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ANTITRUST ISSUES OF NON-PROFIT HOSPITAL MERGERS

INTRODUCTION

Antitrust laws in the United States have an interesting and varied history in the area of non-profit organizations,[1] particularly with respect to non-profit hospitals.[2] The emergence of this legal phenomenon is attributable to the multitude of economic and social questions raised by the health care industry in the antitrust regulation context.[3]

1 *See* N.C.A.A. v. Board of Regents of the Univ. of Oklahoma, 468 U.S. 85, 100 n.22 (1984). "The sweeping language of section one of the Sherman Act applies to non-profit entities." *Id.* In this case, the Supreme Court ruled that NCAA restrictions on which college football games could be televised were an unreasonable restriction of trade. *Id.*; *see also* Maxwell M. Blecher, *Applicability of Federal Antitrust Laws to Not for Profit Organizations, in* NOT FOR-PROFIT ORGANIZATIONS 1992, at 391, 393 (ALI-ABA Course of Study No. C726, 1992) (citing American Society of Mechanical Eng'r, Inc. v. Hydrolevel Corp., 456 U.S. 556, 576 (1982)). Where not-for-profit entities engage in an activity which is commercial in nature, "it is beyond debate that non-profit organizations can be held liable under the antitrust laws." *Id. See generally* Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284, 297 (1985). The Supreme Court analyzed a non-profit cooperative buying association's activity under the Sherman Act. *Id.* The Court, however, held that per se illegality was not applicable in this case absent a showing of anti-competitive impact. *Id.*; National Soc'y of Prof'l Eng'r v. United States, 435 U.S. 679, 692-94 (1978). The Court held that a non-profit association's canon of ethics, prohibiting competitive bidding amongst its members, violated the Sherman Act under the Rule of Reason. *Id.*

2 *Compare* United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278, 1286 (7th Cir. 1990) (affirming prohibition of non-profit hospital merger under section one of Sherman Act, however, circuit court declined to comment on whether district judge was correct in enjoining non-profit organization's merger under purview of section seven of Clayton Act), *with* United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042, *available in* 1989 WL 157282, at *1-3 (4th Cir. 1989) (permitting merger of non-profit hospitals to proceed by holding that merger did not constitute unreasonable restraint on trade under section one of Sherman Act, however, circuit court did not rule on district court's holding that section seven of Clayton Act did not apply to merger). *See generally* F.T.C. v. Freeman Hosp., 69 F.3d 260, 260 (8th Cir. 1995) (noting that Federal Trade Commision's failure to adequately define "relevant market" for non-profit hospitals was reason why circuit court did not grant injunction to stop proposed hospital merger).

3 *See* Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93, 94 (1988) (noting present antitrust constraints on hospital mergers seem novel to hospitals, lawyers, and courts due to dramatic changes in antitrust laws, hospital industry structure, and regu-

Attempts in the last two decades to limit burgeoning health care costs through regulation and the encouragement of competition have done little to slow the rapid increase of health care costs.[4] The result has been a confusing amalgam of regulation and industry guidelines that have failed to simplify what is already a complex and pivotal issue at the forefront of the United States' socio-economic agenda.[5] This confusion has prompted an increased number of hospital mergers, in both the profit and non-profit arenas.[6] The aforesaid system requires a solution that

latory framework applied to hospital activities); *see also* Michael S. Jacobs, *When Antitrust Fails: Public Health, Public Hospitals, and Public Values*, 71 WASH. L. REV. 899, 899 (1996) (claiming large operating deficits have been problematic for public hospitals, forcing these institutions to close, sell, or substantially reduce services, therefore, leading to severe crisis in health care for urban poor and uninsured).

4 *See* Stephen Paul Paschall, *Antitrust and Hospital Mergers: A Law and Economics Rationale for Exemption*, 30 DUQ. L. REV. 61, 63-64 (1991) (noting despite government initiatives, such as Comprehensive Health Planning and Public Health Services Amendments of 1966, to help contain rising costs of health care, both cost and health services continue to expand); *see also* Thomas Campbell & James W. Teevans, *Mixed Signals: Recent Cases Make the Legality of Future Hospital Mergers Less Predictable*, 59 ANTITRUST L.J. 1005, 1007-08 (1990-91) (detailing government's chief rationale for challenging not-for-profit hospital mergers as permitting merger of two local hospitals would reduce number of bidders that HMO's could bargain with, therefore, forcing HMO's to accept higher price and increasing chances of anti-competitive effects); Mark Krause, *"First, Do No Harm": An Analysis of the Non-Profit Hospital Sales Act*, 45 U.C.L.A. L. REV. 503, 565 (1997) (asserting that dominance of for-profit hospitals has anti-competitive effects on non-profit hospitals, and increases potential for higher health care costs).

5 *See* Baker, *supra* note 3, at 96-97 (explaining that government's over-zealous regulation of health care industry has only raised health care prices, forcing hospitals to combine or close their doors). *See, e.g.*, Hospital Corp. of Am. v. F.T.C., 807 F.2d 1381, 1387 (7th Cir. 1986) (discussing effect of certificates of need on hospital markets); Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1325 (7th Cir. 1986) (approving hospitals' right to adopt "PPO" plan because plan did not increase market power of institutions); *Justice Department Will Not Challenge Proposal to Form Provider Network in Santa Fe, New Mexico*, D.O.J. News Release 97-066 (Feb. 12, 1997) (highlighting procedural steps provider network took to avoid antitrust violation).

6 *See* Edward S. Kornreich, *Health Care M & A: Update on Major Regulatory, Legislative, and Industry Initiatives*, *in* HEALTH CARE M & A, 1997, at 101, 105 (PLI Corp. L. Practice Course Handbook Series No. B4-7190, 1997).

> In today's environment, healthcare providers and payors are combining or affiliating with one another at such a rate that by the year 2000 the sole practitioner, the single unaffiliated hospital and the old-fashioned indemnity insurer will be rare examples of a bygone age. Providers and payors are integrating both to gain control over costs as well as to better position themselves to gain access to patient populations through the use of managed care health plans.

Id.; In 1996, 768 hospitals reported involvement in 235 merger and acquisition deals, where in contrast, only 650 hospitals were involved in a total of 184 affiliations in 1994. *Id. See generally FTC Obtains Relief for Health Care Consumers in California County; Hospital and Related Assets to be Divested as Antitrust Remedy For Merger of Two Large Hospital Chains*, F.T.C. News Release (Jan. 29, 1997), *available in* 1997 WL 31911, at *1. Better health care and lower costs are concerns that countervail issues of anti-competition. *Id.*; *FTC Ends Administrative Challenge to Hospital Merger in Grand Rapids Michigan*, F.T.C. News Release (Sept. 26, 1997), *available in* 1997 WL 598649, at *1. The FTC analyzes the decisions to continue litigation against hospital mergers that have

addresses the economic concerns[7] central to antitrust legislation, as well as social policy concerns integral to our nation's well being.[8]

The application of antitrust laws to non-profit hospital mergers fails to adequately serve these concerns.[9] The current state of affairs demands a drastic overhaul and re-evaluation.[10] The solution lies in a new and consistent treatment of non-profit hospitals and the way in which they conduct business.[11] Minor adjustments to the manner in which antitrust laws are applied to non-profit hospital mergers would better serve those same economic and social policy concerns. When analyzing non-profit hospital mergers, courts utilize the per se rule of illegality which is applicable to all antitrust cases.[12] However, this very rule de-

potential antitrust implications on a case by case basis. *Id.*

7 *See generally* William G. Kopit & Robert W. McCann, *Toward a Definitive Antitrust Standard for Non-profit Hospital Mergers*, 13 J. HEALTH POL. POL'Y & L. 635, 636 (1988) (discussing need for clarifying antitrust policy and economic concerns of non-profit hospital mergers).

8 *See generally* David L. Glazer, *Clayton Act Scrutiny of Non-Profit Hospital Mergers: The Wrong RX for Ailing Institutions*, 66 WASH. L. REV. 1041, 1056-58 (1991) (asserting that promotion of non-profit hospital mergers benefits consumers by improving quality of services and access to hospital facilities).

9 *See* Baker, *supra* note 3, at 96 (claiming congressional initiatives have only exacerbated problem of skyrocketing health care costs); *see also* Glazer, *supra* note 8, at 1054 (outlining new standards for antitrust analysis of non-profit hospital mergers); Laura L. Stephens, Note, *Nonprofit Hospital Mergers and Section 7 of the Clayton Act: Closing an Antitrust Loophole*, 75 B.U. L. REV. 477, 503 (1995) (contending that current FTC regulation of non-profits is both uncertain and unnecessary). *But see* Dennis A. Yao, Note, *The Analysis of Hospital Mergers and Joint Ventures: What May Change?*, 1995 UTAH L. REV. 381, 381 (1995) (stating hospital industry should not be treated any differently than any other business in antitrust matters).

10 *See generally* Robert F. Leibenlutt & David R. Pewder, *FTC Antitrust Actions In Health Care Services*, *in* HEALTH CARE 1996, at 487, 510 (PLI Corp. L. Practice Course Handbook Series No. A4-4502, 1996) (indicating new regulation of hospital mergers is needed); Jonathon Choslovsky, Note & Comment, *Agency Review of Health Care Industry Mergers: Proper Procedures or Unnecessary Burden*, 10 ADMIN. L.J. AM. U. 291, 292 (1996) (describing criticism of current anti-trust procedures); William M. Stelwagon, Note, *Does a Healthy Patient Need a Cure? A Response to Health Care Industry Proposals to Reform Antitrust Analysis of Horizontal Hospital Mergers*, 69 ST. JOHN'S L. REV. 553, 572 (1995) (discussing strong objection to federal anti-trust laws that inhibit health care industry reform).

11 *See* William G. Kopit & Tonya B. Vanderbilt, *Unique Issues in the Analysis of Non-Profit Hospital Mergers*, 35 WASHBURN L.J. 254, 254-55 (1996) (examining failure of federal antitrust enforcement agencies to recognize unique nature of hospital industry as compared to others in antitrust arena). *But see* Glazer, *supra* note 8, at 1059 (claiming close scrutiny of non-profit hospital mergers is necessary to protect competition); Yao, *supra* note 9, at 381 (stating that hospital industry poses just as much threat to antitrust as any other industry, and should be treated as such).

12 *See* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 363 (1963) (explaining that mergers which produce firms controlling undue percentage share of relevant market, and result in significant increases in concentration of firms in that market are so inherently likely to lessen competition substantially that they must be enjoined in ab-

feats the principles central to the antitrust laws and health care policy when applied to non-profit hospital mergers.[13]

This Note will analyze the shortcomings of antitrust legislation as applied to non-profit hospital mergers. Part I of this Note will briefly explain the purpose and trace the development of antitrust merger legislation. Part II will introduce the problems that arise in constructing narrow product and geographic markets for non-profit hospitals. Part III will critique the method utilized by courts to predict probable anti-competitive impacts, with a specific emphasis on the per se illegality rule. Finally, Part IV of this Note will analyze affirmative defenses, particularly the efficiencies defense in non-profit hospital mergers, and raise social policy concerns that the courts should consider when scrutinizing these mergers.

I. HISTORICAL BACKGROUND

The government employs Section 1 of the Sherman Act[14] and Section 7 of the Clayton Act[15] to enforce the antitrust merger laws,[16] and to oppose non-profit hospital mergers.[17] The goal of

sence of evidence clearly showing that they are not likely to have such anti-competitive effects); United States v. Baker Hughes, 908 F.2d 981, 982 (D.C. Cir. 1990) (holding that showing of undue concentration in market for particular product in particular geographic area establishes presumption of illegality). *See, e.g.*, United States v. Citizens & S. Nat'l Bank, 422 U.S. 86, 120-22 (1975) (stating government's showing that defendant was predominant banking institution in locale and that proposed acquisitions would increase their market share was enough for government to develop prima facie case under section seven); Brown Shoe v. U.S., 370 U.S. 294, 315 (1962) (discussing tests of illegality under section seven to determine market dominance).

13 *See, e.g.*, United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1286 (7th Cir. 1990) (applying per se illegality, but citing studies which may after more development justify exception to per se rule for non-profit hospitals); F.T.C. v. Butterworth Health Corp., 946 F.Supp 1285, 1295 (W.D. Mich. 1996) (arguing that there is good reason to question applicability of traditional presumption of illegality in non-profit hospital mergers). *But see* F.T.C. v. University Health, Inc., 938 F.2d 1206, 1218 (11th Cir. 1991) (finding hospitals' arguments against per se illegality ineffective against governments prima facie case).

14 Sherman Antitrust Act § 1, 15 U.S.C.A. § 1 (1997).

15 Clayton Act § 7, 15 U.S.C.A. § 18 (1997).

16 *See* Sherman Antitrust Act § 1, 15 U.S.C.A. § 1 (1997) (regulating mergers whose present purpose or effect is to restrain trade); Clayton Act § 7, 15 U.S.C.A. § 18 (1997) (preventing mergers that might have future anti-competitive effects). *See generally Philadelphia Nat'l Bank*, 374 U.S. at 355 (noting that not every violation of section seven, as amended, would necessarily be violative of Sherman Act); *Brown Shoe*, 370 U.S. at 317-18 n.32 (explaining that Clayton Act unlike Sherman Act, was designed to reach future anti-competitive effects under incipiency standard); Times-Picayune Publ'g Co. v. United States, 345 U.S. 594, 614-15 (1953) (describing purpose or effect standard of section one of Sherman Act).

17 *See University Health, Inc.*, 938 F.2d at 1206 (holding that section seven of Clay-

these legislative vehicles is to promote competition, economic efficiency and consumer welfare.[18] Both acts seek to maintain competitiveness in the marketplace by preventing any one seller from controlling a significant portion of the market share in a particular locale.[19] The government's concern is that elimination of competition will result from collusion among competitors,[20] thereby forcing the consumer to bear the burden of increased cost.[21]

The first section of the Sherman Act, passed in 1890, addresses "unreasonable restraints" on trade.[22] Courts have gradually taken advantage of this broad language and applied Section 1 of the Act, in order to prevent the merger of various or-

ton Act applied to asset acquisitions by nonprofit hospital, FTC established that proposed acquisition would substantially lessen competition in violation of section seven of Clayton Act, and that substantial barriers to entry into relevant market existed); United States v. North Dakota Hosp. Ass'n, 640 F.Supp. 1028, 1028 (D. N.D. 1986) (ruling that alleged agreement affected interstate commerce, meeting jurisdictional requirement of Sherman Act and agreement was unreasonable restraint of trade under section One of Sherman Act). *But see* United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 892 F. 2d 1042, 1042 (4th Cir. 1989) (dismissing action under section seven of Clayton Act on ground that it had no application because merging corporations neither had stock nor were they subject to jurisdiction of Federal Trade Commission). *See generally Rockford*, 898 F.2d at 1282 (explaining that both Clayton and Sherman Acts require judicial interpretation and, after three-quarters of century, have converged).

18 *See* Paschall, *supra* note 4, at 74 (discussing goals of antitrust law in general (citing Phillip C. Kissam et. al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595, 670 (1982))); *see also* Baker, *supra* note 3, at 100 (mentioning that economic efficiency has become main goal of antitrust legislation replacing populist goals of past).

19 *See* Glazer, *supra* note 8, at 1045 (explaining impetus behind federal antitrust merger law); *see also* II AREEDA & TURNER, ANTITRUST LAW, ¶ 501 (1978) (defining market power as ability to raise prices by restricting output). *See generally* Atlantic Richfield Co. v. U.S.A. Petroleum Co., 495 U.S. 328, 328 (1990) (holding that independent marketer of gasoline suffered no "antitrust injury"); Cargill, Inc. v. Monfort of Colorado, Inc., 479 U.S. 104, 104 (1986) (deciding that plaintiff's injury would not result from possible merger); United States v. Falstaff Brewing Corp., 410 U.S. 526, 531-32 (1973) (deeming intent irrelevant with respect to potential antitrust merger).

20 *See Cargill*, 479 U.S. at 115 (explaining that purpose of antitrust laws is to protect competition); *see also* Brooke Group LTD. v. Brown & Williamson Tobacco Corp, 509 U.S. 209, 252 n.14 (1993) (stating that antitrust laws are aimed at protecting competition in marketplace); Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 778 (1990) (indicating antitrust laws guard against anti-competitive conspiracies).

21 *See Rockford*, 898 F.2d. at 1282-83 (quoting Hospital Corp. of Am. v. FTC, 807 F.2d. 1381, 1386 (7th Cir. 1986)). ". . .the current understanding of section seven is that it forbids mergers that are likely to 'hurt consumers, as by making it easier for the firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level." *Id.*; *see also* F.T.C. v. Elders Grain, Inc., 868 F.2d 901, 904 (7th Cir. 1989). Anti-competitive practices shift costs on to the consumer. *Id. See generally* United States v. Citizens and Southern Nat'l Bank, 422 U.S. 86, 150 (1975). Dangers of highly concentrated markets are likely to result in higher costs to the consumer. *Id.*

22 *See* 15 U.S.C.A. § 1.

ganizations both profit and non-profit.[23]

In 1914 Congress passed the Clayton Act[24] as a response to concerns that the Sherman Act did not completely prevent anti-competitive mergers.[25] Section 7 of the Clayton Act was enacted to complement Section 1 of the Sherman Act in its attempt to promote sufficient competition in the marketplace.[26] Section 7 granted the government the power to enforce this antitrust legislation, absent the burden of proving that a merger had present anti-competitive effects.[27] The Clayton Act effectively authorized the government to attack any merger that might have potentially harmful effects on the market, without an actual showing of anti-competitiveness.[28]

The adoption of these antitrust merger laws prompted much

23 *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 786-87 (1975) (applying language of section one to non-profit entities). *See generally* F.T.C. v. Motion Picture Adv. Serv. Company, 344 U.S. 392, 393 (1953) (holding unlawful, under section one of Sherman Act, exclusive arrangements whereby four major firms in film industry had foreclosed seventy-five percent of relevant market).

24 15 U.S.C.A. § 7.

25 *See* Jonathan L. Disenhaus, Comment, *Competitor Standing to Challenge a Merger of Rivals: The Applicability of Strategic Behavior Analysis*, 75 CALIF. L. REV. 2057, 2069-70 (1987) (noting Congress found that proof requirements of Sherman Act do not address concerns over illegal mergers); *see also* Mark L. Glassman, Comment, *Can HMO's Wield Market Power? Assessing Antitrust Liability in the Imperfect Market for Health Care Financing*, 46 AM. U. L. REV. 91, 102 (1996) (claiming Clayton Act supplements Sherman Act by making four enumerated practices illegal); Glazer, *supra* note 8, at 1046 (arguing Clayton Act's passage in 1914 was ineffective in forestalling anti-competitive practices); Paul A. Jorissen, Comment, *Antitrust Challenges to Nonprofit Hospital Mergers Under Section 7 of the Clayton Act*, 21 LOY. U. CHI. L.J. 1231, 1237 (1990) (explaining Congress' intent to lower standard of proof under section seven of Clayton Act due to dissatisfaction with court interpretations under Sherman Act).

26 *See* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 354-55 (1963) (stating tests of illegality under Sherman and Clayton Acts are complimentary); *see also* Cargill, Inc. v. Monfort of Colo., Inc., 479 U.S. 104, 124 (1986) (Stevens, J., dissenting) (explaining that section seven of Clayton Act was enacted due to Congress' conclusion that Sherman Act's prohibition against mergers was inadequate); Gulf Oil Corp. v. Copp Paving Co., Inc., 419 U.S. 186, 201 (1974) (indicating that Clayton and Sherman Acts were intended to complement one another).

27 *See* Brown Shoe v. United States, 370 U.S. 294, 317-18 n.32 (1962) (describing forward looking nature of 'incipiency' standard under Clayton Act section seven); *see also* United States v. E.I. Du Pont de Nemours & Co., 353 U.S. 586, 589 (1957) (stating section seven was designed to allow U.S. government to discourage anti-competitive practices).

28 *See* United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 898 F.2d 1278, 1282 (7th Cir. 1990). "The response of the draftsmen of the Clayton Act was to identify particular anti-competitive practices and forbid them upon a showing not that they would, but merely that they might, lessen competition substantially." *Id.*; *see also Brown Shoe*, 370 U.S. at 316. This court recognized that the act was designed to apply to all mergers that lessened competition. *Id.*; William Blumenthal, *Merger Analysis Under the U.S. Antitrust Laws, in* 38TH ANNUAL ANTITRUST LAW INSTITUTE 1997, at 353, 355 (PLI Corp. L. Practice Course Handbook Series No. B4-7183, 1997). The Federal Trade Commission has the authority to discourage any act that tends to effect commerce. *Id.*

confusion regarding the issue of whether Section 1 of the Sherman Act and Section 7 of the Clayton Act could be applied interchangeably.[29] Moreover, it was necessary to determine whether either section even applied to non-profit entities.[30] Today, the proponents of non-profit organization mergers argue that the fact that a particular entity is not for profit rebuts the applicability of antitrust merger legislation to such actions.[31] Proponents proffer the rationale that because non-profit organizations lack the impetus to seek increased returns, they would not be motivated to engage in any activity to eliminate competition.[32] Nevertheless, the Supreme Court has stated that because non-profit entities actively seek revenue, they should not be exempt from antitrust legislation scrutiny.[33] Various cases from the Supreme Court note that non-profit entities are neither free from the language of Section 1 of the Sherman Act,[34] nor the per se illegality

29 *See* American Bar Association, *Seventh Circuit Says No to Rockford Merger*, 4 HEALTH LAWYER, Spring-Summer 1990, at 1 (proposing that section one and section seven standards are quite different).

30 *See* Owen S. Mudge, Jr. & Allan Gibofsky, *The Developing Application of Antitrust Laws to Hospital Mergers*, 15 J. LEGAL MED. 355, 368 (1994) (comparing conflicting holdings of *Rockford* and *Carilion*); *see also* Glazer, *supra* note 8, at 1041 (noting split in federal circuits over whether non- profit mergers are subject to Clayton Act scrutiny).

31 *See* F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1296 (W.D. Mich. 1996) (arguing that many non-profit hospital boards are comprised of community business leaders who have direct stake in maintaining high quality, low cost hospital services); *see also* United States v. Mercy Health Serv., 902 F. Supp. 968, 987 (N.D. Iowa 1995) (asserting hospital's non-profit status and procompetitive intent as defense to merger); United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 849 (W.D.Va. 1989) (concluding that hospital's non-profit status weighed in favor of merger's reasonableness, but declining to answer whether defendants non-profit status exempts them from section one scrutiny). *See generally* Joseph Kattan, *The Role of Efficiency in the Federal Trade Commission's Antitrust Analysis*, 64 ANTITRUST L.J. 613, 614 (1996) (contending that non-profit mergers simply do not instill same concerns as for-profit mergers).

32 *See* Campbell & Teevans, *supra* note 4, at 1026 (explaining fundamental difference between for-profit and not-for-profit entities is that no trustee or administrator of not-for-profit entity could personally profit from pricing decision since they are not shareholders and have no incentive compensation).

33 *See* N.C.A.A. v. Board of Regents of Univ. of Okla., 468 U.S. 85, 101 (1984) (ruling section one antitrust liability applicable to non-profit entities); *see also* American Soc'y of Mechanical Eng'r, Inc. v. Hydrolevel Corp., 456 U.S. 556, 576 (1982) (refusing to lessen antitrust scrutiny for non-profit entity). *But see* Marjorie Webster Junior College Inc. v. Middle States Ass'n of Colleges & Secondary Sch. Inc., 432 F.2d. 650, 654 (D.C. Cir. 1969) (noting that Sherman Act liability is reduced when merging non-profit organizations have no intent to affect commercial competition); Paschall, *supra* note 4, at 68 (arguing that utility maximizing philosophy of hospitals increases profits to improve quality of care and patient capacity).

34 *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 786-87 (1975) (indicating heavy presumption against implicit exemptions to section one of Sherman Act). *See, e.g.*, *N.C.A.A.*, 468 U.S. at 100 n.22 (emphasizing section one's application to non-profit entities); *American Soc'y of Mechanical Eng'r*, 456 U.S. at 576 (finding that non-profit en-

rule set forth in antitrust cases.[35] The Supreme Court has yet to decide, however, whether non-profit hospitals should be subject to the same examination for antitrust violations that other non-profit entities are subject to.[36]

In the last two decades the number of hospital mergers has rapidly increased.[37] Constant changes in the health care industry along with the increase in the number of mergers have consequently resulted in frequent application of antitrust laws to hospitals.[38] Despite the agreement that antitrust legislation is applicable to non-profit hospitals, the courts cannot reach unanimity as to the method of analysis applicable under the Clayton and Sherman Acts.[39] A thorough examination of the purpose of antitrust legislation and its application to non-profit hospitals

tity's liability for acts of agent committed with apparent authority serves both purposes of antitrust law and principles of agency law).

35 *See* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 332 (1982) (holding that price fixing by non-profit organization calls for application of per se rule); John G. Addino et. al. v. Genesee Valley Med. Care, Inc., 593 F.Supp. 892, 892 (W.D.N.Y. 1984) (stating by-laws of non-profit corporation provided its member medical doctors with power to horizontally fix prices among competitors and, therefore, fell within per se illegality under Sherman Act).

36 *See* Joe Sims & Deborah P. Herman, *The Effect of Twenty Years of Hart-Scott Rodino on Merger Practice: A Case Study in the Law of Unintended Consequences Applied to Antitrust Legislation*, 65 ANTITRUST L.J. 865, 880 (1997) (commenting on recent absence of Supreme Court in antitrust arena). *But see* Pradnya Joshi, *New Life in Antitrust, U.S. Challenging Mergers After Years of Little Scrutiny*, N.Y. NEWSDAY, Mar. 11, 1998, at A4 (reporting on recent surge in antitrust enforcement activity by Federal Trade Commission and Department of Justice).

37 *See* Baker, *supra* note 3, at 93 (quoting statistics to demonstrate rapid growth of hospital mergers during 1980's (citing Finkler & Horowitz, *Merger and Consolidation: An Overview of Activity in Health Care Organizations*, 39 HEALTH CARE FIN. MGMT. (Jan. 1985) at 19)); *see also* Krause, *supra* note 4, at 506 (noting changes in health care industry, specifically in non-profit hospital realm, are controversial and highly criticized). *See generally* Mark Peterson, *Introduction: Health Care Into the Next Century*, 22 J. HEALTH POL. POL'Y & L. 291, 298 (1997) (discussing both vertical and horizontal consolidation of hospital services).

38 *See* Baker, *supra* note 3, at 94 (claiming that current antitrust application appears drastically different from previous regulation, and it has become generally understood that most activities of health professions and hospitals are governed by antitrust laws). *See generally*, David A. Westrup, *When the Bottom Line is a Look-Alike Health Care and Antitrust Law*, 6 BUS. L. TODAY 20, 20 (1997) (examining Department of Justice and Federal Trade Commission's use of antitrust laws to regulate health care industry).

39 *See, e.g.*, United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 898 F.2d. 1278, 1284 (7th Cir. 1990) (analyzing merger with narrow view of product market); F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1304-05 (W.D. Mich. 1996) (placing increased emphasis on involvement of community leaders in management of hospitals to ensure increase market share does not result in higher prices and lower competition); United States v. Mercy Health Serv., 902 F. Supp. 968, 988 (N.D. Iowa 1995) (discounting importance of community leaders on board of merging hospitals with regard to motives for anti-competitive behavior); United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 847-48 (W.D. Va. 1989) (analyzing merger with broad view of product and geographic markets).

will reveal the defects traditional in judicial handling of non-profit hospital mergers and suggest areas for improvement.[40]

II. CONSTRUCTION OF A RELEVANT MARKET

A large part of a court's decision in determining whether a specific merger has anti-competitive effects, and thus creates an antitrust injury is primarily derived from "guesswork".[41] While these conjectures are usually based on an exhaustive review of the relevant market[42] for the merging entities (including inquiries into product[43] and geographical market[44] data), it cannot be denied that in the end, the court simply speculates as to the

40 *See generally* Baker, *supra* note 3, at 100-01 (discussing changes in regulation of health care industry and its effect on antitrust laws as applied to hospitals). *But see* Krause, *supra* note 4, at 505 (criticizing special treatment for non-profit hospitals).

41 *See Rockford*, 898 F.2d. at 1286 (articulating regret over fact that antitrust cases are decided on basis of theoretical guesses as to what particular market structure characteristics portend for competition); *see also* Michael L. Weiner, *Antitrust and Enhancing Efficiency*, 11 ANTITRUST 4, 4 (1997) (reflecting on uncertainty surrounding role of efficiency in antitrust analysis).

42 *See* BLACK'S LAW DICTIONARY 1291 (6th ed. 1990).
"'[R]elevant market' is a geographic market composed of products that have reasonable interchangeability for purposes for which they are produced, considering their price, use and quality." *Id.*; *see also* Mark K. Horoschak, *Antitrust Issues Relating to Mergers, Acquisitions and Networks Among Health Care Providers, in* HEALTH CARE M&A 1997, at 151, 157 (PLI Corp. L. and Practice Handbook Series No. B4-7190, 1997). A market definition has two dimensions, both of which must be evaluated when analyzing a merger. *Id.* This definition includes both product (service) and geographic dimensions. *Id.* When determining relevant market for antitrust analysis, courts must consider the extent to which customers could turn to alternative sources if the merged entity were to raise its prices by a small but significant increment. *Id. See generally* Tire Sales Corp. v. Cities Serv. Oil Co., 410 F.Supp. 1222, 1230 (N.D. Ill. 1976). The court points out that in order to establish a claim of monopolization, the plaintiff must first define the relevant market. *Id.*

43 *See* Horoschak, *supra* note 42, at 157-58. The author explains the two aspects of the product market, Demand Side Substitutability and Supply Side Substitutability. *Id.* Demand Side Substitutability requires a review of the areas of health care service for which the merging entities are in competition with the other providers in the area. *Id.* Supply Side Substitutability requires an assessment of whether certain providers, who are not now competitors of the merging firms, would be likely to change their businesses or practices to compete with the merged entity if it raised its rates after the merger. *Id.*

44 *See* Horoschak, *supra* note 42, at 161-62. The Practicing Law Institute lists four considerations when determining the Geographic Market for health care providers. *Id.* Firstly, patient discharge data, one such consideration, does not provide a dynamic analysis of the marketplace and therefore should only be a starting point for defining geographic market. *Id.* Additionally, considering views of payors as to the scope of the geographic market could provide helpful insight. *Id.* Thirdly, the rise of Managed Care has had the effect of expanding local health care markets by threatening to send patients to more distant medical facilities and contracting with 'outreach' clinics on the periphery of traditional service areas. *Id.* Finally, rapid technological advancements for certain medical services may expand geographic markets beyond traditional boundaries. *Id.*

probable effects of a merger on the defined markets.[45] Because the definition of the relevant market to the merger plays such a significant role in the final outcome, courts expend considerable time and effort in determining the boundaries of the relevant market.[46]

A. The Product Market

The outer boundaries of a specific product market are surmised by identifying a set of goods or services that are reasonably interchangeable by consumers for the same purpose or use.[47] This concept considers which alternative products consumers might select in the event of a price increase.[48] In other areas of business and industry this concept may be easily defined, but when the merging entities are hospitals, the range of products are so numerous and diverse that they defy simple categorization.[49] While courts generally agree that the creation of a prod-

45 *See, e.g.*, Erwin A. Blackstone & Joseph P. Fuhr, Jr., *Hospital Mergers and Antitrust: An Economic Analysis*, 14 J. HEALTH & HOSP. L. 383, 399 (1989) (indicating that although mergers may be desirable, numerous cases show that possible cost savings are not very evident); Kopit & McCann, *supra* note 7, at 645-46 n.30 (discussing recent study noting increases in hospital market concentration lead neither to higher prices or lower costs).

46 *See, e.g.*, United States v. Rockford Mem'l Corp., 898 F.2d. 1278, 1283-85 (7th Cir. 1990) (reviewing district court's findings on relevant market); United States v. Long Island Jewish Med. Ctr. and North Shore Health Sys., Inc., 983 F.Supp 121, 141-47 (E.D.N.Y. 1997) (scrutinizing data to determine relevant geographic and product markets for non-profit hospital merger); F.T.C. v. Butterworth Health Corp., 946 F.Supp. 1285, 1289-90 (W.D. Mich. 1996) (noting that prerequisite to establishment of prima facie case by FTC is definition of relevant markets within which merged entity would have significant market power); United States v. Mercy Health Serv., 902 F.Supp 968, 978-80 (N.D. Iowa 1995) (providing extensive review of relevant geographic market); United States v. Carilion Health Sys., 707 F. Supp. 840, 847-48 (W.D. Va. 1989) (expressing necessity of relevant market definition before proceeding with merger analysis).

47 *See* United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 395 (1956) (delineating definite rule on product market definition); HTI Health Serv., Inc. v. Quorum Health Group, Inc., 960 F. Supp. 1104, 1115 (S.D. Miss. 1997) (describing interchangeability of goods as primary characteristic when determining product market (citing Brown Shoe v. United States, 370 U.S. 294, 325 (1962))).

48 *See HTI Health Serv., Inc.*, 960 F.Supp. at 1115 (stating that high cross elasticity of demand between two products indicates that products are in same relevant product market (citing HERBERT HOVENKAMP, ECONOMICS AND FEDERAL ANTITRUST LAW at § 3.3 (1985))); *see also* Domed Stadium Hotel, Inc. v. Holiday Inns, Inc., 732 F.2d 480, 487-88 (5th Cir. 1984) (evaluating significance of economically similar submarkets); Dougherty v. Continental Oil Co., 579 F.2d 954, 963 n.4 (5th Cir. 1978) (explaining interchangeability of relevant product markets).

49 *See* Horoschak, *supra* note 42, at 159. For some time, the courts and the Federal Trade Commission have defined the relevant product market in hospital merger cases as the 'cluster' of inpatient, acute care services offered by hospitals for which there are no outpatient substitutes. *Id.* Although the unique core of hospital services is eroding, defendants generally have not challenged this product market definition. *Id.*; *see also In re*

uct market for hospitals is problematic, they have consistently refused to look beyond the usual methods and develop a new standard for hospital mergers.[50] In defining product markets for hospitals, courts have generally employed one of two approaches.[51] The first is a narrow and specific view, often leading to an affirmative finding of anti-competitive effects,[52] and the alternative is a more broad and general view that does not predict anti-competitiveness.[53]

The courts that have applied the narrow interpretation of product market designate "acute in-patient hospital care"[54] as the only relevant product market to be considered. Similarly, the government also uses this narrow interpretation of product market when examining non-profit hospital mergers pursuant to the "Hart-Scott-Rodino pre- merger notification procedure".[55] The attempts by government agencies and the judiciary to conform hospital mergers into this narrow product market defini-

American Med. Int'l, 104 F.T.C. 1, 32-33 (1984). The decision affirmed acute inpatient care as a relevant product market. *Id. But see* Campbell & Teevans, *supra* note 4, at 1012. Outpatient services have been included in a number of court decisions regarding the product market for hospital mergers. *Id.*

50 *See* Baker, *supra* note 3, at 94 (explaining that changes in regulatory scheme for health care providers call for renewed scrutiny in application of antitrust laws to hospital mergers). *See generally Rockford*, 898 F.2d at 1284 (stating that growing number of services made available by non hospital providers makes it difficult to accurately define hospitals product markets); United States v. Long Island Jewish Med. Ctr., 983 F.Supp. 121, 142-43 (E.D.N.Y. 1997) (analyzing at length corresponding services that other providers in area produced in competition with merging hospitals).

51 *See, e.g., Rockford*, 898 F.2d at 1283 (utilizing service by service view of product markets); *c.f.* United States v. Carillion Health Sys., 892 F.2d 1042, 1042 (4th Cir. 1989) (including outpatient clinics and other providers in hospital's product market).

52 *See generally Rockford*, 898 F. 2d at 1284 (discounting importance of including outpatient services in hospitals product market); F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1290 (W.D. Mich. 1996) (rejecting district court's finding that outpatient services should be included in hospital's product market); *see also* F.T.C. v. University Health, Inc., 938 F.2d 1206, 1210 (11th Cir. 1991) (enumerating general acute care product market as one which has been commonly used to evaluate competitive effects of hospital mergers).

53 *See generally Carilion Health Sys.*, 892 F.2d. at 1043-44 (recognizing that hospitals are comprised of clusters of product markets, each with different degrees of substitutability between inpatient and outpatient services).

54 *See* F.T.C. v. Freeman Hosp., 69 F.3d 260, 268 (8th Cir. 1995) (utilizing acute inpatient hospital care as product market, but denying FTC claim on grounds of insufficient geographic market delineation); United States v. Mercy Health Serv., 902 F.Supp 968, 976 (N.D. Iowa 1995) (agreeing that relevant product market is acute care inpatient services as stipulated by both parties to merger); Horoschak, *supra* note 42, at 159 (discussing product market definition as delineated by FTC).

55 *See* Campbell & Teevans, *supra* note 4, at 1012 (stating that acute inpatient care is product market most often used by government when reviewing hospital mergers). *See generally* United States v. Syufy Enter., 712 F.Supp 1386, 1387 (N.D.Cal. 1989), *aff'd* 903 F.2d 659 (9th Cir. 1990) (discussing at length methods for creation of product market).

tion illustrate the general misconception that non-profit hospitals fit neatly into product categories.[56]

Courts that have employed a broad view of non-profit hospital product markets take into account the wide range of diverse services that hospitals provide.[57] For example, acute in-patient care usually represents only a fraction of the total services hospitals provide to patients.[58] Therefore, for purposes of competitive effect a broad view would consider a variety of outpatient services, including, but not limited to: Outpatient surgery, rehabilitation, physical, speech, and occupational therapy.[59] In direct competition with hospitals for these services are walk-in-clinics, urgent care centers, ambulatory surgery centers, and first medical satellite locations.[60]

56 *See* Paschall, *supra* note 4, at 67 (distinguishing hospital industry from other products that have simple categorization because of variety of hospital structures that exist as well as complexities of health care market); *see also* Milton L. Cruz, *Product and Geographical Market Measurements in the Merger of Hospitals*, 91 DICK. L. REV. 497, 527 (1986) (proposing that non-hospital providers should be included in product market definition when analyzing hospital mergers because collective sum of their services serves as restraint to market power that hospital may possess); Mudge & Gibofsky, *supra* note 30, at 371 (discussing *Carilion* court's acceptance of relevant product market as including inpatient hospitals as well as outpatient clinics because providers of outpatient services compete with hospitals for particular set of participants).

57 *See* Campbell & Teevans, *supra* note 4, at 1015 (enumerating extensive outpatient services provided by hospitals today that surgi-centers, urgent care centers, walk-in clinics and other outpatient providers directly compete for, including: Outpatient surgery, gastroenterology, rehabilitation, physical, speech, and occupational therapy, renal dialysis, cardiac rehabilitation, diagnostic imaging, radiation oncology, substance abuse treatment, laboratory product, electrocardiograms and many others). *See, e.g.*, United States v. Long Island Jewish Med. Ctr. and North Shore Health Sys., Inc., 983 F. Supp. 121, 132 (E.D.N.Y. 1997) (noting many hospitals require physician groups and expand services to remain operational).

58 *See* Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp., *available in* 1995 WL 853037, at *7 (N.D. Cal. 1995) (citing American Hospital Association statistics that show increase in outpatient surgery from 24% to 55.3% between 1983 and 1993); *see also* United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 847 (W.D.Va. 1989) (concluding that relevant service market includes not only other inpatient hospitals but also various outpatient clinics that treat medical problems for which patients might otherwise have sought treatment in an inpatient hospital setting).

59 *See* Campbell & Teevans, *supra* note 4, at 1015 (listing numerous specific services now being offered in outpatient care both by hospitals and other providers); Andy A. Tschoepe II, Note, *Nonprofit Hospital Mergers and Federal Antitrust Law: The Quest for Compatibility*, 15 DEL. J. CORP. L. 539, 565-66 (1990) (predicting that advanced technology and "patient wellness" will increase outpatient services and thus develop outpatient care into viable submarket of hospital "service cluster"). *See generally* Cabell M. Adams, Comment, *Nonprofit Hospital Mergers: Proceed With Caution*, 20 CUMB. L. REV. 719, 733-34 (1989-90) (arguing that although ignoring services provided by alternative, outpatient facilities certainly makes government's task of defining relevant product market less complicated, resulting definition when these services are excluded is not realistic).

60 *See, e.g.*, American Hospital Ass'n., Hospital Statistics (1988) (tabulating statistics and data from inpatient care from which hospital market share can be calculated).

In light of these additional areas of competing services that are not recognized by the acute in-patient care product category, it seems that the narrow product market should be set aside in favor of the more inclusive approach.[61] Under the latter approach, courts considering the possible effect of a merger on competition weigh evidence based on the totality of the circumstances, rather than by an artificially created standard.[62] Moreover, courts utilizing the broad approach will make more informed decisions based upon the real effects of these mergers.[63]

B. Geographic Markets

The delineation of a geographic market often presents as many difficulties to a court as does a product market.[64] A geographic market encompasses the area of effective competition in which the product, or its reasonably interchangeable substitutes, are traded.[65] There are two complimentary tests, which the courts

61 *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 137-38 (rejecting government's narrow definition of product market in favor of more inclusive approach that factors in those services provided by "outpost" as well as those from "anchor" hospitals); *see also Carillion*, 707 F. Supp. at 847-48 (factoring in both other inpatient hospitals and various outpatient clinics in court's decision to allow merger).

62 *See* United States v. Baker Hughes, 908 F.2d 981, 984 (D.C. Cir. 1990). The court concluded that section seven of the Clayton Act should only consider probabilities, not certainties or possibilities. *Id.* It noted the Supreme Court's adoption of a totality-of-the-circumstances approach to the statute, which weighs a variety of factors to determine the effects of particular transactions on competition. *Id.* By using this "totality of the circumstances" approach, the D.C. Circuit in *Baker Hughes* did not simply look at market concentration to determine the illegality of a merger, but rather, it considered a number of other factors including: Ease of entry, probable anti-competitive effect, prospect of efficiencies for merger, excess capacity, degree of product homogeneity, marketing and sales methods, industry structure, inter-industry supply and demand, and others. *Id.* This approach is consistent with the broad product market theory including outpatient services in a hospitals relevant market. *Id.*

63 *See, e.g.*, United States v. Philadelphia Nat'l Bank, 374 U.S 321, 321 (1963) (expanding analysis to service industries classifications of "cluster of service" offerings); HTI Health Serv., Inc. v. Quorum Health Group, Inc., 960 F.Supp. 1104, 1115-21 (S.D. Miss. 1997) (discussing importance of including viable sub-markets in relevant product markets in order that full picture of hospital services may be provided).

64 *See Quorum Health Group*, 960 F. Supp. at 1121 (commenting that precedent unmistakably demonstrates that delineating geographic markets is no easy endeavor and that some 'fuzziness' may be inherent in any attempt to do so); *see also Philadelphia Nat'l Bank*, 374 U.S. at 361 (stating that compromise must be found for intermediate delineation of geographic market that avoids extremes of drawing market either so expansively as to make effect of merger upon competition seem insignificant, or so narrowly as to place appellees in different markets).

65 *See* R.D. Imports Ryno Indus., Inc. v. Mazda Distrib.(Gulf), Inc., 807 F.2d 1222, 1224 (5th Cir. 1987) (arguing substitutable goods are competitive if reasonably interchangeable); Piere v. Ramsey Winch Co., 753 F.2d 416, 435 (5th Cir. 1985) (awarding damages where substitutable goods increase distributor costs and decrease profits); Hood v. Tenneco Texas Life Ins. Co., 739 F.2d 1012, 1018 (5th Cir. 1984) (citing Hornsby Oil

and the Department of Justice utilize to determine geographic markets.[66] The standard originally proposed by the Supreme Court demands two inquiries: First, the area in which sellers operate must be identified, and second, areas to which buyers can practicably turn for alternatives must be discerned.[67] As an additional measure, the court now applies a test recommended by the Department of Justice to determine consumer reactions to "small but significant and non-transitory" increases in price.[68] This two-part analysis examines the effects on competition both in the present day and in the foreseeable post- merger future.[69]

The use of either test alone produces a geographic market that fails to provide an accurate picture of the specific geographic areas that would be affected by the merger, at the present time

standard of substitutability); Hornsby Oil Co., Inc. v. Champion Spark Plug Co., Inc., 714 F.2d 1384, 1393 (5th Cir. 1983) (defining relevant market as bounded by substitutability).

66 *See generally* United States v. Grinnell Corp., 384 U.S. 563, 588-89 (1966) (formulating geographic market based on where potential buyers might seek potential suppliers of desired service in absence of monopoly); Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320 (1961) (explaining seminal statement on geographic market definition); U.S. DEPARTMENT OF JUSTICE MERGER GUIDELINES (1984), *available in* Westlaw, 49 FR 26823, at *26829 (questioning where consumers might turn in event of small but significant and non-transitory increase in price to determine geographic market).

67 *See Tampa Elec. Co.*, 365 U.S. at 327 (discerning line of commerce and its known effective competition before deciding existence of antitrust violation); *see also* United States v. Mercy Health Serv., 902 F.Supp. 968, 975 (N.D. Iowa 1995) (defining relevant market by identifying alternative sources of product or service (citing 2A PHILLIP E. AREEDA, HERBERT HOVENKAMP & JOHN L. SOLOW, ANTITRUST LAW ¶ 530a, at 150 (1995))); Kenneth G. Elzinga & Thomas G. Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 ANTITRUST BUL. 1, 2 (1978) (explaining "E.H." test as looking at empirical data to determine area from which the hospitals draw their patients and where residents in that area go for hospital care); Robert Pitofsky, *New Definitions of Relevant Market and the Assault of Antitrust*, 90 COLUM. L. REV. 1805, 1836 n.141 (1990) (discussing benefits and drawbacks of Elzinga-Hogarty test, "E.H", which is employed by courts in determining area in which entities operate). *But see* Michael J. Vita et. al., *Economic Analysis and Health Care Antitrust*, 7 J. CONTEMP. HEALTH L. & POL'Y 73, 90 (1991) (criticizing static view provided by Elzinga-Hogarty test).

68 *See* MERGER GUIDELINES, *supra* note 66, at *26823 (stating that if increase in price causes buyers in certain location to shift to products produced in other areas so that hypothetical monopolist would not find it profitable to impose such an increase in price, then Department will add that location). *See, e.g.*, H.T.I. Health Serv., Inc. v. Quorum Health Group, Inc., 960 F.Supp. 1104, 1121 (S.D. Miss. 1997) (discussing Elzinga-Hogarty analysis of patient inflows and outflows in primary care and other physician markets); United States v. Mercy Health Serv., 902 F.Supp. 968, 980-81 (N.D. Iowa 1995) (suggesting that if merged entity could sustain 5% price increase, as stated in 1984 Merger Guidelines, for approximately one year, merger should be enjoined as violation of antitrust laws).

69 *See Mercy Health Serv.*, 902 F. Supp. at 978 (noting E.H. analysis is simply starting point of court in determination of illegality of non-profit hospital mergers); *see also Quorum Health Group*, 960 F. Supp at 1121 (stating that once area of operation is determined courts then turn to alternative price and service options that are available to consumer).

and in the foreseeable future.[70] Courts, in merging the two tests provide a more accurate analysis, strongly rooted in the present market realities, and containing predictions as to the possible future effects in the post merger geographic market.[71]

The merged test is flawed, however, in that it fails to take into account the modern trend of consolidation, inherent in the current health care reform movement.[72] Essentially, by using present data and interviews to predict the future behavior of health care consumers in a post merger geographical market,[73] the court assumes consumer decisions will be unaffected by the changing face of the health care marketplace.[74] In light of the drastic changes that have occurred in the health care industry in recent years, it appears that present market realities will provide little guidance for the future.[75]

70 *See Mercy Health Serv.*, 902 F.Supp. at 978. In determining actual geographic market, it is insufficient to take "snapshot" of the current situation; current market behavior must be put in a context that looks at all possible competitive responses. *Id. See generally* F.T.C. v. Freeman Hosp., 69 F.3d 260, 268 (8th Cir. 1995). An examination of market absent a context would serve no purpose. *Id.*; Bathke v. Casey's Gen'l. Stores, Inc., 64 F.3d 340, 345 (8th Cir. 1995). Evidence of alternative source is also crucial to the determination of a geographic market. *Id.*; Morgenstern v. Wilson, 29 F.3d 1291, 1295-96 (8th Cir. 1994). Defendants had to show not only a significant market share, but also a relevant market. *Id.*

71 *See generally Freeman Hosp.*, 69 F.3d at 268-72 (discussing need for dynamic analysis of geographic markets); Pitofsky, *supra* note 67, at 1834-44 (proposing more detailed and inclusive formulation for relevant market).

72 *See* United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 898 F.2d. 1278, 1285 (7th Cir. 1990). A large part of this problem can be attributed to the courts' persistent classification of hospitals as local in nature. *Id.* While some patients will sometimes travel long distances for highly exotic or elective hospital treatment, for the most part hospital services are local. *Id.* People want to be hospitalized in hospitals where their own local doctors have hospital privileges. *Id. See generally* Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp., *available in* 1995 WL 853037, at *3 n.2 (N.D. Cal. 1995). The difficulty in measuring market definition in health care cases is attributable to the structure and nature of the health care market and the dynamic changes it is undergoing today. *Id. But see* Campbell & Teevans, *supra* note 4, at 1018 (quoting Brief of American Hospital Association as Amicus Curiae in Support of Petitioners, *Rockford*, No. 90-162). "The AMA believes that geographic hospital markets are growing, and that hospital competition is becoming regional in nature." *Id.*

73 *See* Campbell & Teevans, *supra* note 4, at 1020 (criticizing consumer interview approach as arbitrary, dangerous and unreliable (citing W. BAUMOL, ECONOMIC THEORY AND OPERATIONS ANALYSIS 228 (4th ed. 1977))).

74 *See Mercy Health Serv.*, 902 F. Supp. at 978 (attacking heavy reliance on past conditions and failure to assess possible future competitive responses based on invalid assumption of doctor patient loyalty).

75 *See id.* (finding that government's case rested too heavily on past health care conditions and invalid assumptions as to reactions of third-party payers and patients to price changes).

III. PREDICTION OF PROBABLE ANTI-COMPETITIVE IMPACT

Once the relevant product and geographic markets have been established, the court must then determine whether the party challenging the merger has made a prima facie case of probable anti-competitive impact.[76] The most widely used method to establish this impact, is an examination of the high concentration of market shares[77] in the relevant markets.[78]

A. Market Concentration Analysis

"Market concentration is a function of the number of firms in the market and their respective market shares."[79] Federal antitrust regulators utilize the Herfindahl-Hirschman Index ("HHI") to determine market concentration.[80] This test calculates market

76 *See Freeman Hosp.*, 69 F.3d at 268 (determining relevant market is necessary predicate to finding Clayton Act violation); Los Angeles Mem'l Coliseum Comm'n v. National Football League, 726 F.2d 1381, 1392 (9th Cir. 1984) (stating that trier of fact must first determine relevant market); H.T.I. Health Serv., Inc., v. Quorum Health Group, Inc., 960 F. Supp. 1104, 1126 (S.D. Miss. 1997) (stating showing of probable anti-competitive impact is plaintiff's final hurdle in presenting its section seven prima facie case (citing Domed Stadium Hotel, Inc. v. Holiday Inns Inc., 732 F.2d. 480, 491 (5th Cir. 1984))).

77 *See* U.S. DEP'T OF JUSTICE AND FED. TRADE COMM'N MERGER GUIDELINES (1992), *reprinted in* JOHN J. MILES, HEALTH CARE AND ANTITRUST LAW: PRINCIPLES AND PRACTICE 12-2, at B6 (1994) (claiming merger concentration strongly indicates merger's anti-competitive effects); *see also* Stephens, *supra* note 9, at 495 (citing Merger Guidelines § 1.52, *reprinted in* Miles, at B6-18) (describing any merger creating firm with large market share and significantly increasing market concentration as raising rebuttable presumption that merger violates section seven of Clayton Act).

78 *See H.T.I. Health Serv., Inc.*, 960 F. Supp. at 1126. "In a horizontal merger situation, there are two basic methods that a plaintiff can employ to meet its burden of proof." *Id.* Plaintiffs must either demonstrate that the size of the merging entities makes them inherently suspect in light of Congress' design to prevent undue [economic] concentration or in cases where size is not inherently suspect, show that other characteristics of the market make the merger more economically harmful than the bare market share and market concentration statistics would otherwise indicate. *Id. See generally* United States v. Philadelphia Nat'l. Bank, 374 U.S. 321, 363 (1963). The case provides a general description of the plaintiff's burden of proof. *Id.;* United States v. Archer-Daniels–Midland Co. & Nabisco Brands Inc., 866 F.2d 242, 245 (8th Cir. 1988). This case outlines the underlying factual circumstances upon which plaintiff must satisfy the burden of proof. *Id.*

79 *See* F.T.C. v. Butterworth Health Corp., 946 F.Supp. 1285, 1294 (W.D. Mich. 1996) (explaining market concentration calculation). *See generally* United States v. Gen'l. Dynamics Corp., 415 U.S. 486, 501 (1974) (criticizing past market share analysis and stating that fundamental changes in structure of coal market render evidence of past production less reliable predictor of future ability to compete).

80 *See, e.g.*, F.T.C. v. University Health, Inc., 938 F.2d. 1206, 1211 n.12 (11th Cir. 1991) (elaborating on methodological approach of "HHI"); F.T.C. v. P.P.G. Ind. Inc., 798 F.2d. 1500, 1502-04 (D.C. Cir. 1986) (commenting that "HHI" is preferred method to establish market concentration); *Butterworth Health Corp.*, 946 F. Supp. at 1294 (utilizing "HHI" to find high market concentration and establish prima facie case of anti-competitive effects); Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp., *available in*

concentration as the sum of the square of each competing firm's market share in the relevant market.[81] Before a complete analysis of a hospital's market concentration can be entertained, each participating hospital's market share must first be calculated.[82]

Market share is defined as the percentage of a market that is controlled by a firm.[83] Courts typically employ two measures of hospital market share: (1) hospital share of total inpatient discharges, and (2) hospital share of beds.[84] This analysis presupposes that the relevant market for hospitals utilizes the acute inpatient health care standard as its product.[85] As discussed above, this approach is inherently flawed in that it does not consider all of the other products that hospitals provide in addition to long term inpatient care.[86] For example, a hospital that main-

1995 WL 853037, at *10 (N.D. Cal. 1995) (stating that "HHI" is commonly used to quantify market concentration); F.T.C. v. Freeman Hosp., 911 F. Supp. 1213, 1221-22 (W.D. Mo. 1995) (describing Department of Justice Merger Guideline's definition of highly concentrated market as those where post merger "HHI" exceeds 2000).

81 *See* Horoschak, *supra* note 42, at 163. Market concentration significantly indicates market power. *Id.* An HHI score below one thousand indicates an unconcentrated market, while a score of ten thousand represents a total monopoly. *Id.* A score above one thousand is indicative of a moderately concentrated markets that may pose antitrust concerns, and scores above eighteen hundred represent a highly concentrated market that is likely to raise substantial antitrust issues. *Id. See, e.g., Santa Cruz Med. Clinic*, 1995 WL 853037, at *11. This case offers a discussion of the parameters of the Herfindahl-Hirschman index. *Id.*

82 *See* Stephens, *supra* note 9, at 495 (calculating market shares for relevant competitors by measuring such factors as excess patient beds, admissions statistics and revenues); *see also* E. THOMAS SULLIVAN & JEFFREY L. HARRISON, UNDERSTANDING ANTITRUST AND ITS ECONOMIC IMPLICATIONS 9, at 301 (1994) (noting that each hospital's share of market is ratio expressed in percentage of relevant market it controls).

83 *See* BLACK'S LAW DICTIONARY 971 (6th ed. 1990) (defining market share).

84 *See Santa Cruz Med. Clinic*, 1995 WL 853037, at *11 (noting two measures are typically used to determine hospital market share); United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 848 (W.D. Va. 1989) (applying two measures: [1] hospital share of total inpatient discharges; and [2] hospital share of beds).

85 *Compare Butterworth Health Corp.*, 946 F. Supp. at 1285 (utilizing general acute care in-patient hospital service as product market most commonly applied to evaluate competitive effects of hospital mergers), *with* United States v. Long Island Jewish Med. Ctr. and North Shore Health Sys., Inc., 983 F. Supp. 121, 141-45 (E.D.N.Y. 1997) (suggesting that market share test based on net number of patients for services rendered in various inpatient and outpatient product markets would render more accurate market share number, and thus market concentration).

86 *See Carilion Health Sys.*, 707 F.Supp. at 844-45. In general, witnesses agree that some hospital services are restricted to in-patient care while others are handled strictly on an outpatient basis. *Id.* However, in recent years the number of services that may be treated in either way has increased dramatically. *Id.* Moreover, reasonable doctors differ as to whether problems should be handled on an inpatient or outpatient basis. *Id.* Furthermore, various insurance carriers have restructured their reimbursement policies in recent years in order to encourage patients to use outpatient services, which are less ex-

tains the majority of beds or inpatient discharges in a geographic market, but does not enjoy the same advantage in various other outpatient services that competitors provide, will reflect an artificially inflated market concentration that does not adequately portray the market conditions.[87]

A more effective approach to market concentration is an analysis based on the various products that are included in the broad market method, and subsequent approval or rejection of the proposed merger based on the data for all of the products.[88] Although this technique may create a more complex review for courts and parties to these actions, it would result in a more comprehensive and accurate estimation of the target hospital's market concentration.[89]

B. Per Se Illegality and Its Inapplicability to Non-Profit Hospital Mergers

Once the review of market concentration yields a high HHI number, a prima facie case of anti-competitive impact is established, and the proposed merger will be deemed per se illegal. [90]

pensive than inpatient care. *Id.* Since patients or their doctors often choose to have problems treated either in a hospital or in an outpatient clinic or doctor's office, courts have found certain clinics and other providers of outpatient services compete with hospitals to treat various medical needs. *Id.*; *see also Long Island Jewish Med. Center*, 983 F. Supp. at 144. The court found that the defendant hospital on Long Island competed with medical outposts of Manhattan hospitals that were also located on the island. *Id.*

87 *See Carilion Health Sys.*, 707 F. Supp. at 848. In *Carilion*, the government argued that the merger of the two hospitals would give them a market concentration of over seventy percent based on share of patient occupancy. *Id.* The court rejected this calculation because it was based on inaccurate market assumptions. *Id.* When the court included other hospitals in the geographic market surrounding defendants, however, defendants' market share could not have been expected to approach the estimates advanced by the government. *Id.* Essentially, the court rejected the government's case for relying solely on inpatient care in calculating the market concentration. *Id.*

88 *See generally* H.T.I. Health Serv., Inc. v. Quorum Health Group, 960 F. Supp. 1104, 1126-37 (S.D. Miss. 1997) (analyz ing relevant market share percentages for major services that each hospital provides on inpatient and outpatient basis and concluding that plaintiff failed to show adequate market power necessary for violation of Clayton Act).

89 *See id.* (exemplifying comprehensive estimation of market concentration that includes multitude of hospital services); *see also* Adams, *supra* note 59, at 733-34 (ignoring outpatient services facilitates definition of product market; however, it does not afford realistic view).

90 *See* F.T.C. v. Butterworth Health Corp., *available in* 1997 WL 420543, at *2-3 (6th Cir. 1997) (finding high market concentration presented prima facie case of lessened competition, however, court held defendant hospitals had successfully rebutted presumption of illegality by showing high market share does not automatically result in high prices). *See generally* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 364-66 (1963) (enjoining merger on grounds that it would result in increased market concentra-

The theory behind the per se or presumptive illegality approach is that high market shares reflect the ability to control prices or exclude competitors,[91] precisely what antitrust legislation was enacted to prevent.[92] The entities intending to merge must subsequently present evidence refuting the designation of the relevant markets, contest the market share analysis conducted for market concentration, or assert affirmative defenses.[93] These arguments, however, are not the only recourse for non-profit hospitals.[94]

The seminal argument against application of per se illegality to non-profit organizations is that non-profits, by nature, preclude maximizing profits[95] by increasing price and reducing

tion of thirty-three percent); United States v. Archer-Daniels-Midland Co. & Nabisco Brands Inc., 866 F.2d 242, 246 (8th Cir. 1988) (ruling that sugar and corn syrup were not in same product market, therefore, increasing risk that defendant's merger would result in high market concentration, and be deemed per se illegal).

91 *See* Campbell & Teevans, *supra* note 4, at 1023 (citing *Rockford*, 898 F.2d at 1285). "[I]n the Seventh Circuit's view, high market shares in a concentrated market make it 'easier for firms in market to collude, expressly or tacitly, thereby forcing price above competitive levels.'" *Id.*

92 *See* Herbert Hovenkamp, *Distributive Justice and the Antitrust Laws*, 51 GEO. WASH. L. REV. 1, 4 (1982) (stating overriding goals of antitrust legislation as maximizing consumer welfare through efficient allocation of resources); *see also* Robert H. Lande, *Wealth Transfers as the Original and Primary Concern of Antitrust: The Efficiency Interpretation Challenged*, 34 HASTINGS L. J. 65, 150 (1982) (describing antitrust laws as growing out of desire to protect consumer's property rights, and antipathy toward corporate aggregation of economic, social, and political power).

93 *See* Campbell & Teevans, *supra* note 4, at 1023 (following showing of highly concentrated market, presumption of illegality attached and burden shifted to defendants to show that some defense could overcome presumption); *see also* United States v. Baker Hughes, 908 F.2d 981, 986 (D.C. Cir. 1990) (noting acceptable defenses to per se illegality are: Changing market conditions, financial conditions of firms in relevant market, special factors effecting foreign firms, nature of product and terms of sale, information about specific transaction and buyer market characteristics, conduct of firms in market, market performance and efficiencies). *See generally* Paschall, *supra* note 4, at 75 (discussing strength of both efficiency and failing firm defenses).

94 *See Baker Hughes*, 908 F.2d. at 984 (explaining that variety of factors can rebut prima facie case, including absence of significant entry barriers in relevant market). *See, e.g.*, United States v. Citizens and S. Nat'l Bank, 422 U.S. 86, 120-23 (1975) (rebutting presumption with showing that market share statistics gave inaccurate description of acquisitions probable effects); United States v. Long Island Jewish Med. Ctr. and North Shore Health Sys., Inc., 983 F. Supp. 121, 141 (E.D.N.Y. 1997) (demonstrating that proposed merger enhances, rather than hinders, competition due to increased efficiency, to rebut government's prima facie case).

95 *See* William J. Lynk, Ph D., *Property Rights and the Presumption of Merger Analysis*, 39 ANTITRUST BUL. 363, 368–69 (1994) (contending that research confirms that difference between for profit and non-profit organizations does matter economically with regard to competition). *But see* Robert E. Bloch, Chief, Professions and Intellectual Property Section, Antitrust Division, U.S. Dep't of Justice, Antitrust Enforcement in Health Care: On the Cutting Edge, Speech to the National Health Lawyers Association (Jan. 27, 1989) (arguing that non-profit hospitals have strong practical incentives to revenue maximize to meet budgets and compete with rivals); Henry B. Hansmann, *The Role of Non-Profit Enterprise*, 89 YALE L.J. 835, 866 (1980) (asserting fact that treating doctor is

services, which are the forbidden anti-competitive effects.[96] However, this view has been consistently rejected by the courts since the landmark case of *N.C.A.A. v. Board of Regents of the University of Oklahoma*.[97] The rationale behind the *N.C.A.A.* decision and its progeny, was that although non-profit organizations do not possess the profit motives common to ordinary corporations, they may still act in a manner to increase profit by raising prices and reducing services when they have a high concentration of market power.[98] However, convincing data illustrates that high market shares for non-profit hospitals do not result in anti-competitive effects, rather they result in better services and lower prices, thus defeating the rationale behind per se illegality.[99]

essentially for-profit player discounts theory that non-profits are not competitive).

96 *See* Stephens, *supra* note 9, at 478 (noting that F.T.C. oversight has traditionally not applied to non-profit firms because charitable entities allegedly lack motive to engage in anti-competitive practices); *see also* United States v. Mercy Health Serv., 902 F. Supp. 968, 989 (N.D. Iowa 1995) (asserting hospital's defenses of non-profit status and pro-competitive intent); United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 849 (W.D. Va. 1989) (arguing defendants' non-profit status militates in favor of finding combination reasonable). *See, e.g.*, Community Blood Bank v. F.T.C., 405 F.2d 1011, 1020 (8th Cir. 1969) (stating that F.T.C. has no jurisdiction over non-profit blood bank established for charitable, educational, civic, patriotic, social welfare, health, scientific and research purposes).

97 468 U.S. 85, 100 n.22 (1984) (explaining how language of Sherman Act applies to non-profit entities). *See* American Soc'y of Mechanical Eng'r, Inc. v. Hydrolevel Corp. 456 U.S. 556, 576 (1982) (finding non-profit organizations engaged in commercial activity may be liable under antitrust laws); Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 337-38 (1982) (describing non-profit organizations lack of exemption from per se illegality).

98 *See N.C.A.A.*, 468 U.S. at 100 n.22 (finding NCAA's non-profit character questionable since trial court found that NCAA and its member institutions were in fact organized to maximize revenues); *see also* United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 898 F.2d. 1278, 1285 (7th Cir. 1990) (rejecting defendant's argument that non-profit status removed grounds for concern that they might seek to maximize profits through avoidance of price or service competition since ideology of non-profits is cooperative, not competitive (*citing* Hospital Corp. of Am. v. F.T.C., 807 F.2d 1381, 1390-91 (1986))).

99 *See* William J. Lynk, Ph.D., *Non-Profit Hospital Mergers and the Exercise of Market Power*, 38 J. LAW AND ECON. 437, 459 (1995) (stating that private non-profit hospitals have significantly lower association between higher market shares and higher prices relative to for profit hospitals, and increased non-profit market share is associated with lower, not higher, prices); *see also* F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1295 (W.D. Mich. 1996) (arguing that high market concentration should not be presumed to result in anti-competitive effects); Glazer, *supra* note 8, at 1056-58 (proposing that mergers between non-profit hospitals do not necessarily result in anti-competitive effects when they eliminate duplication of services, benefit consumers by restraining hospital costs, maintaining hospital access in marginal areas and result in better quality of health care); Hansmann, *supra* note 95, at 866 (providing comprehensive treatment of economics of non-profit organizations); Lynk, *supra* note 95, at 363-83. (arguing against presumption that for profit mergers and mergers between non-profit entities have the same effect upon markets).

If this data proves to be the norm, rather than the exception, it may justify the eradication of the per se illegal rule as applied to non-profit hospital mergers.[100] Furthermore, it would be counter-intuitive to cling to outdated notions of antitrust law when studies indicate that non-profit hospitals possessing high market concentration actually comport better to the goals of antitrust than do low market concentration, non-profit hospitals.[101] Moreover, low market concentration non-profit hospitals, which are enjoined from merging with other non-profit hospitals because of the courts' high market concentration analysis, would suffer the most.[102] As the demand for inpatient hospital services declines, smaller, non-profit hospitals will attract fewer patients, and thus be forced to raise prices to meet their expenses and remain operational.[103] This sort of chain reaction would actually decrease competition; a result completely adverse to the original intentions of antitrust laws.[104]

Changes in the health care industry over the past several

100 *See Butterworth Health Corp.*, 946 F. Supp. at 1295 (opining that highly concentrated markets could be home to both lower prices and higher profit margins due to lower costs); *see also* Paschall, *supra* note 4, at 69 (arguing that benefit of law and economics analysis should be to step back from trenches of antitrust litigation to determine whether systemic problems in health care merit such systemic solutions as exemptions for mergers).

101 *See* Tokarski, *Mergers Don't Cut Access*, MODERN HEALTHCARE, Nov. 26, 1990, at 2 (citing study indicating that mergers maintain access and increase services provided); *see also* Glazer, *supra* note 8, at 1056 (claiming that strict application of antitrust laws to non-profit hospital mergers conflicts with goals of antitrust regulation). *See generally* Lynk, *supra* note 99, at 459. (discussing benefits of non-profit hospital mergers that result in highly concentrated markets).

102 *See* Glazer, *supra* note 8, at 1041-42. Escalating costs, reduced revenues, and fundamental changes in the delivery of health care have led to unprecedented numbers of hospital closures during the past five years. *Id.* In order to remain operational, hospital boards consider merging their hospitals with those of competitors. *Id.* Such mergers may lead to the viability of marginal institutions, reduced excess hospital capacity, and enhanced quality and accessibility of health care. *Id.* However, the problem is that these mergers pose serious risks of violating federal and state antitrust laws. *Id.*

103 *See* Kopit & McCann, *supra* note 7, at 643-44 (explaining pricing decisions of non-profit hospital are based on financial requirements, not market prices, and therefore, are lower than prices at for profit hospitals); *see also* Glazer, *supra* note 8, at 1056 (stating excess hospital capacity is particularly costly as overall demand for inpatient hospital services declines, and that unused capacity adds to overhead costs that hospitals must allocate among fewer patients, adding to cost of individual patient's hospital services (citing J. SUVER & B. NEUMANN, MANAGEMENT ACCOUNTING FOR HEALTH CARE ORGANIZATIONS 111 (1981))).

104 *See* Glazer, *supra* note 8, at 1056. Since demand for hospital services is declining and strict application of antitrust laws to non-profit hospital mergers prevents hospitals from combining forces, these institutions are struggling to stay in operation. *Id.* As a result, these hospitals will not be competitive and therefore, do not further antitrust goals. *Id.*

years have provided additional incentive to abandon the per se illegality rule for high market concentration.[105] As previously stated, per se illegality presumes that the merging entities will be able to control prices.[106] However, the essence of this argument is defeated when the merging parties are non-profit hospitals.[107] Generally, a hospital's largest source of revenue comes from government payors,[108] who offer set prices to hospitals for their services.[109] This practice eliminates the opportunity to control prices that the per se illegality rule presumes.[110] Essen-

105 *See* Baker, *supra* note 3, at 96. The regulations put into place by the government in the 1960's exacerbated biases in favor of increased health care prices and continued excess supply of health care provision. *Id.* Medicare and Medicaid, enacted in 1965, relied upon retrospective cost base reimbursement of health care providers and hospitals. *Id.* Prices in health care continued to rise at a rate substantially higher than prices generally. *Id.* Congress addressed these skyrocketing health care costs in the 1970's and early 1980's by placing limitations on the quantity of health care provided to consumers. *Id.* Large hospital capital expenditures became subject to the supervision of state regulatory boards through the requirement of a Certificate of Need ("CON") *Id.* Due to numerous government restraints on health care expenditures there is little need for a continued application of the per se illegality rule to merging hospitals. *Id.*; *see also* E. William Barnett et. al., *Interview with James C. Miller, III, Chairman, Federal trade Commission*, 53 ANTITRUST L.J. 5, 5-11 (1984). The changes in perspective have led to the relaxation of the doctrines of per se illegality based upon pre-Chicago economic analysis. *Id.*; Millstein Kessler, *The Antitrust Legacy of the Reagan Administration*, 33 ANTITRUST BULL. 505, 513-14 (1988). The per se illegality rule has been relaxed in all areas except naked price fixing. *Id.*

106 *See* Campbell & Teevans, *supra* note 4, at 1023 (stating that premise underlying per se illegality is that high market shares reflect ability to control prices or exclude competitors); *see also* United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) (noting higher market shares make it easier for firms in market to collude, and thereby force prices above competitive levels).

107 *See* Adams, *supra* note 59, at 723 (noting difference in distribution of profits exists between for-profit and non-profit hospitals which affects motives and decisions of hospital's management); *see also* Kopit & McCann, *supra* note 7, at 643 (stating non-profit hospital pricing tends to be based on hospital financial requirements instead of market prices); Stephens, *supra* note 9, at 499 (discussing arguments that antitrust laws should not apply to non-profit hospital mergers since they are not organized to maximize shareholder profits, and therefore lack incentives to engage in anti-competitive behavior).

108 *See* Kopit & Vanderbilt, *supra* note 11, at 268. These government payors include programs such as Medicare and Medicaid. *Id.*

109 *See* Baker, *supra* note 3, at 97-98 (arguing that hospitals cannot debate price increases because they rely on government plans, which provide for standardized payments, for large volume of patients). *See generally* Social Security Amendments of 1983, PUB. L. NO. 98-21, §§ 601-607, 97 STAT. 65, 149-72 (codified as amended in scattered sections of 42 U.S.C.) (emphasizing Medicare's utilization of Prospective Payment System, which now covers substantial fraction of hospital revenues).

110 *See* Kopit & Vanderbilt, *supra* note 11, at 268. In hospital markets, it is critically important to note that only a subset of consumers can experience higher prices as the result of a merger. *Id.* Government payors, such as Medicare and Medicaid which are typically a hospital's largest source of revenue, set their own payment schedules and offer hospitals a 'take it or leave it' deal on prices. *Id.* Virtually no hospital can afford to leave it. *Id. See generally* 42 C.F.R. § 124.603 c(1)(ii) (1995). Hospitals receiving funds under the Hill-Burton Program have a legal obligation to accept Medicare and Medicaid

tially, government payors, and other large health care providers (e.g. Blue Cross and Blue Shield), will be able to resist potential price increases attempted by merging hospitals, thus defeating the presumption that non-profit hospitals with a high market concentration will automatically control prices and produce anti-competitive effects.[111]

IV. AFFIRMATIVE DEFENSES[112] AND SOCIAL POLICY CONCERNS

After the party challenging the proposed non-profit hospital merger is successful in pleading anti-competitive effects that the merger may cause, the burden shifts to the merging entities to rebut the presumption of illegality.[113] In order to rebut this pre-

patients in perpetuity if they are eligible to do so. *Id.*; Fredric J. Entin et. al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107, 128 (1994). Medicare and Medicaid set their own payments by regulation and are not responsive to hospital pricing. *Id.* "Increases in hospital charges generate no additional revenue from these patients." *Id.*

111 *See* Kopit & Vanderbilt, *supra* note 11, at 268. Hospitals do not have market power over government payors, and large private purchasers because these groups control a high volume of patients, enabling them to resist attempted price increases. *Id.* As a result, any price increases resulting from a merger can only affect a subset of purchasers, typically certain managed care payors. *Id.*; *see also* Entin, *supra* note 110, at 128. A hospital's ability to exercise market power is often constrained by the fact that its pricing decisions affect only a small portion of its business. *Id. See, e.g.*, 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, 138 (1995). "Excess hospital capacity in a market should provide strong incentives for hospitals to negotiate price to obtain selective contracts that promise a certain volume of services." *Id.*

112 Though this note deals primarily with the defense of efficiencies, it may be useful to briefly introduce some other major defenses employed by merging hospitals. *See* Horoschak, *supra* note 42, at 165-67 (describing utilization of ease of entry defense when new competitors can easily enter relevant market or remaining competitors of merged entity can readily expand their capacity); *see also* Campbell & Teevans, *supra* note 4, at 1032 (discussing failing company defense as powerful rebuttal to presumption of illegality when defendant proves that acquired hospital is in 'failing condition' and that there are no reasonable available alternatives other than merging or selling assets).

113 *See* United States v. Mercy Health Serv., 902 F. Supp. 968, 987 (N.D. Iowa 1995) (quoting F.T.C. v. University Health Inc., 938 F.2d 1206, 1222 (11th Cir. 1991)). "The courts have recognized that in an appropriate case, 'a defendant may rebut the government's prima facie case with evidence showing that the intended merger would create significant efficiencies in the relevant market.'" *Id.* Although courts have recognized affirmative defenses to rebut a prima facie case, some confusion exists as to what the burden of proof is. *Id.* In *Mercy*, the government argued that the defendants were required to establish such a defense by clear and convincing evidence. *Id.* The defendants countered by arguing that case law only required the normal preponderance of the evidence standard. *Id.* The court, however, held that the defendants had failed to meet even the lower burden. *Id. But see* F.T.C. v. Proctor & Gamble Co., 386 U.S. 568, 580 (1967). The court found that the possibility of efficiencies could not be used as a defense to rebut presumption of illegality in section seven merger cases. *Id.*; United States v. Philadelphia Nat'l. Bank, 374 U.S. 321, 371 (1963). A merger, which may affect the market by substantially lessening competition, is not saved because it may be deemed beneficial. *Id.*

sumption, non-profit hospitals may rely on the affirmative defense of "efficiencies".[114] Today, efficiencies are generally recognized as a legitimate defense to the notion that mergers that result in high market concentration always cause anti-competitive effects.[115]

A. Efficiencies

The courts have been so slow to give credence to an efficiency based defense despite both legislative and executive branches mandating the reduction of excess hospital capacity and elimination of duplicative services as a means of controlling aggregate health care costs.[116] Hesitation by the courts to adequately consider efficiency may be rooted in the traditional notion that competition equates with efficiency.[117] It seems more appropriate to view competition as a means to a more efficient end.[118] As previ-

114 *See generally* F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1300 (W.D. Mich. 1996) (describing impetus for proposed merger as defendants' desire to avoid substantial capital expenditures, and achieve significant operating efficiencies); *Mercy Health Serv.*, 902 F. Supp. at 987 (explaining one of defendants' affirmative defenses, that efficiencies which result from merger will outweigh any anti-competitive effects which may result from merger); United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 849 (W.D.Va. 1989) (stating *Carilion's* serious need to expand and *Community's* need for more patients leads to various ways in which more efficient operations can save money thereby enabling them to offer services more competitively than ever, to patients' benefit).

115 *See* Horoschak, *supra* note 42, at 169 (recognizing that merger guidelines consider potential efficiencies of merger when they are substantial; could not be accomplished without mergers; are not offset by cost increases or quality decreases; and are likely to flow to consumers, not to shareholders or others); *see also University Health*, 938 F.2d at 1222 (concluding that defendant may rebut government's prima facie case under section seven by showing intended merger would create significant efficiencies in relevant market). *But see* Brown Shoe v. United States, 370 U.S. 294, 344 (1962) (chronicling continued debate over validity of efficiencies defense).

116 *See* Glazer, *supra* note 8, at 1056 (arguing that exemption for non-profit hospitals from section seven is consistent with current federal mandates to reduce hospital capacity and eliminate duplicative services as means of controlling aggregate health care costs (citing National Health Planning and Resources Development Act ("NHPRDA"), 42 U.S.C.A. §§ 300k-300n-6 (1997))). *See generally* American Hospital Association, *Hospital Statistics: A Comprehensive Summary of U.S. Hospitals*, xxxi (1990) (recognizing high costs of excessive hospital capacity as demand for inpatient hospital services declines).

117 *See* Paschall, *supra* note 4, at 75 (suggesting court's failure to address efficiency defense is because it is often equated with competition); James F. Ponsoldt, *Immunity Doctrine, Efficiency Promotion, and the Applicability of Federal Antitrust Law to State-Approved Hospital Acquisitions*, 12 J. CORP. L. 37, 72 (1986) (noting goal of antitrust is promotion of economic efficiency). *See generally* Baker, *supra* note 3, at 161 (reminding that substantial efficiencies did not historically save an acquisition with potential for collusion).

118 *See* Duncan Cameron, *Hospital Mergers and Joint Ventures: The Not So Special Case*, 1995 UTAH L. REV. 403, 405 (1995) (stating that competition forces innovation in efficient health care delivery); Frances H. Miller, *Health Insurance Purchasing Alliances:*

ously discussed, however, the correlation between increased competition and efficiency, irrespective of the viewpoint, is losing strength.[119]

In the long run the merging of two non-profit hospitals will often save struggling hospitals from closing their doors and foster greater competition.[120] This situation arises when one non-profit hospital requires more space in order to increase their health services, while another in the same geographical market has little patient demand in relation to the amount of facilities that they have to offer.[121] In this case, the latter has unused capacity, thereby, adding to overhead costs which must be allocated among fewer patients.[122] Concurrently, the former is inhibited from expanding its health care services.[123] Permitting the merger

Monopsony Threat or Procompetitive Rx For Health Sector Ills, 79 CORNELL L. REV. 1546, 1547 (1994) (arguing that competition would force providers to improve efficiency of health service delivery); Toby G. Singer, *Recent Developments in Antitrust Enforcement: Hospital Mergers*, *in* HEALTH CARE REFORM LAW INSTITUTE 1994, at 87, 102 (PLI Corp. L. Practice Course Handbook No. A4-4455, 1994) (claiming that competition promotes, rather than hinders delivery of high quality, cost effective health care).

119 *See* Sean O'D. Bosack, Comment, *Antitrust Immunity For Health Care Providers In Wisconsin: The State Action Immunity Doctrine and Wisconsin's Health Care Cooperative Agreement Legislation*, 80 MARQ. L. REV. 245, 255 (1996) (claiming health care industry believes that collaboration, rather than competition, is best way to achieve efficiency and contain health care costs).

120 *See* Glazer, *supra* note 8, at 1057 (proffering exemption of non-profit hospital mergers from Clayton Act scrutiny may help maintain patient access to vital services by keeping marginal hospitals viable in undeserved communities); Tokarski, *supra* note 101, at 2 (citing study indicating that mergers maintain access and increase services provided).

121 *See* United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 845 (W.D.Va. 1989). The facts in Carilion provide a perfect example. *Id.* Defendants wanted to merge in order to enhance the competitive positions of both Roanoke Memorial and Community. *Id.* Roanoke Memorial needed more space in which to offer its obstetrics services and for various other clinical and administrative functions. *Id.* In contrast, Community's occupancy has declined faster than that of Roanoke's other hospitals. *Id.*; *see also* Jane Hochberg, Comment, *The Sacred Heart Story: Hospital Mergers and Their Effects on Reproductive Rights*, 75 OR. L. REV. 945, 962 (1996). The author recounts federal antitrust regulators approved a merger between two hospitals where the merger shifted all obstetric services to one hospital and eliminated their services in other hospitals. *Id.*; Horoschak, *supra* note 42, at 169. Indeed, at times, scale economies will be achieved in a non-profit hospital merger. *Id.* In such an instance, "the consolidation will ensure a higher level of quality service, or (even better) is necessary to provide the service at all." *Id.*

122 *See Carilion Health System*, 707 F. Supp. at 845 (lamenting over hospital with extra space and need for patients); Glazer, *supra* note 8, at 1056 (noting that unused capacity increases overhead costs). *See generally* Choslovsky, *supra* note 10, at 296 (claiming that antitrust exemption is consistent with reducing excess hospital capacity and eliminating duplication of services).

123 *See* Choslovky, *supra* note 10, at 295 (explaining that need for non-profit hospital mergers is necessitated by fact that some hospitals have overabundance of technology while others face shortage of doctors and facilities); Stelwagon, *supra* note 10, at 572 (asserting over capacity and needlessly duplicative services will be abated by hospital

of these hospitals on efficiency grounds creates a two-fold effect; it results in increased quality of health care, and the revival of a non-profit hospital that once decreased competition because of low patient volume.[124] By allowing the non-profit hospitals to rely on the efficiency defense as support for their merger,[125] the courts would be better promoting the goals of antitrust legislation.[126]

The unique nature of hospitals in general and non-profit hospitals in particular tends to lead to gross inefficiencies due to the market tendency for capacity to vastly outpace demand.[127] A number of commentators attribute this strange market behavior to inconsistent intrusion of governmental regulation.[128] Some

mergers). *See generally Carilion Health Sys.*, 707 F.Supp. at 845 (merging hospitals gain facilities necessary to expand their health care).

124 *See Carilion Health Sys.*, 707 F. Supp. at 845-46. The defendants planned to consolidate all clinical services of both hospitals. *Id.* The merger was expected to help the two hospitals strengthen and expand joint operations. *Id.* The court was satisfied through testimony at trial that the merger would produce capital avoidance and efficiencies in excess of forty million dollars. *Id.*; *see also* Bazzoli, *supra* note 111, at 138. Hospital mergers provide some consumer benefits, especially those mergers that can consolidate redundant services and administrative functions. *Id.*; Stephens, *supra* note 9, at 478. "Hospitals facing closure consider the merger option because it allows them to offer new services or to streamline the costs of providing current services." *Id.*

125 *See, e.g.*, F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1300 (W.D. Mich. 1996) (permitting efficiencies defense to rebut government's prima facie case); United States v. Mercy Health Serv., 902 F. Supp. 968, 987 (N.D. Iowa 1995) (stating that courts will allow defendant to rebut government's prima facie antitrust case with efficiencies defense); *Carilion Health Sys.*, 707 F.Supp. at 849 (allowing efficiencies defense to support merger).

126 *See* Baker, *supra* note 3, at 100 (stating that economic efficiency has become lode star of antitrust); Phillip C. Kissam et. al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595, 670 (1982) (enunciating that goals of antitrust legislation, promoting competition and economic efficiency, can be served by allowing non-profit hospital mergers); Paschall, *supra* note 4, at 74 (stating goals of antitrust legislation are to promote competition, economic efficiency and consumer welfare).

127 *See* Campbell & Teevans, *supra* note 4, at 1010 (noting National health policy's goal of forcing hospitals to be more efficient, evidenced by 698 hospital closures in 1980's); Paschall, *supra* note 4, at 65 (recognizing unique economic characteristics of health care market which influence effects of antitrust policy and hospital mergers); Joe Sims, *A New Approach to the Analysis of Hospital Mergers*, 64 ANTITRUST L.J. 633, 638 (1996) (describing how most health care facilities were built to meet traditional hospital demands and have very high fixed costs, thereby adding to problem of excess capacity).

128 *See* Campbell & Teevans, *supra* note 4, at 1009. Hospital mergers are on the rise because of national health care policies. *Id.* Current antitrust enforcement efforts to curb hospital mergers are in conflict with most national policies affecting hospitals. *Id.* Given this, it is unclear whether current antitrust enforcement efforts promote the consumer interest. *Id.*; *see also* Richard A. Feinstein, *Health Care Mergers: Federal Antitrust Law and Significant Trends*, *in* HEALTH CARE LAW 1993, at 9, 36 (PLI Corp. L. Practice Course Handbook Series No. A4-4428, 1993). In one instance this can be seen with regulatory barriers to entry into the marketplace. *Id.* Hospital mergers often provide evidence of both high and low entry barriers. *Id.* If the relevant market consists of a cluster of hospital services in a region governed by state laws and regulations, investment capital necessary to construct a new competing facility and the delay of Certificate of Need

have gone so far as to suggest that hospitals should be exempt from merger analysis in general.[129] The efficiency argument, though still in its infancy, appears strong enough to legitimize adjusting the antitrust approach in health care to, if not encourage non-profit hospital mergers, then at least give them the benefit of per se legality.[130]

B. Social Benefits to Promoting Non-profit Hospital Mergers

Non-profit hospitals play an important role in the health care industry in this country.[131] They were originally founded to care for the welfare of the public by providing access to health care to those who could not otherwise afford it.[132] One of the primary goals of antitrust legislation is consumer welfare.[133] By clinging

hearings may raise significant barriers to entry. *Id. See, e.g.*, Hospital Corp. of Am. v. F.T.C., 807 F.2d 1381, 1387 (7th Cir. 1986). In this case, a hospital's ability to expand and merge with other hospitals is hampered by Tennessee's Certificate of Need law and approval requirements by state agencies. *Id.*

129 *See* Glazer, *supra* note 8, at 1055. Public policy favors exempting non-profit hospital mergers from rigorous antitrust scrutiny for two reasons: First, it is consistent with repeated congressional mandates to reduce hospital capacity and eliminate duplication of services, and second, these mergers often benefit consumers by maintaining access to hospital care and improving the quality of services. *Id.*; *see also* National Health Planning and Resource Development Act, 42 U.S.C.A. §§ 300k–300n-6 (1997). The NHPRDA was designed to prevent duplication of hospital services. *Id.*; Kopit & McCann, *supra* note 7, at 642. Although Congress repealed the NHPRDA, Congress affirmed the principles behind it. *Id.*

130 *See* Joseph Kattan, Comment, *Efficiencies and Merger Analysis*, 62 ANTITRUST L.J. 513, 515 (1994). Efficiency considerations have begun to figure prominently in judicial decisions upholding mergers challenged by federal agencies. *Id.* The growing acceptance of the efficiencies claims is evident in the Federal Merger Guidelines. *Id.*; Robert Pitofsky, *Proposals for Revised United States Merger Enforcement in a Global Economy*, 81 GEO. L.J. 195, 206 (1992). "Claims of efficiency can be offered as a relevant factor in the enforcement agencies' exercise of prosecutorial discretion." *Id. But see* F.T.C. v. Proctor & Gamble Co., 386 U.S. 568, 580 (1967). "Possible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies but it struck the balance in favor of protecting competition." *Id.*

131 *See generally* Adams, *supra* note 59, at 721-22 (stating that non-profit hospitals provided first widely available medical care in United States and are still needed to care for those who cannot afford private health care); Stephens, *supra* note 9, at 477 (describing early non-profit hospitals as charitable institutions providing long term care for less fortunate); White, *The American Hospital Industry Since 1900: A Short History*, 3 ADVANCING HEALTH ECON. & HEALTH SERV. RES. 143, 145 (1982) (indicating that initial non-profit hospitals were established by community associations or religious groups to provide medical care for indigent persons).

132 *See id.*

133 *See* Paschall, *supra* note 4, at 61 (claiming that consumer welfare is goal of antitrust law); *see also* Eric James Fuglsang, Comment, *The Arbitrability of Domestic Antitrust Disputes: Where Does the Law Stand?*, 46 DEPAUL L. REV. 779, 794 n.139 (1997) (arguing that under welfare transfer theory, antitrust legislators aimed to protect consumers from exploitation by preventing monopolists from creating "welfare loss"); Michael S. Jacobs, *Rural Health Care and State Antitrust Reform*, 47 MERCER L. REV. 1045,

to the traditional notions of antitrust and competition, antitrust regulators sacrifice the welfare of the general public for the welfare of the consumer.[134]

Hospital consolidation is occurring at a record pace in the 1990's, and non-profit hospitals, finding it difficult to compete, are eventually forced to close their doors.[135] While mergers between private hospitals and the continued consolidation of managed care companies appear to have generated lower prices for paying consumers, they have also jeopardized the continued existence of social programs and charity care, the province of non-profits, for those too poor to be considered consumers.[136] Many of these hospitals, in order to remain functional, are expanding their service in other for profit areas to help fund the non-profit services, thus threatening their non-profit status.[137] It is not difficult to imagine a time in the not so distant future when non-profit hospitals cease to exist, leaving those who could not afford care to begin with even more worse off.

When courts prevent the mergers of non-profit hospitals the

1045 (1996) (stating that federal antitrust laws promote activity most conducive to consumer welfare).

134 *See* Joseph F. Brodley, *The Economic Goals of Antitrust: Efficiency, Consumer Welfare, and Technological Progress*, 62 N.Y.U. L. REV. 1020, 1024 (1987) (noting that general public is hurt because antitrust analysis is judged in long-run, rather than in immediate and transitory); Jacobs, *supra* note 3, at 904 (distinguishing health care from other markets subject to antitrust analysis because of conflict between consumer welfare and well-being of poor); Nancy L. Sander, Note, *Health Care Alliances – Good Medicine for an Ailing Health Care Industry, or Antitrust Illness to Fence In?*, 27 U. TOL. L. REV. 687, 688 (1996) (questioning whether current lenient philosophy in antitrust enforcement is protecting consumer welfare in health care market).

135 *See* Baker, *supra* note 3, at 100. The large increase in health care over the past thirty years has led to the need for consolidation in order to compete with less demand. *Id.*; Glazer, *supra* note 8, at 1059-60. Dramatic changes in the delivery of health care services are resulting in rapid consolidation of non-profit hospitals. *Id.* Attempts to prevent mergers between non-profit hospitals neither accords with sound legal interpretation, nor with important public policy objectives. *Id.* Instead, they may prevent beneficial mergers by which non-profit hospitals can reduce costs, maintain access to services, and improve the quality of care provided. *Id.*

136 *See* Jacobs, *supra* note 3, at 916 (commenting that because everyone is entitled to health care, consumer welfare model of antitrust analysis is ill-fitted to health care industry); *see also* Jennifer Preston, *As Revenues Drop, Hospitals Talk of Forsaking Charity Care*, N.Y. TIMES, Apr. 14, 1996, at A1 (reporting that effect of managed care is to deprive uninsured of free medical treatment).

137 *See generally* Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1548 (1996) (increasing cost pressures due to insurer demands for discounts changes face of non-profit hospitals); Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1101 (1996) (discussing joint ventures and other types of alliances between for-profit hospitals and catholic rural hospitals); Stephens, *supra* note 9, at 499-500 (discussing non-profit hospital forays into for profit areas to fund programs for poor, which is in turn threatening their status as non-profit).

problem is that they fail to grant enough consideration to the potential benefit that the merging hospitals will provide to the community.[138] Permitting these mergers to go through would result in better medical services, allowing the use of improved facilities and attracting specialists to the area hospitals.[139] In addition, local community members who serve on the hospital boards assure high quality health care.[140] The presence of community members on the board will ensure that the merging hospitals do provide this benefit to the public, and defeat the proposition that allowing non-profit hospitals to merge will force the community to pay higher prices for the same services.[141]

138 *See* Jacobs, *supra* note 3, at 917. "The exclusive focus of antitrust courts precludes their consideration of the social values that inform, or ought to inform, the debate about competition in health care markets." *Id.*; *see also* United States v. Carilion Health Sys. and Community Hosp. of Roanoke Valley, 707 F. Supp. 840, 849 (W.D.Va. 1989). Defendant hospitals sought to merge to strengthen competition. *Id.* Based on Roanoke Memorial's limited space and Community's need for more patients, a merger of the two facilities would save them money and allow them to offer services more competitively than ever. *Id. But see* United States v. Rockford Mem'l Corp. and Swedish Am. Corp., 898 F.2d. 1278, 1286 (7th Cir. 1990). Judge Posner stated that the district court was free to reject the efficiencies resulting from the merger. *Id.*

139 *See* H.T.I. Health Serv. v. Quorum Health Group, Inc., 960 F.Supp. 1104, 1143 (S.D. Miss. 1997). The court stated that a public interest analysis necessarily involves two inquiries: whether permitting the merger to go forward will result in better medical services for the area, and whether health care cost to consumers will rise if the merger is not enjoined. *Id.* The court further found that the merger would increase the recruitment of needed specialists and sub-specialists as well as the collaborative efforts by the physicians to procure technologically advanced medical equipment. *Id.*; *see also* Murray S. Monroe, *Health Care: Current Antitrust Issues*, 20 N. KY. L. REV. 365, 388 (1993). An organization should enter into the merger only if there is a valid business reason tied to improved efficiency of the operating facilities. *Id.*; Kurt A. Wagner, Commentary, *Federal Income Taxation of Non-Profit Hospital Joint Ventures*, 14 J. LEGAL MED. 479, 499 (1993). Hospital mergers attract physicians because of their benefits, (i.e. profits) and improve utilization of hospital's facilities for the public. *Id.*

140 *See* F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1296 (W.D. Mich. 1996). Non-profit hospitals do not operate in the same manner as profit maximizing businesses because of the presence of community business leaders on the hospital boards. *Id.*; Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not–For–Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 49 n.193 (1995). The Catholic Health Association takes the position that community views are important, and therefore, encourages community members to be involved in identifying needs and developing plans. *Id.*; Ikemoto, *supra* note 137, at 1124. Hospital boards that are comprised of community members appear to be more sensitive to organized efforts that propose cuts in service. *Id.*

141 *See Butterworth Health Corp.*, 946 F.Supp. at 1296 (noting when non-profit organizations are controlled by people who depend on it for service, there will be no rational economic incentive to raise prices even if power to do so exists); Lynk, *supra* note 99, at 440 (analogizing merging non-profit hospital to consumer co-operative where profits are put back into business for community's benefit); Tschoepe, *supra* note 59, at 556 n.105 (comparing members of non-profit hospital to shareholders of non-profit corporation whose members include people of community who elect board of directors responsible for hospital's conduct).

CONCLUSION

The analysis that courts conduct in determining the antitrust implications involved in non-profit hospital mergers is based on numerous inaccuracies. These inaccuracies are a result in large part of the misplaced presumption that the health care market is similar to and behaves like other industries to which antitrust analysis is better suited. The narrow construction of the relevant markets for hospitals and failure to recognize the legitimacy of the efficiency and social arguments, which are the result of the application of a traditional antitrust analysis, defeats the efforts of modern legislators to reform health care in the United States. Non-profit hospitals can and will play an important role in effecting this reform if they are allowed to develop in the manner in which the health care industry dictates. Placing traditional antitrust restrictions on non-profit hospital mergers only serves to propagate an inefficient system and prevents these institutions from ultimately serving the welfare of the public.

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