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Clayton Act Scrutiny of Nonprofit Hospital Mergers: The Wrong Rx for Ailing Institutions

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CLAYTON ACT SCRUTINY OF NONPROFIT HOSPITAL MERGERS: THE WRONG Rx FOR AILING INSTITUTIONS

Abstract: The Sherman and Clayton antitrust laws have long been used to challenge anticompetitive mergers between for-profit entities. Recently, the federal government began challenging mergers between nonprofit hospitals under the Clayton Act. Two federal circuit courts are divided on whether nonprofit mergers are subject to Clayton Act scrutiny. This Comment examines the statutory interpretations and the policy arguments suggested by the two cases, and concludes that the Clayton Act does not, and should not, apply to nonprofit hospital mergers.

Memorial Hospital[1] was founded in the 1950s, during the heyday of hospital construction. It was one of two nonprofit hospitals serving Littleton, a town of 65,000 inhabitants situated three hours north of Metropolis. For over thirty years, Memorial was a fixture in the community. A generation of Littleton residents were born there, or at St. Luke's, its cross-town rival. Although Memorial's facilities had decayed over the years, the hospital seemed healthy, so townspeople were surprised when the hospital board announced that Memorial would soon close.

Nonprofit hospitals[2] throughout the country face daunting challenges caused by escalating costs, reduced revenues, and fundamental changes in the delivery of health care.[3] These challenges have led to unprecedented numbers of hospital closures during the past five years.[4] Before hospital boards[5] consider closure, they consider less drastic alternatives, including merging their hospitals with those of competitors.[6] Mergers[7] between nonprofit hospitals can maintain the viability of marginal institutions, reduce excess hospital capacity,[8] and

1. Memorial Hospital is fictional, but represents a real facility in New England that closed in 1987.

2. The terms "nonprofit hospital" and "hospital" used throughout this Comment refer to nonprofit, non-governmental, acute-care facilities. Although for-profit hospitals exist in large numbers, nonprofit hospitals predominate, and are the subject here.

3. *See infra* note 25 and accompanying text.

4. *See infra* note 27.

5. *See infra* note 30 for a discussion of the role of nonprofit hospital boards.

6. *See infra* note 30.

7. The term "merger" as used here refers generically to the various methods of consolidating former competitors (often called "horizontal" mergers). It does not include mergers between non-competitors.

Mergers are categorized as one of three types: horizontal, vertical, or conglomerate. *See* IV E. KINTNER, FEDERAL ANTITRUST LAW §§ 33.6–33.9 (1984).

8. Reduction can occur through the conversion of underused acute-care facilities to other purposes, including the provision of outpatient, long-term, psychiatric, substance-abuse

enhance the quality and accessibility of health care provided in a community.[9] Such mergers, however, pose serious risks of violating federal and state antitrust laws.[10]

Nonprofit hospital mergers may violate either of two antitrust laws:[11] section 1 of the Sherman Act,[12] or section 7 of the Clayton Act.[13] These acts apparently differ significantly in their scrutiny of mergers.[14] Section 1 of the Sherman Act prohibits mergers where the purpose or actual effect is to restrain trade.[15] Section 7 of the Clayton Act proscribes mergers that may have future anticompetitive effects, without a showing of actual effects.[16]

The United States Supreme Court has yet to decide whether section 7 of the Clayton Act applies to nonprofit entities, such as nonprofit hospitals.[17] The federal government,[18] however, has for the first time in history begun challenging these mergers under the Clayton Act.[19] Although Clayton Act section 7 expressly applies only to stock acqui-

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treatment, or other specialized health care services. *See, e.g.*, Greene, *Do Mergers Work?*, MODERN HEALTHCARE, Mar. 19, 1990, at 28.

9. *See infra* notes 133–41 and accompanying text.

10. Most states have antitrust laws that parallel federal law. *See* Wood et al., *Acquisitions and Mergers*, CORPORATE LAW AND PRACTICE COURSE HANDBOOK SERIES Appendix A, 644 PLI/Corp 225, June 1, 1989 (PLI Order No. B4-6880) (text on WESTLAW). State antitrust law is beyond the scope of this Comment.

11. Note that this Comment does not discuss all provisions of the Sherman and Clayton Acts under which mergers may be challenged. For example, some mergers may violate the prohibitions of section 2 of the Sherman Act ("attempts to monopolize"), or section 5 of the Clayton Act ("unfair competition").

12. 15 U.S.C.A. § 1 (West 1973 & Supp. 1991).

13. *Id.* § 18.

14. Commentators disagree whether, in practice, the Sherman and Clayton Acts impose different standards. *See* American Bar Ass'n, *Seventh Circuit Says No to Rockford Merger*, 4 HEALTH LAWYER, Spring-Summer 1990, at 1 (suggesting the standards are different). *But see* II P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 304 (1978) (arguing that there is no difference). *See also* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 355 (1963), where the Court said: "To be sure, not every violation of § 7, as amended, would necessarily be a violation of the Sherman Act . . . ."; United States v. Penn-Olin Chem. Co., 378 U.S. 158, 170–71 (1964); Brown Shoe v. United States, 370 U.S. 294, 317 n.30 (1962).

15. *See* Times-Picayune Publishing Co. v. United States, 345 U.S. 594 (1953) (on the "purpose or effect" standard).

16. *See Brown Shoe*, 370 U.S. at 317–18 & n.32; United States v. E.I. Du Pont de Nemours & Co., 353 U.S. 586, 589 (1957) (discussing "incipiency" standard under Clayton Act section 7).

17. The author can find no Supreme Court cases involving mergers between nonprofit entities under section 7 of the Clayton Act.

18. The Department of Justice (DOJ) and Federal Trade Commission (FTC) have concurrent authority to enforce most antitrust laws. *See* Wood, *supra* note 10, at 15. Despite overlapping authority, the practical effects of DOJ or FTC enforcement are very different. *See* Burda, *A Legal Drama in Two Acts: Why Hospital Execs Should Know the Law in Antitrust Defense*, MODERN HEALTHCARE, Feb. 5, 1990, at 40.

19. Kopit & McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 J. HEALTH POL., POL'Y & L. 635, 647–48 (1988).

sitions, or to asset acquisitions by entities subject to Federal Trade Commission (FTC) jurisdiction,[20] two circuit courts recently split on the proper interpretation of section 7. In *United States v. Rockford Memorial Corp.*,[21] the Seventh Circuit said in dicta that Clayton Act section 7 does apply to nonprofit hospitals.[22] In *United States v. Carilion Health System*,[23] by contrast, the Fourth Circuit affirmed the dismissal of a section 7 claim for lack of FTC jurisdiction over the nonprofit hospitals.[24]

This Comment examines the statutory interpretations used in *Rockford* and *Carilion*, and concludes that neither the language of Clayton Act section 7, nor the legislative history behind it, supports its application to nonprofit hospital mergers. Furthermore, exempting nonprofit hospitals from section 7 of the Clayton Act is consistent with public policy initiatives aimed at systematically reducing hospital capacity, maintaining access to health care, and improving the quality of care provided. Finally, the Sherman Act offers sufficient protection against any harmful effects of nonprofit hospital mergers.

I. BACKGROUND: HOSPITAL MERGERS AND ANTITRUST LAW

A. The Current Status of Hospitals

The hospital industry underwent a dramatic transformation during the 1980s, fundamentally changing the way hospital services are delivered and paid for.[25] These changes reduced the demand for inpatient

20. 15 U.S.C.A. § 18 (West 1973 & Supp. 1991). The scope of FTC jurisdiction is contained in sections 4 and 5 of the FTC Act, 15 U.S.C.A. §§ 44, 45 (West 1973 & Supp. 1991).

21. 898 F.2d 1278 (7th Cir.), *cert. denied*, 111 S. Ct. 295 (1990).

22. *Id.* at 1281.

23. 892 F.2d 1042 (4th Cir. 1989) (unpublished opinion) (text in WESTLAW, Federal directory, CTA4 file), *aff'g* 707 F. Supp. 840 (W.D. Va. 1989).

24. *Id.* In a case decided as this Comment goes to press, the Eleventh Circuit Court of Appeals reversed a district court and enjoined a merger between two nonprofit hospitals in Augusta, Georgia. FTC v. University Health, Inc., No. 91-8308, 1991 U.S. App. LEXIS 16503, 1991-2 Trade Cas. (CCH) ¶ 69,508 (11th Cir. July 26, 1991). The court relied heavily on Judge Posner's dictum in *Rockford* and held that section 7 of the Clayton Act was applicable to nonprofit hospital mergers. 1991 U.S. App. LEXIS 16503 at *14–20.

25. This transformation involved two broad, and related, areas of change: (1) a fundamental shift away from cost-based reimbursement for hospital services under federal, state, and private insurance plans; and (2) changes in the way health care services are delivered, through the rapid growth of competitive alternatives to inpatient hospital services. These broad categories are discussed briefly below; for more thorough treatment of these issues, see Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW &

hospital services,[26] and contributed to unprecedented numbers of hospital closures[27] and mergers.[28] The majority of closures and mergers involved nonprofit hospitals.[29]

Mergers are an important option for nonprofit hospitals struggling to survive.[30] Recently, however, the federal government has chal-

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CONTEMP. PROBS. 93 (1988); Comment, *The Role of Medicare Reimbursement in Contemporary Hospital Finance,* 11 AM. J. L. & MED. 501 (1986).

In 1983, the federal government stopped reimbursing hospitals based on the actual costs of treating Medicare patients (called "cost-based" reimbursement), and instituted the Prospective Payment System (PPS), which reimburses hospitals a fixed rate based on the average cost of treating a patient diagnosed with a particular condition. *Id.* at 508–09. This change put hospitals at risk for any costs incurred that exceeded the fixed reimbursement amount. *Id.* During the 1980s, increases in Medicare reimbursement failed to keep pace with increases in hospital costs. *Id.* Moreover, states and private insurers instituted a variety of similar means of constraining reimbursement. *See* AMERICAN HOSPITAL ASS'N (AHA), HOSPITAL STATISTICS: A COMPREHENSIVE SUMMARY OF U.S. HOSPITALS xxxi (1990) [hereinafter AHA HOSPITAL STATISTICS]; BLUE CROSS/BLUE SHIELD, ENVIRONMENTAL ANALYSIS 1990, at 16–18.

During the 1980s, technological breakthroughs and new payment incentives caused dramatic changes in the delivery of hospital services. Many treatments previously performed only in hospitals are now performed on an outpatient basis at freestanding medical, surgical, and diagnostic centers. AHA HOSPITAL STATISTICS at xxxi, xli. Hospitals thus compete with one another, and with numerous other institutions, to provide health services. *Id.* Statistics demonstrate this trend: in 1979, 86 percent of surgeries were performed on an inpatient basis; by 1989, this figure was about 50 percent. *Id.* at xxxviii. Between 1979 and 1989, the number of outpatient surgeries increased by 300 percent, while the number of inpatient surgeries declined by 30 percent. *Id.*

26. Demand for inpatient hospital services declined throughout most of the 1980s, resulting in poor financial performance by many hospitals. AHA HOSPITAL STATISTICS, *supra* note 25, at xxxv–xxxix. Total hospital admissions fell 11 percent between 1979 and 1989. *Id.* at xxxvi. Average hospital occupancy rates fell from 74 percent in 1979 to 66 percent in 1989. *Id.* at xxxii. According to AHA estimates, 20 percent of existing inpatient hospital capacity is expected to close by the year 2000. AHA News, June 20, 1988, p. 3.

27. Since 1980, 508 community hospitals have closed in the U.S. AHA HOSPITAL STATISTICS, *supra* note 25, at xxxiii. Still more hospitals are "ailing"—unable to meet operating expenses or to accumulate capital reserves to replace buildings and equipment. In 1989, the average hospital generated less than one-half of one percent margin from patient care revenues. BLUE CROSS/BLUE SHIELD, *supra* note 25, at 17. *See also* OFFICE OF INSPECTOR GENERAL, DEP'T OF HEALTH AND HUM. SERV., HOSPITAL CLOSURE: 1987, PUB. NO. OAI-04-89-00740 (May 1989), *reprinted in* [New Developments] Medicare & Medicaid Guide (CCH) ¶ 37,864 (1989).

28. Between 1980 and 1987, 167 nonprofit hospitals were involved in mergers. Burke, *Mixed Signals From Government Have Chilling Effect On Mergers,* HOSPITALS, June 5, 1990, at 36.

29. Between 1980 and 1987, 87 percent of hospital mergers involved nonprofit hospitals. *Id.* Further, 83 percent of community hospital closures in 1986 were nonprofit facilities. Muller, *45% More Community Hospitals Closed In '86,* HOSPITALS, May 5, 1987, at 32.

30. Nonprofit hospitals are usually directed by volunteer boards with close ties to the community. For background on the role of such boards, see A. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 114–19 (2d ed. 1988); Gray & McNerney, *For-Profit Enterprise in Health Care: The Institute of Medicine Study,* 314 NEW ENG. J. MED. 1523, 1524 (1985); Horwitz, *Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax-Exempt, Nonprofit Hospital?,* 13 AM. J.L. & MED. 527, 529–31 (1988); Oleck, *Nature of*

lenged such mergers as violations of the antitrust laws.[31] The proper application of these laws thus will determine whether such mergers are legal.[32]

B. Federal Antitrust Merger Law

Federal antitrust merger law seeks to maintain the competitiveness of the marketplace, and thus protect consumers, by preventing sellers from achieving sufficient market power[33] to significantly affect market prices.[34] The underlying concern with mergers is the elimination of competition, resulting in either collusion among competitors, or pure monopoly.[35] Two statutes form the basis for merger law: section 1 of the Sherman Act,[36] and section 7 of the Clayton Act.[37] Cases interpreting these laws define the bounds of merger doctrine.[38]

1. The Sherman Act

The Sherman Act, passed in 1890, broadly proscribes anticompetitive practices. Section 1 of the Act states, "[e]very contract, combination . . . , or conspiracy, in restraint of trade . . . , is declared to be illegal."[39] Because section 1 of the Sherman Act is both broad and vague, courts have sought to define its limits.[40] Importantly, courts have interpreted section 1 to mean that only unreasonable restraints of trade are illegal.[41]

To determine whether a restraint is unreasonable, courts categorize activities as either: (1) "per se" illegal; or (2) subject to "rule of rea-

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Nonprofit Organizations in 1979, 10 U. TOL. L. REV. 962, 965–68, 980–84 (1979) (on the number and strength of nonprofits).

31. This appears to be part of a trend of stepped-up antitrust enforcement against all hospitals—for-profit and nonprofit. Holthaus, *FTC Joins Examiners of Not-For-Profit Mergers,* HOSPITALS, Dec. 5, 1988, at 52. *See generally,* Campbell & Teevans, *Mixed Signals: Recent Cases Make the Legality of Future Hospital Mergers Less Predictable,* 59 ANTITRUST L.J. 1005, 1007–09 (1991) (discussing the history of hospital merger prosecutions).

32. *See supra* note 14; *infra* notes 39–57 and accompanying text.

33. "Market power is the ability to raise prices by restricting output." P. AREEDA & D. TURNER, *supra* note 14, at ¶ 501.

34. For a thorough discussion of the economic basis for antitrust policy, *see id.* at ¶ 401.

35. IV P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 901 (1980). The fewer the number of competitors, the easier they can collude—explicitly or implicitly—to restrict output and raise prices. *Id.*

36. 15 U.S.C.A. § 1 (West 1973 & Supp. 1991).

37. *Id.* at § 18.

38. *See* P. AREEDA & D. TURNER, *supra* note 35, at ¶ 909.

39. 15 U.S.C.A. § 1 (West 1973 & Supp. 1991).

40. *See* Chicago Bd. of Trade v. United States, 246 U.S. 231 (1918).

41. *Id.*; Standard Oil Co. v. United States, 221 U.S. 1 (1911).

son" analysis.[42] Certain activities, such as price-fixing by competitors, are considered inherently unreasonable, and are categorized as per se illegal.[43] Other activities, including mergers, may or may not be reasonable, depending upon their particular facts. These activities are examined on a case-by-case basis under the rule of reason standard.[44]

The goal of Sherman Act section 1 regarding mergers is to prohibit combinations where the purpose or effect is to limit competition.[45] Under this standard, a defendant must have anticompetitive intent, or the actual effect of a merger must be anticompetitive, to violate the statute.[46]

2. *The Clayton Act*

The Clayton Act was passed in 1914, in response to a widespread belief that the Sherman Act was ineffective in forestalling many anticompetitive practices.[47] The Clayton Act specifically defined proscribed activities,[48] including certain mergers, and permitted the government to enjoin potentially harmful mergers without showing actual anticompetitive effects.[49]

Originally, section 7 prohibited only mergers accomplished through the acquisition of stock or capital shares.[50] Thus, as enacted, section 7 contained a loophole through which businesses consolidated by

42. *See Standard Oil,* 221 U.S. at 63–65 (1911) (explaining per se and rule of reason standards). Courts do not hear justifications for per se illegal activities. *Id.*

43. *Id.*

44. Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 23 (1979) ("Mergers . . . are not *per se* illegal, and many of them withstand attack under any existing antitrust standard."); *see also* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984).

45. Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 614 (1953).

46. *Id.; see also Copperweld,* 467 U.S. at 768; *Standard Oil,* 221 U.S. at 59–60.

47. *See* E. KINTNER, *supra* note 7, at § 33.1.

48. The specific proscriptions of the Clayton Act contrast with the broad scope of the Sherman Act. *See* A. SOUTHWICK, *supra* note 30, at 187–90.

49. Section 7 of the Clayton Act says: "No person . . . shall acquire . . . the stock or other share capital and no person subject to the jurisdiction of the [FTC] shall acquire . . . the assets of one or more persons . . . where . . . the effect . . . may be substantially to lessen competition . . . ." 15 U.S.C.A. § 18 (West 1973 & Supp. 1991). Courts have interpreted this language to permit challenges of mergers where there is a probable anticompetitive effect, but no actual effect. Minnesota Mining & Mfg. Co. v. New Jersey Wood Finishing Co., 381 U.S. 311, 323 (1965); United States v. Penn-Olin Chem. Co., 378 U.S. 158, 170–71 (1964).

50. Clayton Act, ch. 323, § 7, 38 Stat. 730 (1914) (codified as 15 U.S.C.A. § 18 (West 1973 & Supp. 1991)).

purchasing the assets of other entities.[51] In 1950, Congress amended the Act to close this loophole.[52]

The Celler-Kefauver amendments extended section 7 coverage to asset acquisitions that were, in substance, mergers.[53] However, the amendments did not proscribe all mergers accomplished by asset acquisition. The amendments expressly limited section 7 coverage to mergers by entities subject to FTC jurisdiction.[54]

The scope of FTC jurisdiction is contained in sections 4 and 5 of the Federal Trade Commission Act ("FTC Act"),[55] passed the same year as the Clayton Act. Sections 4 and 5 of the FTC Act, taken together, limit FTC jurisdiction over corporations to those operating for profit.[56] Thus, the assets acquisition clause of Clayton Act section 7 apparently applied only to for-profit entities.[57]

Courts have occasionally extended section 7 of the Clayton Act to cover commercial entities not expressly within the amended statute.[58]

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51. Businesses simply acquired the assets of a target company without changing the ownership of the target company's stock. Several early Supreme Court decisions upheld the legality of asset acquisitions in challenges under the original section 7. *See, e.g.*, Arrow-Hart & Hegeman Elec. Co. v. FTC, 291 U.S. 587 (1934) (strictly construing Clayton Act section 7); FTC v. Western Meat Co., 272 U.S. 554, 561 (1926) (rejecting the application of section 7 to non-stock acquisitions).

52. Celler-Kefauver Act, ch. 1184, 64 Stat. 1125 (1950) (codified at 15 U.S.C.A. §§ 18, 21); *see* P. AREEDA & D. TURNER, *supra* note 35, at ¶ 902.

53. For a thorough legislative history of the Celler-Kefauver Amendments to the Clayton Act, see 4 E. KINTNER, THE LEGISLATIVE HISTORY OF THE FEDERAL ANTITRUST LAWS AND RELATED STATUTES 3385–644 (1980).

54. *See supra* note 49.

55. Federal Trade Commission Act, ch. 311, §§ 4, 5, 38 Stat. 719 (1914) (codified at 15 U.S.C.A. §§ 44, 45 (West 1973). The FTC Act created and defined the scope of FTC activity.

56. Section 4 of the FTC Act defines "corporations" as, "any company, . . . or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members . . . ." *Id.* at § 44.

57. Almost all states prohibit nonprofit corporations from issuing stock or share capital, and from distributing any net revenues to their directors, officers, or members. *See* T. BAROCCI, NON-PROFIT HOSPITALS: THEIR STRUCTURE, HUMAN RESOURCES, AND ECONOMIC IMPORTANCE 77 (1981); A. SOUTHWICK, *supra* note 30, at 118–20.

58. United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963); United States v. Chelsea Sav. Bank, 300 F. Supp. 721 (D. Conn. 1969).

Courts have split over whether the FTC has jurisdiction to challenge nonprofit entities in antitrust cases not brought under Clayton Act section 7. *See, e.g.*, Community Blood Bank v. FTC, 405 F.2d 1011, 1022 (8th Cir. 1969) (holding that nonprofit organizations that did not operate in the pecuniary interests of their members were not within FTC jurisdiction); *see also* Hospital Corp. of Am. v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987), in which Judge Posner said: "[t]here is a possible gap in the FTC's jurisdiction over acquisitions involving nonprofit corporations . . . ."; Baker, *supra* note 25, at 113 n.104. *But cf.* American Medical Ass'n v. FTC, 638 F.2d 443 (2nd Cir. 1980), *aff'd*, 455 U.S. 676 (1982) (holding that FTC could assert jurisdiction over nonprofit entity acting in the pecuniary interests

In *United States v. Philadelphia National Bank,*[59] the Supreme Court said it was proper to extend coverage of section 7 to for-profit banks if consistent with congressional purpose.[60] The Court examined several factors to determine congressional purpose: (1) the meaning of key provisions when read together;[61] (2) congressional debates and other legislative history surrounding the Clayton amendments;[62] and (3) the rule that "immunity from the antitrust laws is not lightly implied."[63] The Court concluded that Congress did not intend to exempt banks from section 7 simply because banks were not subject to FTC jurisdiction.[64]

C. *The Circuits Split in* Rockford *and* Carilion

Although the Supreme Court has yet to decide whether section 7 of the Clayton Act applies to mergers between nonprofit entities, two federal circuit courts recently split on this issue. The cases, *United States v. Rockford Memorial Corp.*[65] and *United States v. Carilion Health System,*[66] involved nonprofit hospital mergers in Rockford, Illinois, and Roanoke, Virginia. Although similar in their facts, the cases were decided under very different interpretations of the Clayton Act. The *Rockford* court concluded that section 7 is applicable to nonprofit hospitals, while the *Carilion* court held that section 7 does not so apply.[67]

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of its members); FTC v. National Comm'n on Egg Nutrition, 517 F.2d 485 (7th Cir. 1975) (same holding), *cert. denied,* 426 U.S. 919 (1976).

59. 374 U.S. 321 (1963).

60. The *Philadelphia* Court held that a type of bank merger not expressly within the jurisdiction of the FTC was nevertheless proscribed by section 7 of the Clayton Act, because Congress intended to close a "loophole" permitting such mergers. *Id.* at 342–43. *See infra* notes 61–64 and accompanying text.

61. *Philadelphia,* 374 U.S. at 342–43. The Court concluded that Congress intended the stock and assets clauses of section 7, when read together, to cover mergers that were neither purely one nor the other.

62. *Id.* at 337–42. The Court cited legislative history to the effect that the Celler-Kefauver amendments to section 7 were intended to "plug a loophole" in the original Act. *Id.* at 341 n.19.

63. *Id.* at 348 (citations omitted). Courts have held, for example, that public policy considerations are not a defense to, or justification for, anticompetitive practices. *See, e.g.,* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982); National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978). In *Engineers,* the Court condemned under the per se rule an attempt to enhance public safety by limiting competitive bidding. *Id.* at 693–95.

64. *Philadelphia,* 374 U.S. at 343–44. The Court noted that Congress did not exempt banks from the stock-acquisition provisions of section 7. *Id.* at 348. Rather, the Court said, Congress intended to put asset acquisitions on a par with stock acquisitions. *Id.* at 347 n.23.

65. 898 F.2d 1278 (7th Cir. 1990), *aff'g* 717 F. Supp. 1251 (N.D. Ill. 1989).

66. 892 F.2d 1042 (4th Cir. 1989), *aff'g in unpublished opinion* 707 F. Supp. 840 (W.D. Va.).

67. *See infra* notes 70, 82 and accompanying text.

1. The Rockford *Approach*

Rockford stands for the principle that section 7 of the Clayton Act applies to nonprofit hospitals because they are part of an industry subject to FTC jurisdiction.[68] In *Rockford*, the Seventh Circuit upheld a district court injunction preventing the merger of two nonprofit hospitals, because the merger violated the Sherman Act.[69] In dicta, however, the *Rockford* court said that section 7 was applicable to nonprofit hospital mergers.[70]

The court reasoned that the section 7 requirement of FTC jurisdiction over entities engaging in asset acquisitions might refer to the jurisdictional limitations in section 11 of the Clayton Act,[71] and not to those imposed by the FTC Act.[72] The court said that Clayton Act section 11 gave five different agencies—including the FTC—authority to enforce portions of the Clayton Act.[73] Four of those agencies had enforcement authority directed toward specific industries.[74] The FTC, however, was given residual authority to enforce section 7 against "all other character of commerce."[75]

The court determined that although section 11 of the Clayton Act limits FTC jurisdiction over industries that are within the scope of the other four agencies, it permits unlimited FTC jurisdiction over "all other character of commerce."[76] Consequently, the court said, only "mergers in the regulated industries enumerated in section 11" are

68. The court did not apply section 7 of the Clayton Act in this case for technical reasons. *Rockford*, 898 F.2d at 1281.

69. *Id.* at 1286. The court said that section 7 applied to the merger, but that the government had waived the claim by improper argument. *Id.* at 1280–81.

70. Judge Posner, writing for the court, said, "we believe . . . that the merger *is* subject to section 7." *Id.* at 1281 (emphasis in original).

71. The relevant portion of section 11 says that "[a]uthority to enforce compliance with sections [2, 3, 7, and 8 of the Clayton Act] by the persons respectively subject thereto is vested in . . . the Federal Trade Commission where applicable to all other character of commerce." 15 U.S.C.A. § 21(a) (West 1973 & Supp. 1991).

72. *Rockford*, 898 F.2d at 1280.

73. *Id.* These agencies include the Interstate Commerce Commission, Federal Communications Commission, Civil Aeronautics Board (now defunct), and Federal Reserve Board. *Id.*

74. *Id.*

75. *Id.* Note, however, that the Supreme Court considered and rejected a similar argument. United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 336 n.11 (1963). *See infra* text accompanying note 111.

76. *Rockford*, 898 F.2d at 1280.

exempt from section 7.[77] The hospital industry was not such an exempted industry.[78]

2. *The* Carilion *Approach*

The principle behind *Carilion* is that section 7 of the Clayton Act only applies to asset acquisition mergers between entities subject to FTC jurisdiction.[79] *Carilion* involved the proposed merger of two large, nonprofit hospitals by means of asset acquisition.[80] The Fourth Circuit affirmed a lower court ruling permitting the hospitals to merge.[81]

The *Carilion* district court dismissed the government's section 7 claim saying that the statute did not apply to non-stock, nonprofit mergers.[82] The court relied upon the legislative history of the 1950 amendments to the Clayton Act.[83] The court reasoned that the proposed merger of non-stock, nonprofit hospitals did not fall within the scope of section 7 of the Clayton Act, as amended.[84] The Fourth Circuit affirmed in an unpublished opinion.[85]

II. ANALYSIS: GLEANING CONGRESSIONAL PURPOSE

Section 7 of the Clayton Act does not, and should not, apply to nonprofit hospital mergers. Supreme Court opinions are non-dispositive on whether section 7 applies to nonprofit entities.[86] Statutory construction, however, reveals that section 7 does not apply to nonprofit

77. *Id.*

78. *Id. But see,* Adventist Health System/West, No. 9234 (FTC, Aug. 2, 1990) (initial decision) (WESTLAW, Antitrust directory, FABR-FTC file) (assets acquisition by nonprofit hospital is not subject to FTC jurisdiction under Clayton Act section 11).

79. United States v. Carilion Health System, 707 F. Supp. 840, 841 n.1 (W.D. Va.), *aff'd in unpublished opinion,* 892 F.2d 1042 (4th Cir. 1989) (text in WESTLAW, Federal directory, CTA4 file).

80. *Carilion,* 707 F. Supp. at 842.

81. The Fourth Circuit affirmed the decision without reconsidering the applicability of Clayton Act section 7 to nonprofit hospitals. *Carilion,* 892 F.2d at 1042.

82. *Carilion,* 707 F. Supp. at 841 n.1.

83. Note, *Nonprofit Hospital Mergers and Federal Antitrust Law: The Quest for Compatibility,* 15 DEL. J. CORP. L. 539, 560 n.130 (1990). *See supra* notes 52–54 and accompanying text for a description of the legislative history of the Clayton Act amendments.

84. *Carilion,* 707 F. Supp. at 840.

85. *Carilion,* 892 F.2d at 1042.

86. Note that in *Rockford,* the government argued that *Philadelphia* was dispositive, and attempted to analogize acquisition of a nonprofit hospital with a stock purchase. United States v. Rockford Memorial Corp., 898 F.2d 1278, 1281 (7th Cir.), *cert. denied,* 111 S. Ct. 295 (1990). The court rejected the analogy between banks and nonprofit hospitals as "unnecessarily venturesome," adding that the view was not "in vogue in the Supreme Court . . . ." *Id.*

hospitals. In addition, public policy favors exempting nonprofit hospitals from section 7.

A. Statutory Construction of Clayton Act Section 7

1. Supreme Court Opinions Are Non-dispositive

Although the Supreme Court has never addressed the applicability of Clayton Act section 7 to nonprofit entities, it has demonstrated the proper method of construing section 7 de novo.[87] The Court determined in *United States v. Philadelphia National Bank* that section 7 applies to entities not subject to FTC jurisdiction only if such application is consistent with congressional purpose.[88] Congress' purpose in enacting section 7 was to halt consolidations by national, for-profit conglomerates,[89] not to forestall nonprofit hospital mergers.[90] So construed, section 7 of the Clayton Act does not apply to nonprofit hospitals because non-application is consistent with congressional purpose.

2. The Plain Language and Legislative History of Clayton Act Section 7 is Consistent With Exemption of Nonprofit Hospitals

Both the plain language and legislative history of Clayton Act section 7 suggest that exemption of nonprofit hospitals is proper. The *Philadelphia* Court outlined the proper method of determining the applicability of section 7 to entities not expressly within FTC jurisdiction.[91] There, the Court ascertained congressional intent chiefly by looking at three factors: (1) the meaning of key provisions when read together;[92] (2) congressional debates and other legislative history;[93] and (3) the rule that "immunity from antitrust law is not lightly implied."[94]

(a) The Meaning of Key Provisions Read Together

Key provisions of the Clayton and FTC Acts, when read together, suggest that Clayton Act section 7 does not apply to mergers between nonprofit hospitals. As first enacted, section 7 of the Clayton Act cov-

87. *See supra* notes 59–64 and accompanying text.
88. 374 U.S. 321, 337 (1963).
89. *See* Brown Shoe Co. v. United States, 370 U.S. 294, 315–16 and n.27 (1962); *see also infra* notes 112–23 and accompanying text.
90. *See infra* note 115 and accompanying text.
91. *See supra* notes 59–64 and accompanying text.
92. *See Philadelphia,* 374 U.S. at 342.
93. *Id.* at 337–42.
94. *Id.* at 348.

ered only stock acquisitions.[95] The 1950 amendments added coverage of asset acquisitions where the acquiring entity was subject to FTC jurisdiction.[96] The scope of FTC jurisdiction is contained in sections 4 and 5 of the FTC Act, and includes only organizations that operate for profit.[97] Consequently, section 7 of the Clayton Act, as amended, cannot apply to non-stock, nonprofit mergers. Mergers between nonprofit hospitals necessarily fit this category of excluded mergers, because such entities, by law, may not issue stock or operate for profit.[98]

Although the *Rockford* court said that section 11 of the Clayton Act gave the FTC authority to enforce section 7 against nonprofit hospitals,[99] the court reached this conclusion by ignoring principles outlined by the Supreme Court in *Philadelphia.* The *Rockford* court reasoned that section 11 was "self-contained"[100] and not dependent on provisions of the FTC Act for definition or limitation. Thus, the court said, section 11 of the Clayton Act, when read in isolation, did not exempt the hospital industry.[101]

There are three problems with the *Rockford* court's suggested interpretation. First, accepting the court's interpretation requires the court to read sections 4 and 5 of the FTC Act completely out of existence.[102] Sections 4 and 5 expressly limit the scope of FTC jurisdiction to entities organized for profit.[103] The *Rockford* court's interpretation, therefore, controverts the *Philadelphia* Court's mandate to read key provisions together.[104]

Second, the *Rockford* court's interpretation of section 11 of the Clayton Act to create independent FTC jurisdiction requires the court to take the phrase, "all other character of commerce," out of the context of the statute. Section 11 says, in relevant part: "Authority to enforce compliance with sections [2, 3, 7, and 8] of [the Clayton Act] *by the persons respectively subject thereto* is vested in . . . the [FTC] *where applicable* to all other character of commerce . . . ."[105]

95. *See supra* note 50 and accompanying text.

96. *See supra* note 53 and accompanying text.

97. *See supra* notes 55–57 and accompanying text.

98. *See* A. SOUTHWICK, *supra* note 30, at 110–13.

99. United States v. Rockford Memorial Corp., 898 F.2d 1278, 1280 (7th Cir.), *cert. denied,* 111 S.Ct. 295 (1990).

100. *Id.*

101. *Id. See supra* text accompanying notes 76–78.

102. *See supra* note 56 and accompanying text.

103. 15 U.S.C.A. § 44, 45 (West 1973 & Supp. 1991).

104. *See* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 342 (1963).

105. 15 U.S.C.A § 21 (West 1973 & Supp. 1991) (emphasis added).

The phrases "*by the persons . . . subject thereto*" and "*where applicable,*" indicate that section 11 is not independent and self-contained, but instead refers to other statutory language to define the persons "subject thereto." Consequently, section 11 provides no independent basis for asserting FTC jurisdiction over nonprofit hospitals.

Third, the *Rockford* court's interpretation of Clayton Act section 11 is inconsistent with the Supreme Court's *Philadelphia* decision. In *Philadelphia*, the Court rejected the government's argument that section 11 of the Clayton Act gave the FTC independent jurisdiction over banks.[106] The Court reasoned that section 11 did not disturb the FTC's traditional lack of jurisdiction over banks.[107] The Court also implicitly rejected any notion of independent jurisdiction under section 11.[108]

The *Philadelphia* rationale holds equally well for nonprofit hospital mergers, that were traditionally not subject to FTC scrutiny. Section 7 of the Clayton Act originally applied only to stock transactions.[109] This excluded mergers between nonprofit entities because they did not, and could not, issue stock.[110] At the same time, the FTC Act expressly limited FTC jurisdiction over nonprofit entities.[111] Thus, the *Philadelphia* rationale rejects the view that section 11 of the Clayton Act upsets the traditional lack of FTC jurisdiction over nonprofit hospital mergers.

(b) Congressional Debate Surrounding the Enactment of Section 7 Favors Exemption of Nonprofit Hospitals

Congressional debate concerning the 1950 amendments to the Clayton Act suggests that Congress did not intend to cover nonprofit entities.[112] These debates show that Congress' purpose in amending Clayton Act section 7 was to stem the "rising tide of economic concentration" caused by "unchecked corporate expansion."[113] Congress intended to close the loophole in the original section 7 that permitted

106. *See Philadelphia,* 374 U.S. at 336 n.11.

107. *Id.* ("We reject the argument that § 11 of the Clayton Act, as amended . . . confers jurisdiction over banks upon the FTC.").

108. *Id.* ("[T]here is no intimation in the legislative history . . . that the FTC's traditional lack of jurisdiction over banks was to be disturbed.").

109. *See supra* note 50 and accompanying text.

110. *See supra* note 57.

111. *See supra* notes 54–57 and accompanying text.

112. *See supra* note 62 and accompanying text.

113. *See* Brown Shoe Co. v. United States, 370 U.S. 294, 315 (1962).

corporations to merge through asset acquisitions where they could not merge by stock acquisitions.[114]

Nonprofit entities were not the subjects engaging in "unchecked corporate expansion" that congressional debates addressed. Nor were nonprofit mergers the target of earlier section 7 proscriptions, because nonprofit hospitals could not merge by acquiring stock. Thus, it follows that Congress did not intend to address nonprofit mergers in amending section 7.[115]

(c) Legislative History of the Celler-Kefauver Amendments

The legislative history of the 1950 amendments to the Clayton Act indicates that Congress did not intend to affect nonprofit mergers. The legislative history centers around a single theme: congressional alarm at increased economic concentration resulting in aggregation of wealth and power by large corporations.[116] Numerous reports by the FTC, congressional committees, and executive agencies, attest to this concern with the increased concentration of national, industrial corporations.[117] The 1950 amendments were a remedial step to close a gap, not an attempt to expand Clayton jurisdiction to previously uncovered entities.[118] Thus, the amendments enlarged the types of mergers covered under section 7, without extending the scope of entities covered to include mergers between nonprofit organizations.

(d) The Rule that Antitrust Immunity is Not Lightly Implied

Although antitrust immunity is not lightly implied,[119] exempting nonprofit hospitals from section 7 of the Clayton Act is proper for two reasons. First, exemption from Clayton Act section 7 would not, and should not, exempt nonprofit hospitals from all antitrust laws.[120] Rather, a narrow exemption from section 7 would amount to partial immunity, at most.

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114. *Id.* at 316 n.29.

115. Congress apparently never discussed nonprofit entities during debates surrounding the Clayton Act amendments. *See* Kopit & McCann, *supra* note 19, at 651.

116. *See* E. KINTNER, *supra* note 53, at 3611–16.

117. *See* Id. at 3385–86; *Brown Shoe*, 370 U.S. at 315 n.27; *see also,* FEDERAL TRADE COMMISSION, THE MERGER MOVEMENT: A SUMMARY REPORT (1948), reprinted in 4 E. KINTNER, THE LEGISLATIVE HISTORY OF THE FEDERAL ANTITRUST LAWS AND RELATED STATUTES 3236 (1980).

118. *See* S. REP. NO. 1775, 81st Cong., 2nd Sess. 2 (1950) (describing remedial purpose of amendments).

119. United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 348 (1963).

120. Sherman Act proscriptions would continue to apply to nonprofit entities. *See supra* notes 39–41 and accompanying text.

Second, Congress strongly implied that immunity for nonprofit hospitals was proper, both by the express jurisdictional limitations contained in the FTC Act, and by its refusal to modify those limitations. Congress has repeatedly considered amendments to broaden FTC jurisdiction, but has not given the FTC jurisdiction over nonprofit entities.[121] Moreover, Congress has expressly refused to grant the FTC jurisdiction over nonprofit entities when specifically requested to do so.[122]

3. *Congressional Intent to Exempt Nonprofit Entities from Section 7 of the Clayton Act*

Both the language and legislative history of the Clayton amendments indicate that Congress did not intend section 7 to apply to mergers between nonprofit entities. Congress was certainly aware of the existence and role of nonprofit entities when it amended section 7 of the Clayton Act.[123] Thus, the express limitations placed on FTC jurisdiction over nonprofit entities exempts such entities from scrutiny under Clayton Act section 7.

B. *Policy Considerations Favor Exclusion of Nonprofit Hospital Mergers From Clayton Section 7*

Public policy favors exempting nonprofit hospital mergers from the rigorous scrutiny of Clayton Act section 7 for at least two reasons. First, such an exemption is consistent with repeated congressional mandates to reduce hospital capacity and eliminate duplication of services.[124] Second, nonprofit hospital mergers often benefit consumers by maintaining access to hospital care and improving the quality of services provided.[125]

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121. *See, e.g.*, 135 CONG. REC. S7338, (daily ed. June 22, 1989) (statement by Senator Bryan).

122. *See, e.g., Federal Trade Comm'n Amendments of 1977 and Oversight: Hearings Before the Subcomm. on Consumer Protection and Finance of the Comm. on Interstate and Foreign Commerce, House of Representatives* Serial No. 95-36, 95th Cong., 1st Sess. 81–82 (1977) (statement of Calvin J. Collier, Chairman, FTC, in support of H.R. 3816, which would have extended FTC jurisdiction to include nonprofit corporations); *see also* Kopit & McCann, *supra* note 19, at 650 n.47.

123. Congress was particularly familiar with the role of nonprofit hospitals. Just four years before amending the Clayton Act, Congress passed a landmark bill to subsidize the construction of nonprofit hospitals. Hospital Survey and Construction ("Hill-Burton") Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (current version at 42 U.S.C.A. § 291 (West 1973 & Supp. 1991)).

Nonprofit organizations exist because Congress grants them special treatment due to their perceived benefits to society. *See* Gray & McNerney, *supra* note 30, at 1523. This special treatment involves numerous laws. *See* Note, *supra* note 83 at 563.

124. *See infra* note 126 and accompanying text.

125. *See infra* notes 133–41 and accompanying text.

1. Exemption is Consistent With Congressional Mandates to Reduce Hospital Capacity and Eliminate Duplication of Services

Exempting nonprofit hospitals from section 7 is consistent with current federal health policy mandates. Both Congress and the Executive Branch have repeatedly mandated reduction of excess hospital capacity and elimination of duplicative services as a means of controlling aggregate health care costs.[126]

Excess hospital capacity is particularly costly as overall demand for inpatient hospital services declines.[127] Unused capacity adds to the overhead costs that hospitals must allocate among fewer patients, thus adding significantly to the cost of an individual patient's hospital services.[128]

Unnecessary duplication of services, moreover, results from hospitals attempting to obtain physician loyalty by purchasing expensive medical technology, regardless of community need.[129] Studies show that this unnecessary duplication adds significantly to hospital costs, resulting in increased costs to consumers.[130]

Exempting nonprofit hospitals from section 7 of the Clayton Act can help constrain hospital costs by fostering beneficial mergers that eliminate both excess capacity and the motivation behind unnecessary

126. *See* National Health Planning and Resources Development Act (NHPRDA), 42 U.S.C.A. §§ 300k–300n-6 (West 1973 & Supp. 1991). A major goal of NHPRDA was to prevent unnecessary duplication of services. 42 U.S.C.A. § 300l-2(a)(4). NHPRDA was amended in 1979 to foster competition in health care. However, the amendments singled out inpatient health services for continued planning and coordination. 42 U.S.C.A. § 300k-2. Although NHPRDA was repealed by Act of Nov. 14, 1986, Pub. L. No. 99-660, § 701(a), 100 Stat. 3799, Congress reaffirmed the principles behind NHPRDA. *See* Kopit & McCann, *supra* note 19, at 642 n.18. Many states retain some or all of the controls mandated by NHPRDA. *See* B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, HEALTH LAW: CASES, PROBLEMS & MATERIALS 396, 406. (1987) [hereinafter HEALTH LAW] (discussing health planning); T. LITMAN & L. ROBINS, HEALTH POLITICS AND POLICY 354–55 (1984); *see also* National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378, 393 (1981) (holding that NHPRDA did not completely preempt antitrust, but that some mandated activities might have antitrust immunity).

127. *See supra* note 26.

128. *See* J. SUVER & B. NEUMANN, MANAGEMENT ACCOUNTING FOR HEALTH CARE ORGANIZATIONS 111 (1981).

129. *See* Ettinger, *Justice Lacks a Credible Case Against Some Hospital Mergers,* MODERN HEALTHCARE, Mar. 19, 1990, at 36; Higgins, *Myths of Competitive Reform,* HEALTH CARE MGMT. REV., Winter 1991, at 67 (discussing unnecessary equipment purchases by hospitals, and closure of necessary services).

130. *See* McManis, *Competition's Failure Means It's Time for Collaboration,* MODERN HEALTHCARE, June 11, 1990, at 57. Studies indicate that hospital costs are highest in markets where there is greater competition for technology, physicians, and patients. *Id.*

duplication.[131] Promoting such beneficial mergers is thus consistent with policy mandates to reduce excess hospital capacity and eliminate unnecessary duplication of services.[132]

2. *Exempting Nonprofit Hospital Mergers Also Benefits Consumers*

Exempting nonprofit hospital mergers from section 7 of the Clayton Act benefits consumers indirectly by restraining hospital costs.[133] Exemption may also benefit consumers directly, by maintaining access to hospital services in facilities that would otherwise close,[134] and by improving the quality of services available.[135]

(a) Nonprofit Mergers May Help Maintain Access

Exempting nonprofit hospital mergers from Clayton Act section 7 may help maintain patient access to vital services. Studies indicate that hospitals most often close in areas where residents' health care needs are already underserved.[136] Such closures further reduce access to hospital services in these areas.[137] Nonprofit hospital mergers, however, can help maintain access by keeping marginal hospitals viable, thereby enabling them to continue meeting community needs.[138] Consequently, permitting such mergers helps maintain vital community access to health care.

(b) Nonprofit Mergers Can Result in Better Quality of Care

Nonprofit hospital mergers may also benefit consumers by increasing the quality of care hospitals provide. Studies show that hospitals performing larger volumes of services produce better patient out-

131. *See* Greene, *supra* note 8, at 28. In *Rockford*, the City of Rockford filed an amicus brief arguing that the proposed merger would benefit consumers by decreasing hospital costs. Burda, *Rockford Merger Rejection Not Best for Patients — Briefs*, MODERN HEALTHCARE, Sept. 10, 1990, at 100.

132. *See* HEALTH LAW, *supra* note 126, at 402–06.

133. These consumer benefits are indirect because most consumers have health insurance that pays for hospital costs. *See* BLUE CROSS/BLUE SHIELD, ENVIRONMENTAL ANALYSIS 1990, *supra* note 27, at 8.

134. *See infra* notes 136–38 and accompanying text.

135. *See infra* notes 139–41 and accompanying text.

136. *See* Higgins, *supra* note 129, at 66; J. HOLLINGSWORTH & E. HOLLINGSWORTH, CONTROVERSY ABOUT AMERICAN HOSPITALS: FUNDING, OWNERSHIP AND PERFORMANCE, 125–50 (1987).

137. *See* Higgins, *supra* note 129, at 66. Even when marginal hospitals survive, they frequently must cut those unprofitable services that are most needed in the community. For example, between 1984 and 1988, 25 percent of hospital trauma units were closed. *Id.* at 67.

138. *See* Burda, *supra* note 131, at 100; *see also* Tokarski, *Mergers Don't Cut Access*, MODERN HEALTHCARE, Nov. 26, 1990, at 2 (citing study indicating that mergers maintain access and increase services provided).

comes,[139] as evidenced by lower morbidity and mortality figures.[140] Exempting nonprofit hospitals from Clayton Act section 7 permits them to consolidate services and increase the volume of services performed.[141] As a result, exemption can improve the quality of care that hospitals provide.

3. *Judicial Reluctance to Recognize Policy Factors in Evaluating Antitrust Liability*

Despite the impact that antitrust law has on the cost, quality and accessibility of health care, most courts are reluctant to recognize public policy factors as defenses to alleged antitrust violations.[142] In *National Society of Professional Engineers v. United States,*[143] for example, the Court rejected the argument that enhanced public safety justified restrictions on competitive bidding among engineers.[144]

The rationale in *Engineers,* however, is distinguishable on two grounds. First, *Engineers* involved a horizontal restraint similar to price-fixing, that has long been considered a per se violation of the Sherman Act. Permitting public policy justifications in merger cases under rule of reason analysis, on the other hand, merely allows courts to weigh all factors in balancing putative benefits and costs.

Second, in *Engineers* there was no causal link between price-fixing and the quality of engineering services.[145] The Court rejected the tenuous link between price competition and competent work by professionals.[146] In cases of marginal hospitals, on the other hand, the causal link is much clearer: the issue is not whether quality of care will suffer, but whether the hospital will remain viable and able to provide any care at all.

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139. *See, e.g.,* Flood, Scott & Ewy, *Does Practice Make Perfect?: The Relation Between Hospital Volume and Outcomes for Selected Diagnostic Categories,* 22 MEDICAL CARE, Feb. 1984, at 98; Maerki, Luft & Hunt, *Selecting Categories of Patients for Regionalization: Implications of the Relationship Between Volume and Outcome,* 24 MEDICAL CARE, Feb. 1986, at 148; Showstack, Rosenfeld, Garnick, Luft, Schaffarzick & Fowles, *Association of Volume With Outcome of Coronary Artery Bypass Graft Surgery: Scheduled vs. Nonscheduled Operations,* 257 J. A.M.A. 785 (1987).

140. Morbidity and mortality are statistical measures of sickness and death, respectively. MOSBY'S MEDICAL, NURSING, & ALLIED HEALTH DICTIONARY 770–71 (3d ed. 1990).

141. Hospitals can consolidate services by eliminating duplication of low volume services.

142. *See, e.g., supra* note 63.

143. 435 U.S. 679 (1978).

144. *Id.* at 693–94.

145. Id.

146. *Id.* at 686.

C. *A Proposal for Continued Sherman Act Scrutiny of Nonprofit Hospital Mergers*

Although congressional intent, statutory construction, and public policy favor exempting nonprofit hospitals from section 7 of the Clayton Act, some commentators argue that without close scrutiny, nonprofit hospital mergers will permit collusion among hospitals, thus destroying competition in the hospital industry.[147] In the event such mergers do threaten consumers, however, two safeguards exist. First, section 1 of the Sherman Act continues to protect the public against demonstrably harmful hospital mergers. Second, Congress can readily amend either the Clayton or FTC Acts to permit FTC jurisdiction over nonprofit hospital mergers under Clayton Act section 7.

Clayton Act section 7 properly applies to mergers where the dangers of incipient harm are great, and the potential benefits of permitting mergers are few. Nonprofit hospital mergers represent the opposite paradigm; the dangers are few, while the potential benefits are great. Instead of extending the Clayton Act to cover nonprofit hospital mergers, courts should continue to use the Sherman Act standard to scrutinize these mergers.[148]

The Sherman Act section 1 standard is appropriate for two reasons. First, it adequately protects consumers from demonstrably harmful mergers by permitting the government to challenge nonprofit hospital mergers that are motivated by anticompetitive purpose, or actually result in harm to consumers. Second, the standard under section 1 of the Sherman Act benefits consumers and society, by permitting mergers where the evidence does not support a clear finding of harmful effect. Under section 1 of the Sherman Act, some beneficial mergers would likely occur that would be foreclosed by Clayton Act section 7 scrutiny. These mergers can help hospitals reduce unnecessary costs, maintain access to services, and improve the quality of care provided. Such benefits should not be traded away for the ethereal promise of competitive gains, by preserving a multitude of weak hospitals rather than fewer, more viable ones.

III. CONCLUSION

Nonprofit hospitals are undergoing rapid consolidation in response to dramatic changes in the delivery of, and reimbursement for, health care services. Recently, the federal government has attempted to fore-

147. *See, e.g.*, Baker, *supra* note 25, at 115.

148. See *supra* note 42 and accompanying text for discussion of the Sherman Act standard.

stall this consolidation by applying the Clayton Act to mergers between nonprofit hospitals. Applying section 7 of the Clayton Act to nonprofit hospital mergers neither accords with sound legal interpretation, nor with important public policy objectives. Instead, Clayton Act scrutiny may prevent beneficial mergers by which nonprofit hospitals can reduce costs, maintain access to services, and improve the quality of care provided. Courts should continue to scrutinize nonprofit hospital mergers under the proscriptions of the Sherman Act, and should avoid extending the Clayton Act to mergers not within its intended scope.

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