds.[219] It was estimated that these federal benefits could amount to $50 billion annually.[220] In 2005, however, the U.S. Government Accountability Office ("GAO") concluded that the tax-exempt policy failed to hold nonprofit hospitals accountable for the services they provided to the public.[221] Particularly, many hospitals were not even eligible for tax-exemption based on the value of charity care if expressed in cost rather than charges.[222]

The community benefit standard has been challenged in recent years. It was questioned by the *Wall Street Journal*, which published the abusive

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215. *Id.*

216. *See PPACA Hearing*, *supra* note 9, at 7 (prepared statement of Prof. Thomas L. Greaney).

217. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

218. U.S. GOV'T ACCOUNTABILITY OFFICE, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFITS REQUIREMENTS 10 (2008).

219. Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 310–11 (2007).

220. *Id.* at 311.

221. *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. 19 (2005) (statement of David M. Walker, Comptroller General of the United States), *available at* http://www.gao.gov/products/GAO-05-743T.

222. Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 465 (2007) (citing studies by the Cong. Budget Off., the Gen. Acct. Off, and the Ctr. For Tax and Budget Accountability); *see also* CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (2006); *Nonprofit Hospitals: Better Standards Needed for Tax Exemption: Hearing Before the H. Select Comm. on Aging*, 101st Cong. (statement of Mark V. Nadel, Associate Director for National and Publich Health Issues, U.S. General Accounting Office); HEATHER O'DONNELL & RALPH MARTIRE, CTR. FOR TAX AND BUDGET ACCOUNTABILITY, AN ANALYSIS OF THE TAX EXEMPTIONS GRANTED TO COOK COUNTY NON-PROFIT HOSPITALS AND THE CHARITY CARE PROVIDED IN RETURN (2006). The term "bad debt" is used to describe the financial losses incurred by a hospital regarding the difference between what they receive and what it costs to provide the service. O'DONNELL & MARTIRE, *supra*, at 2. Conversely, "for-profits refer to [uncompensated care] as bad debt; nonprofits refer to it as charity care." John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare For the Poor*, 51 ST. LOUIS U. L.J. 433, 433 (2007).

billing practices of a number of nonprofit hospitals.[223] The *Wall Street Journal* reported that nonprofit hospitals were more financially stable than for-profit hospitals.[224] According to one article, seventy-seven percent of nonprofit hospitals earned a profit whereas only sixty-one percent of for-profit hospital earned one.[225] The articles' criticism of the community benefit standard is supported by case law.[226] Together, these concerns forced Congress to alter the community benefit standard and ensure that nonprofit hospitals were providing sufficient levels of charity care through Section 9007.[227]

The PPACA requires that hospitals perform a "community health needs assessment" ("CHNA") every three years to keep their federal nonprofit status.[228] The CHNA was implemented in response to the varied charity practices among nonprofit hospitals that allowed hospitals to inflate their charges.[229] Under the CHNA standard, each hospital is required to implement a strategic plan to address the community's health needs by making the information publicly available and consulting health experts and local community members.[230] Additionally, under the PPACA, tax-exempt hospitals are limited in the amount they can charge for care

223. *See* Amanda W. Thai, *Is Senator Grassley Our Savior?: The Crusade Against "Charitable" Hospitals Attacking Patients for Unpaid Bills*, 96 IOWA L. REV. 761, 771 n.62 (2011).

224. John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once for the Poor, Strike It Rich*, WALL ST. J., Apr. 4, 2008, at A1.

225. *Id.* Many states have stripped nonprofit status from hospitals and have more stringent tax-exemption standards than the federal government. *See* Provena Covenant Med. Ctr. v. Dep't of Revenue, 925 N.E.2d 1131, 1144 (Ill. 2010) ("[T]ax exemption under federal law is not dispositive of whether real property is exempt from property tax under Illinois law."); Dialysis Clinic, Inc. v. Levin, 938 N.E.2d 329 (Ohio 2010) (reconsideration denied).

226. The Supreme Court of Utah revoked the state tax-exemption of several hospitals that used less than one percent of their revenues for treatment of the poor. Utah Cnty. v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985). Also, the Supreme Court of Pennsylvania required a nonprofit hospital to donate a substantial portion of its services to be eligible for state tax status. Hospital Utilization Project v. Commonwealth, 487 A.2d 1306, 1319 (Penn. 1985). Over time, more nonprofit hospitals' tax-exempt statuses were challenged. Colombo, *supra* note 221, at 435–56. In *Provena Covenant Medical Center*, the Illinois Supreme Court ruled that the hospital lacked availability of charity care to justify tax-exemption. *Provena Covenant*, 925 N.E.2d at 1145–55.

227. Bobby A. Courtney, *Hospital Tax-Exemption and the Community Benefit Standard: Considerations for Future Policymaking*, 8 IND. HEALTH L. REV. 365, 396 (2011).

228. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). All § 9007 requirements other than CHNA apply to taxable years beginning after March 23, 2010. *Id.* § 9007(f).

229. *See* Lisa Kinney Helvin, Note, *Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 455 (2008).

230. Patient Protection and Affordable Care Act § 9007(a)(1)(3). The PPACA also requires a description by each hospital of how it plans to address the needs of the community and an explanation of why the hospital has not addressed those needs in the past. *Id.* § 9007(d).

provided to patients who are eligible for financial assistance.[231] The PPACA limits these charges to no more than the amount generally billed to insurance companies, which typically bargain for a lower price.[232] The PPACA intends to limit the amount billed to those who qualify for financial assistance and to base the charges on negotiated commercial rates or Medicare rates.[233]

Modifying the way in which charity care is approached at the federal level will fundamentally change the antitrust analysis.[234] In *Butterworth*, the court acknowledged that nonprofit hospitals were in the charity business and deferred judgment to the healthcare sector to provide for the community's best interest.[235] These trends led to a string of cases in which antitrust enforcers lost challenges to proposed mergers.[236] However, now that the amount of charity care provided is more closely scrutinized,[237] providers will face a higher hurdle when demonstrating charitable benefits of the merged entity.[238] Additionally, before the implementation of the PPACA, the uninsured patient's bills were covered by hospitals through charity care.[239] Now that all persons are required to be insured in some form under the PPACA, fewer people will be eligible for charity care provided by hospitals.[240] In summary, the PPACA (1) limits the amount

231. *See id.* § 9007(a)(1)(5), § 10903(a).

232. *Id.*

233. STAFF OF JOINT COMM. ON TAXATION, JCX-18-10, TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" 82 (2010). Under the PPACA, the Department of Treasury will review a hospital every three years. Patient Protection and Affordable Care Act § 9007(c). Hospitals that do not meet the CHNA requirement for any year will be fined an excise tax of $50,000 and could lose their federal tax-exempt status. *Id.* § 9007(b).

234. *See* Lizzy Magarian, Note, *PPACA: Leveling the Payment Field*, 20 ANNALS HEALTH L. 57 (2011), *available at* http://luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/ issue6/ magarian.pdf.

235. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996). One scholar calls judges' historic reluctance to apply antitrust principles to health care mergers as "judicial disdain" and an outright "rejection of conventional norms that guide competition law." Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF. 185, 187–88 (2002). Greaney notes that case law has limited the government's "ability to control concentration and has given overly permissive signals to providers who are contemplating further consolidation." *Id.* at 193.

236. *See* FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1053 (8th Cir. 1999); FTC v. Freeman Hosp., 69 F.3d 260, 273 (8th Cir. 1995); California v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot on unrelated grounds*, 107 F.3d 632 (8th Cir. 1997).

237. *See* JOINT COMM. ON TAXATION, *supra* note 233.

238. *See* Magarian, *supra* note 234.

239. *See* Havighurst & Richman, *supra* note 11, at 858.

240. *See* Courtney, *supra* note 227, at 379.

that hospitals can charge for charity-care services and (2) reduces the number of people eligible for charity care. Combined, these two effects will make it more difficult for hospitals to rely on the charity-care defense.

Overall, it does not appear that the PPACA will increase hospital consolidation. In actuality, it may prevent mergers from occurring in the first place.[241] At first glance, the PPACA's encouragement of ACOs that consist of networks of hospitals and patients seems like a potential antitrust problem. However, government agencies developed a framework with hospital consolidation in mind and have sought to ensure that ACOs would not encourage hospital mergers.[242] First, hospital mergers and ACOs are analyzed under separate frameworks.[243] Accordingly, the PPACA's encouragement of ACOs is not likely to advance healthcare consolidation. Second, the changes in the charity care proposed by the PPACA inhibit one of hospital systems' main defenses: the charity-care defense. No longer can hospitals inflate charges to the uninsured and count that towards charity-care expenditures.[244] Moreover, because the government is now covering many previously uninsured patients, the opportunity for hospitals to provide charity care is reduced.[245] Therefore, the ACO and charity-care portions of the PPACA are not likely to advance hospital consolidation.

## CONCLUSION

Traditionally, hospital mergers were seen as a benefit to consumers. The belief was that even if hospital consolidation led to higher prices, any additional profits would be funneled back to the community through charity care. However, that is no longer the case. After years of nonprofit hospitals engaging in price inflation and misreporting charity care, new hospital mergers will be more heavily scrutinized, and courts may distinguish previous decisions to find an antitrust violation.[246]

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241. *See PPACA Hearing*, *supra* note 9, at 8–9 (prepared statement of Prof. Thomas L. Greaney).

242. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a)(1)(5), 124 Stat. 119, 855 (2010).

243. *See* ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS, *supra* note 206.

244. *See* Patient Protection and Affordable Care Act § 9007(a)(1)(5), § 10903(a).

245. *See* Courtney, *supra* note 227, at 379.

246. *See* FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1080 (N.D. Ill. 2012). The district court in *OSF* distinguished the previous pro-merger holdings of FTC v. Freeman Hosp., 69 F.3d 260 (8th Cir. 1995); FTC v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999); FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996); and United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997). *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1080–82.

Specifically, the revised version of the 2010 Guidelines shrinks the relevant market, separates hospital services into individual lines, and requires more than a good faith standard for evidence of proposed efficiencies.[247] Additionally, courts have moved away from the belief that nonprofit hospitals will not seek to maximize profits[248] and have allowed post merger challenges on that basis.[249] Challenging already consummated mergers has uncovered direct evidence that hospital executives were increasing prices as a monopolist[250] and has worked to discredit previous studies supporting the notion that nonprofit hospitals exhibit a lower association between market share and price.[251] The resurgence of hospital merger cases in the federal courts combined with the PPACA provisions—namely, ACO implementation and redefined charity-care standards—will subject mergers to heightened scrutiny. Arguably some damage has already been done in the hospital merger setting,[252] but it is certain that, going forward, nonprofit hospitals no longer enjoy the same deference as before.

*Collin Z Groebe*[*]

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247. *See* Complaint, Reading Health Sys., *supra* note 109, at 10; 2010 GUIDELINES, *supra* note 61, § 10.

248. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1081.

249. *See* Evanston Nw. Healthcare Corp., No. 9315, 2007 WL 2286195, at *12 (F.T.C. Aug. 6, 2007).

250. *See id.*

251. In *Butterworth*, the court cited Lynk's article, *supra* note 171, in determining whether nonprofits price lower than for-profits. FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1296 (W.D. Mich. 1996). The article finds that "nonprofit hospitals, whether private or public, have statistically significantly lower list and net prices than for-profit hospitals." Lynk, *Nonprofit Hospital Mergers*, *supra* note 171, at 449–52. The court in *Evanston Nw. Healthcare Corp.*, rejected the application of Lynk's article. *See Evanston Nw. Healthcare Corp*., 2007 WL 2286195, at *12–13.

252. *See* Havighurst & Richman, *supra* note 11, at 871.

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