Note

NONPROFIT HOSPITAL MERGERS AND FEDERAL ANTITRUST LAW: THE QUEST FOR COMPATIBILITY

I. Introduction

Last year, for the first time in the history of federal antitrust law, the Department of Justice (DOJ) sued to enjoin the merger of nonprofit, charitable hospitals in Roanoke, Virginia, and Rockford, Illinois.

These lawsuits came close on the heels of a year when a record ninety-six hospitals across the nation, most of them nonprofit institutions, went out of business. Faced with this rash of closings, the increasing costs of competition and a tighten-
and care functions are combined within a single organization. Health maintenance organizations provide comprehensive health care to subscribers who pay a predetermined amount, regardless of the amount or cost of medical services actually used. Health maintenance organizations provide services through a staff of salaried physicians, a contract with physicians, or a contract with a physician partnership or corporation. *Id.* at 393.

A preferred provider organization sells the health care services of independent providers to health insurance companies at a discounted rate in exchange for expedited payment and preferential access to insured consumers. Consumers may use providers who are not a part of the preferred provider organization, but usually pay an increased cost for that choice. *Id.* at 476.

As early as 1943, the American Medical Association was convicted of a criminal violation of the antitrust laws for attempting to suppress the growth of health maintenance organizations. *See* American Medical Ass' n v. United States, 317 U.S. 519, 529-33 (1943). Since then, numerous cases involving alternative care providers have arisen in the antitrust context. *See, e.g.*, Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (maximum-fee agreements among physicians as "foundations for medical care"); Ball Memorial Hosp. v. Mutual Hosp. Ins., 784 F.2d 1325 (7th Cir. 1986) (nonprofit providers of health care financing for consumers).


6. The Reagan Administration cut Medicare spending by over $30 billion. In the 1988 fiscal year, while only 9% of the outlays went to Medicare, the program sustained 36% of the cuts. Thus, "little attempt has been made to align Medicare budget allocations with expressed statutory intent to provide quality, accessible care to Medicare beneficiaries." *Brief of Amicus Curiae of the American Hospital Association at 7, United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va.), aff'd, 892 F.2d 1042 (4th Cir. 1989) (text of opinion available on WESTLAW, No. 89-2625 (Nov. 29, 1989)) [hereinafter AHA Amicus Brief].


A hospital is typically reorganized as a "hospital system" with a "parent corporation" in control. Tax Advisory Group of the Office of Legal and Regulatory Affairs, American Hospital Association, *The Public Charity Status of Hospitals and Health Care Organizations Under the "Operated in Connection with" Relationship Test of Section 509(a)(3) of the Internal Revenue Code*, 32 J. HEALTH & HOSP. L. 1, 1 (1989) [hereinafter AHA Advisory Group]. In most cases, the hospital corporation retains ownership and also continues to fulfill several of its traditional functions, such as provision of outpatient care, promotion of public health, medical research, and teaching. *Id.* at 2. At the same time, an amendment to the hospital corporation's bylaws forms a parent corporation, which may then form for-profit subsidiaries with the parent corporation itself owning as much as 100% of the subsidiary's
numbers. The downside of such advantageous arrangements has been increased antitrust scrutiny from the DOJ's Antitrust Division.

Conflicting district court decisions in the Roanoke and Rockford cases indicate that the issue as to the applicable antitrust analysis for the horizontal merger of nonprofit hospitals is far from settled.

stock. Id.

The parent-subsidiary model is the preferred method of hospital reorganization for a variety of reasons. Mulholland, supra, at 375. For example, this setup serves an asset-protection function by keeping high-risk and low-risk assets separate. AHA Tax Advisory Group, supra, at 3. As a result, the potential for claimants, creditors, and other regulators of one subsidiary to "look through" the restructured system in an attempt to reach the assets of a sister subsidiary or the parent corporation is limited. Id. at 3; Mulholland, supra, at 375. Furthermore, compliance with the requisite corporate formalities will minimize the risk that a court will permit the newly created corporate structure to be disregarded. Beautyman & Thallner, Does Hospital Restructuring Make Sense Today?, 20 Hosp. L. 121, 124 (1987). The parent subsidiary model also facilitates efficient management and allows a hospital to depart from debt-financing through tax-exempt bonds as its predominant financial resource by creating new service revenues, which can be used to meet the rising capital demands of the increasingly competitive health care market. AHA Tax Advisory Group, supra, at 3; Beautyman & Thallner, supra, at 121-22. Additionally, the parent-subsidiary model may help a hospital achieve desired expansion without the necessity of complying with a state's expensive and time-consuming certificate of need requirements. AHA Tax Advisory Group, supra, at 3; Beautyman & Thallner, supra, at 122. See infra notes 26-31 and accompanying text (discussing state certificate of need requirements). Finally, diversification through a parent-subsidiary model is advantageous for reimbursement matters. AHA Tax Advisory Group, supra, at 4; Beautyman & Thallner, supra, at 122-24.

8. As many as 34% of United States hospitals responding to American Hospital Association surveys have undergone corporate restructuring since 1979. Alexander & Orlikoff, Hospital Corporate Restructuring Gains Widespread Acceptance, Trustee, Jan. 1987, at 16-17.

Furthermore, according to the American Hospital Association, 91 hospital mergers and consolidations occurred between 1980 and 1986. AHA Amicus Brief, supra note 6, at 2 n.1.

9. Generally, the greatest advantage of a merger is the increased capital which naturally flows to a cluster of entities. M. Beautyman, Remarks at Drinker, Biddle & Reath Seminar for Health Care Providers (Dec. 1, 1988) (videotape of seminar available from Drinker, Biddle & Reath, Philadelphia, Pa.)

10. Congress' provision of two federal antitrust enforcement agencies, the DOJ and the FTC, has been called an exercise in "procedural redundancy," due to a great deal of overlap in the two agencies' jurisdiction. The DOJ is empowered to bring suits in federal district court, under the Clayton Act, §§ 4A and/or 15, 15 U.S.C. §§ 15a, 25 (1982). When a merger appears to require investigation, the DOJ and the FTC will consult one another and expeditiously determine which one will pursue the claim. Davis, Antitrust Analysis of Mergers, Acquisitions, and Joint Ventures in the 1980s: A Pragmatic Guide to Evaluation of Legal Risks, 11 Del. J. Corp. L. 25, 25-26 n.1 (1986).

11. "Where the merging firms are in the same product and geographic market,
This comment, will analyze the issues raised by these two cases and will attempt to forecast the future viability of such mergers as a competitive mechanism and a survival tactic for nonprofit charitable hospitals.12

II. The Dynamics of the Health Care Industry

In order to put nonprofit hospital mergers into context, one should first consider the regulatory history and dynamics of the health care industry.

A. Regulation in the Industry

In response to President Truman's post-World War II push for greater access to medical care, Congress passed the Hill-Burton Hospital Survey and Construction Act of 1946,13 which offered federal grants and loans for construction and renovation of hospital facilities.14 However, receipt of Hill-Burton funds was conditioned upon adoption of comprehensive regulations governing hospital licensure.15

the merger is horizontal.17 United States Department of Justice Merger Guidelines, U.S. Department of Justice, Antitrust Division Manual § 3.0 (2d ed. 1987) [hereinafter Merger Guidelines]. Generally, this definition covers a merger between firms which engage in direct competition prior to the merger.

12. A nonprofit corporation is one which is barred from distributing profits, if any, to those individuals who control the corporation, namely, its members, officers, directors, or trustees. The nonprofit corporation is not barred from making a profit; it is only the distribution to those in control which is prohibited. See American Jersey Cattle Club v. Glander, 152 Ohio St. 506, 510, 90 N.E.2d 433, 435 (1950).

Some state nonprofit corporation laws explicitly permit profit-making, so long as it does not inure to the benefit of the members, directors, or officers. See, e.g., Ind. Code Ann. § 23-7-1.1-4(c) (Burns Supp. 1989).


Some commentators argue that the nonprofit form is not the best corporate form for hospitals and other health care facilities. See Clark, Does the Nonprofit Form Fit the Hospital Industry?, 93 Harv. L. Rev. 1416 (1980); Marmor, Schlesinger & Smithey, A New Look at Nonprofits: Health Care Policy in a Competitive Age, 3 Yale J. Reg. 313, 339-49 (1986).


15. Id. §§ 291c, e.
In 1965, the federal Medicare\textsuperscript{16} and Medicaid\textsuperscript{17} programs were enacted to continue the pursuit of increased access to health care.\textsuperscript{18} Like the Hill-Burton Act, these programs saddled recipients\textsuperscript{19} with burdensome contingent regulatory provisions.\textsuperscript{20} Nonetheless, nonprofit hospitals welcomed the reimbursement program as a means of recouping payment for indigent care which had previously gone uncompensated.\textsuperscript{21}

Meanwhile, the bed-building spree resulting from the Hill-Burton incentives turned 1947's "pressing need for more hospital beds"\textsuperscript{22} into 1988's national daily surplus of 350,000 beds per one million.\textsuperscript{23} To curtail this rapid growth, Congress enacted the National Health Planning and Resources Development Act of 1974,\textsuperscript{24} creating health planning agencies at the state and local levels.\textsuperscript{25} Under the Act, the state health planning and development agencies supervise, among other things, the state's certificate of need (CON) program.\textsuperscript{26} This program requires a facility to obtain a CON before making most

\begin{thebibliography}{99}

17. Id. §§ 1396-1396p.
18. The enactment of the Medicare and Medicaid statutes suggests that Congress perceived the need for increased access to be particularly pressing among the poor and the elderly, the primary beneficiaries of these programs. See Mulholland, supra note 7, at 346.
19. In this context, a Medicare or Medicaid "recipient" is the institution receiving the reimbursement for indigent care, not the indigent patient.
20. Id. at 346-47. For example, the Medicare Conditions of Participation for Hospitals enacted in 1966 not only made conventional plant safety demands, but also created detailed requirements concerning the operation of the facility and its medical staff. Id. at 346 (citing 42 C.F.R. §§ 405.1011-1042 (1984)). See, e.g., 42 C.F.R. §§ 405.1101-.1137 (1988) (listing conditions of participation for skilled nursing facilities).
21. Today, Medicare and Medicaid payments account for 50\% of the total revenues of most hospitals. AHA Amicus Brief, supra note 6, at 9.
23. Holthaus, supra note 4, at 47.
25. 42 U.S.C. §§ 300l, 300l-1(b), 300l-4 (1982) (repealed 1986). At the local level, health systems agencies developed and implemented general health service plans for the area. A health systems agency may be a private, nonprofit agency, a public regional planning body or a single unit of local government. Id. § 300l-1(b)(1)(A) to (C).
capital expenditures costing more than $600,000 and resulting in a substantial change of services or number of beds provided. The facility contemplating such expenditures must engage in exhaustive administrative procedures through which the state health planning and development agencies may approve or deny their application for a CON. Although Congress repealed the National Health Planning and Resource Development Act of 1974 in 1986, many states have retained a similar format of regulation.

Perhaps the most onerous regulatory development in the health care industry was the 1983 enactment of a Prospective Pricing System.

---

27. Id. §§ 300m-6(a)(1), 300n(6) (1982).

28. The facility must file an application with the health systems agency. A hearing is held, after which the health systems agency makes its recommendation to the state health planning and development agency. The state health planning and development agency may hold its own hearing before deciding whether or not to grant the CON. Both the facility and the health systems agency may appeal the decision to the appeals board. After such remedies are exhausted, appeals may be taken to the state court. See id. §§ 300m-6(a)(3), 300n-1(b)(12).

29. Id. § 300n-1(b)(12). The major goal of CON laws is the avoidance of wasteful duplicative services in a given geographic area. Thus, the agency's job is to "certify" that there is actually a need for the services the applicant seeks to create. However, case law indicates that CON laws have, in many instances, merely retarded, not barred or reduced, the creation of such duplications. See generally Hinsdale Sanitarium & Hosp. v. Illinois Health Facilities Planning Bd., 523 N.E.2d 53, 55 (Ill. App. 1988) (approving an application for a CON variance for construction of a hospital despite an excess of beds in existing facilities); Department of Health of Neb. v. Lutheran Hosp. & Homes, 227 Neb. 116, 121, 416 N.W.2d 222, 225 (Neb. 1987) (approving CON application for new equipment and services even though inconsistent with state need projections and state health plan).


The prospective pricing system represents a complete turn around in federal policy concerning Medicare reimbursement. The previous system, a retrospective or cost reimbursement system, allowed hospitals to bill Medicare on all reasonable charges for services provided to the patient, no matter how extended his stay. Furrow, Johnson, Jost & Schwartz, supra note 5, at 456. This system underscored the effects of health care's inelastic demand by allowing hospitals to survive without engaging in either quality or price competition. See Teitelman, Taking the Cure, Forbes, June 4, 1984, at 89 (noting the "powerful disincentive to efficiency" provided by previous reimbursement system).

By the same token, it cannot be said that the enactment of PPS took the industry by surprise. Congress on previous occasions had expressed its concern over the inefficiency of the health care market, despite a "massive infusion" of federal funds into the health care system. See, e.g., 42 U.S.C. §§ 300k(a)(2), (3) (1982) (repealed 1986) (setting forth congressional findings underpinning the National Health Planning and Resource Development Act of 1974).
(PPS) of Medicare reimbursement. PPS reimburses the hospital a fixed amount based on patient diagnosis, regardless of how much the treatment of that diagnosed illness actually costs the hospital. The PPS system has dramatically reduced the amount of reimbursement that nonprofit hospitals receive for indigent care. Finally, hospitals are also subject to extensive scrutiny from the Joint Commission on Accreditation of Hospital Organizations and various peer review organizations.

B. Increased Hospital Liability

The judiciary has also drawn new lines for the health care industry, resulting in a marked increase in hospital liability. For

33. Teitelman, supra note 32, at 82. The PPS program categorizes patients in diagnostic-related groups based on relative intensity of services. The amount of reimbursement is standardized according to the severity of the diagnosis, i.e., the severity of the diagnostic-related groups. Furrow, Johnson, Jost & Schwartz, supra note 5, at 456. Conversely, if a patient requires fewer expenditures than permitted under the diagnostic-related groups assigned, the hospital is nonetheless reimbursed the full amount allowed and may, therefore, receive a windfall.

34. Since the beginning of PPS, the costs of goods and services purchased in provision of indigent care have risen 22%, while PPS reimbursement rates have increased only 11%. It is estimated that if the current PPS rate setting trends continue, by 1990 half of the nation's hospitals will experience losses on patient care paid under PPS. AHA Amicus Brief, supra note 6, at 7-8.

35. The federal government has delegated to the Joint Commission on Accreditation of Hospital Organizations the task of Medicare-certifying hospitals according to federal standards of quality. See 42 U.S.C. §§ 1395x(e), 1395bb (1982 & Supp. 1987); Jost, The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest, 24 B.C.L. Rev. 835, 843-44 (1983).

36. The peer review organization program created nonprofit corporations throughout the country to assure that the services provided by hospitals under the Medicare and Medicaid programs conformed to professional standards, were medically necessary, and could not have been as effectively provided on an outpatient basis. If the peer review organization determines that the care provided was warranted, it must instruct the Medicare carrier to deny reimbursement. See Aronson, Expecting PRO Review: Here are Some Practical Considerations, 18 Fed. Assoc. Hosp. 88 (Jan./Feb. 1985); Gosfield, Hospital Utilization Control by PRO's: A Guide Through the Maze, Health Span, Feb. 1985, at 3, 7.; 42 U.S.C. §§ 1320c to c-12, 1395pp(c) (1982 & Supp. 1987).

37. The increase in hospital liability has resulted in skyrocketing malpractice insurance premiums for both physicians and hospitals. The parade of huge personal injury awards drove premiums so high in some states that state legislatures enacted statutory caps on recovery or created provisions for binding arbitration of malpractice claims. See, e.g., Etheridge v. Medical Center Hosp., 376 S.E.2d 525 (Va. 1989) (upholding constitutionality of statutory $750,000 cap).
example, the "charitable immunity doctrine," espoused by courts for many years, has gradually been discarded. Hospitals also were immune from vicarious liability for many years. Today, however, most states have rejected this theory in favor of patient-oriented theories such as ostensible agency and corporate liability. Finally, the parameters of hospital antitrust liability were significantly extended in the mid-1970s, when the Supreme Court brought hospital activities under the broad sweep of the commerce clause.  

38. Some courts justified hospital tort immunity by theorizing that an organization that reduced the government burden and was free from the taint of private gain should not have its charitable mission disrupted by plaintiffs' judgments and insurance premiums. Others cited fear that hospital benefactors would be discouraged from making contributions if they knew their gifts would be used to pay tort claims. It was also commonly held that charity patients had no right to recover damages for services rendered gratuitously. See Note, Hospitals' Expanding Role and Responsibility in Health Care Delivery, 14 WASHBURN L.J. 580, 605-06 (1975).


40. Immunity from vicarious liability resulted from the view that a hospital does not direct its physicians in their treatment of patients. See Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

41. Ostensible agency is sometimes called "apparent agency" or "agency by estoppel." The doctrine imposes liability on a hospital (1) when the patient has looked to the hospital, rather than the individual physician, for care; and (2) when the hospital has "held out" the physician as its employee, although he may be an independent contractor. See Simmons v. St. Clair Memorial Hosp., 332 Pa. Super. 444, 452, 481 A.2d 870, 874 (1984) (citing Restatement (Second) of Torts § 429 (1965)).

42. Some states have expanded a hospital's duty to select its employees with due care into a duty to supervise the quality of medical care rendered by physicians who enjoyed staff privileges but were not employees of the hospital. See Darling v. Charleston Community Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966). See also Thompson v. Nason, 370 Pa. Super. 115, 535 A.2d 1177 (1988) (recognizing a corporate liability cause of action for the first time). See generally Ludlum, The Impact of the Darling Decision Upon the Practice of Medicine and Hospitals, 11 FORUM 756 (1976) (discussing how Darling and its progeny have drastically widened the parameters of potential liability for a hospital and its board of trustees); Moore, Medical Staff—Corporate Accountability, 43 INS. COUNSEL J. 110 (1976) (discussing instances in which a hospital's trustees may be held personally liable much the same as the directors of any corporation).

43. The Supreme Court held that out-of-state patient flow, fees paid to out-of-state parent corporations, and interstate purchase of medical equipment and
C. The Peculiar Economics of the Health Care Market

It is indeed a strange market where the consumer is neither the buyer nor the payor, yet such is the nature of health care. In many cases it is the physician who functions as both the buyer and the product itself.44 Furthermore, it is third-party payors who do most of the paying.45 In the health care economy, the consumer’s only function is consumption.

The inelasticity of health care demand is also peculiar. In an elastic or price-dependent, supply-and-demand economy, a surplus implies a decrease in demand, and prices are driven down.46 However, health care demand is episodic, necessary and specific, and relatively unaffected by price.47 Health care demand is triggered by illness, not excess capital.48 A consumer who must have an appendectomy will not—cannot—settle for a tonsillectomy because it is


44. Groner, Hospital Mergers, Health Planning, and the Antitrust Laws: A Principled Approach to Implied Repeal, 7 J. Legal Med. 471, 493 (1986). It is estimated that physicians control 60 to 80% of health care spending through their decisions about ordering services and products for their patients. Morreim, Cost Containment and the Standard of Medical Care, 75 Calif. L. Rev. 1719, 1723-24 (1987).

45. Groner, supra note 44, at 491.


47. Groner, supra note 44, at 492-94. See Rule, Antitrust Enforcement and Hospital Mergers: Safeguarding Emerging Price Competition, 21 J. Health & Hosp. L. 125, 126 (June 1988) (stating that the historical lack of price competition is irrelevant to the DOJ’s merger analysis, given what the DOJ perceives as emerging price sensitivity among consumers and increased price competition among hospitals for selective contracts with insurers).

Nonetheless, previously it has been agreed that because of financial constraints, prevalence of insurance coverage, and the lack of consumer information regarding hospital services, hospitals do not compete on the basis of price, but rather on the basis of the quality of their services and staff. See J. Newhouse, The Economics of Health Care: A Policy Perspective 54-55, 61-65, & 89-100 (1978).

48. In a theory explaining the demand for health care, Joseph P. Newhouse hypothesized that insurance coverage acts like a subsidy to the costs of medical care and lowers the cost per unit. Consequently, the demand is elastic and as a result of insurance, health care demand is increased. However, demand changes in response to the cost of insurance coverage, not the costs of health care. Newhouse hypothesized that demand is indifferent until the consumer becomes ill, triggering health care expenditures. This, says Newhouse, is what makes the demand for health care inelastic. See Newhouse, supra note 47, at 4-15.
less expensive. Thus, despite a continuing decline in inpatient days recorded, hospital spending continues to increase faster than hospital revenues. Furthermore, Prospective Pricing System (PPS)-related losses continue to diminish the likelihood that nonprofit providers will be financially situated to control prices for their non-medicare patients.

III. ANTITRUST LAW IN THE HOSPITAL INDUSTRY

In reviewing potentially anticompetitive mergers courts have generally focused their analyses on section 1 of the Sherman Act and section 7 of the Clayton Act.

49. Although hospitals enjoyed an annual increase in the number of inpatient days recorded between 1972 and 1981, these figures began to drop in 1982, a trend that continued through 1986. The decline was most notable in 1984 and 1985, when inpatient days recorded dropped 6.1% and 7.8%, respectively. AHA Amicus Brief, supra note 6, attachment C, at xxiii (American Hospital Association statistics (1987)) (unpublished) (available at American Hospital Association, Chicago, Illinois).

50. See Robinson, Economists See Closures, Cost Cuts Ahead, Hosp., Jan. 5, 1988, at 23. It is generally agreed that competition between hospitals is based less on price and more on the quality of health care services provided. Groner, supra note 44, at 494. For this reason, a hospital's competitive expenditures are often designed to attract the best doctors to its facility. For example, a hospital may purchase expensive, state-of-the-art equipment, hire extra nurses in order to increase the nurse-to-doctor ratio, or provide physicians with office space at reduced rates. Id.

Costs of competition may also be observed in start-up and maintenance expenses incurred when a hospital broadens its base of services provided, in hopes of eventually increased revenues. See Note, Defining the Relevant Market in Health Care Litigation: Hospital Mergers, 75 Ky. L.J. 175, 177-78 & n.10 (1986-87).

51. While hospital fixed costs have risen 22% since the inception of PPS, reimbursement rates have increased by only 11%. AHA Amicus Brief, supra note 6, at 7-8.

52. See id. at 9. In this respect, it seems fair to say that PPS is at least partially to blame for the increase in costs to non-medicare patients.

53. 15 U.S.C. § 1 (1982). Section 1 provides:

Every contract, combination in the form of a trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id.


No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or part of the stock or other
A. Section 1 Analysis

Despite the bold prohibition in section 1 against "every" combination in restraint of trade,55 the section has long been interpreted to prohibit only those business combinations which "unreasonably" restrain trade.56

Certain combinations have been labeled as "per se" violations of section 1 because of their "pernicious effect on competition" and their "lack of any redeeming virtue."57 However, the Supreme Court's continuing development of the "rule of reason" standard has made it clear that although mergers between competitors eliminate competition, including price competition, they are not necessarily per se illegal.58

Although a thorough market analysis is implicit in the "rule of reason" analysis, the Supreme Court has enumerated several other considerations to be used to determine whether trade is unreasonably restrained. They include: "the percentage of business controlled [by the new entity], the strength of the remaining competition, whether the action springs from business requirements or a purpose to monopolize, the probable development of the industry, consumer demands, and other characteristics of the market."59

B. Section 7 Analysis

The purpose behind the broad language of section 7 of the Clayton Act was to arrest at inception those threats to competition that the Sherman Act did not reach.60 Thus, section 7 of the Clayton

share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

Id.

Act requires only a determination that the merger may substantially lessen competition in the relevant markets.61

A merger contest alleging a section 7 violation requires a delineation of the line of commerce (the product or services market) and the section of the country in which the merging parties do business (the geographic market), as well as the merger’s probable effect on those competitive markets.62

1. Defining the Relevant Product Market

Defining the line of commerce pinpoints what product or service market would be subject to any anticompetitive effects of the merger. Products and services included in the product market should be reasonably interchangeable in use or exhibit cross-elasticity of demand.63 However, the relevant market cannot meaningfully include all possible product substitutes.64 Furthermore, although certain products may compete with each other in some sense, it is not appropriate “to place them in the same market if by themselves they constitute distinct product lines.”65 In United States v. Philadelphia National Bank,66

the Supreme Court defined the product market vis-à-vis commercial banks as a "cluster of services" composing such a distinct line of commerce that commercial banks were effectively insulated from the competitive efforts of a broad range of individual substitute services.67

The FTC's disposition of the leading hospital merger case, In re Hospital Corp. of America,68 utilized the "cluster" analysis to determine the product market for an acquisition involving two proprietary hospital chains.69 FTC Commissioner Calvani endorsed the product market definition set forth in In re American Medical International: a "cluster of general [inpatient] acute care hospital services."70 Calvani noted that although free-standing outpatient facilities appeared to compete with hospitals for many outpatients, it also appeared that hospitals offered, and inpatients consumed, "a cluster of services that [bore] little relation to outpatient care."71 Ultimately, the Seventh Circuit adopted Calvani's analysis.72

2. Defining the Relevant Geographic Market

The second prong of section 7 analysis requires a determination of the section of the country, or geographic market, where the relevant

67. Id. at 356-57. See Note, supra note 50, at 181-84 (discussing bank merger cases).


69. Id. at 464-65. Hospital Corporation of America, the largest proprietary hospital chain in the United States, acquired Hospital Affiliates International in a $650 million stock transaction. As a result of this transaction, Hospital Corporation of America acquired ownership or management of five acute care hospitals in the general area of Chattanooga, Tennessee. A few months later, Hospital Corporation of America gained control of a sixth Chattanooga hospital through its acquisition of Health Care Corporation. Thus, Hospital Corporation of America became owner or manager of 7 of the 14 hospitals in the six county Chattanooga metropolitan statistical area. The court ultimately ordered divestiture of two of the facilities acquired in the Hospital Affiliates International/Health Care Corporation transactions and enjoined Hospital Corporation of America from further acquisitions in the Chattanooga area without prior Commission approval. Id. at 455-56.

70. Id. at 466 (quoting In re American Medical Int'l Inc., 104 F.T.C. 1, 17 (1984)).

71. Id. at 465. Thus, Calvani felt that defining the product market as "inpatient care" more accurately reflected the competitive realities. Calvani was also persuaded by his belief that anticompetitive behavior by the hospital firms could significantly lessen competition for hospital inpatients—an exercise of market power that could not be defeated by competition from non-hospital outpatient providers. Id.

product competes. The DOJ has identified the geographic market as an area where a hypothetical monopolistic firm could impose small but significant price increases without losing buyers. Therefore, the geographic market must be defined broadly enough that buyers within that market would be unable to switch to alternate sellers in sufficient numbers to defeat such an exercise of market power.

Although there is "no pat formula" for defining the relevant geographic market, the definition adopted must correspond to the commercial realities of the industry under scrutiny. It should be noted that the relevant geographic market in the health care industry may vary depending on the level of care sought. Primary and secondary care may be fairly local markets, whereas tertiary care markets could feasibly span the entire nation.

73. "'[T]he area of effective competition in the known line of commerce must be charted by careful selection of the market area in which the seller operates, and to which the purchaser can practicably turn for supplies.' " White & White, Inc. v. American Hosp. Supply Corp., 723 F.2d 495, 501 (6th Cir. 1983) (quoting Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320, 327 (1961)).

74. MERGER GUIDELINES, supra note 11, § 2.31.

75. In re Hospital Corp., 106 F.T.C. at 466. The government typically will seek to draw the lines of the geographic market by looking for an area (as small as possible) where a "hypothetical monopolist, controlling all the hospitals" could profitably maintain a 5-10% price increase over a one-year period. Rule, supra note 47, at 126-27.

76. Pennzoil, 252 F. Supp. at 977.

One method of defining the geographic market applies the Elzinga-Hogarty test. The test is based on LIFO (Little In From Outside) and LOFI (Little Out From Inside) and suggests that if few patients leave an area in search of services, and few enter from outside in search of services, the effects of the merger would be deemed almost entirely local. When the Elzinga-Hogarty test is met, courts in hospital cases may designate the National Health Planning and Resource Development Act of 1974's Health Service Area as the relevant geographic market. See Hospital Chain Ordered to Divest Acute Care Facilities in Chattanooga Area, [July-Dec.] Antitrust & Trade Reg. Rep. (BNA) No. 1189, at 846, 847 (Nov. 8, 1984).

77. Pennzoil, 252 F. Supp. at 975.

78. Primary care services involve the prevention, early detection and treatment of disease. Such services include obstetrics, gynecology, internal medicine and general surgery. A hospital that limits itself to providing primary care usually has some diagnostic equipment to do X-rays and laboratory analysis. Secondary care involves more sophisticated treatment and may include cardiology, respiratory care and physical therapy, and equipment and laboratory facilities which are generally more sophisticated. Carilion, 707 F. Supp. at 843.

79. "Tertiary care is designed to arrest disease in process." Carilion, 707 F. Supp. at 843. Services usually include heart surgery and cancer treatments such as chemotherapy. Equipment at these facilities is usually very sophisticated. Id.

80. Id. at 844 (court's discussion of the variance in competition faced by Roanoke hospitals from the primary, secondary, and tertiary care markets).
3. Determining the Probability of Anticompetitive Effects

The DOJ measures the substantiality of anticompetitive effects by comparing the pre- and post-merger levels of market concentration.\textsuperscript{81} Determining market concentration first requires the allocation of market shares to all competitors in the relevant product and geographic markets.\textsuperscript{82} The DOJ then relies on the Hirschman Herfindahl Index (HHI), the sum of the squares of the pre-merger shares of all competitors in the relevant market, to establish market concentration figures.\textsuperscript{83} According to the DOJ's 1987 Merger Guidelines, an HHI result in excess of 1800 is considered to be "highly concentrated,"\textsuperscript{84} and a merger that increases the HHI figure by more than fifty points is likely to be contested.\textsuperscript{85}

C. Defenses

The DOJ claims that it will not contest a hospital merger where "special circumstances" exist.\textsuperscript{86} The DOJ's past actions indicate that such special circumstances are implicated where the failing firm\textsuperscript{87} or

\begin{itemize}
\item \textsuperscript{81} Merger Guidelines, supra note 11, §§3.0, 3.11. Determining the market concentration reveals to what extent the market's business is divided up between many competitors or, as the case may be, to what extent the business is concentrated in one or a few competitors. Post-merger market concentration purportedly reflects the degree to which a merger will "substantially lessen competition." See 15 U.S.C. §18 (1982 & Supp. 1987); Merger Guidelines, supra note 11, §3.11 n.13.
\item \textsuperscript{82} Merger Guidelines, supra note 11, §3.1. Because competing hospitals vary in their abilities to supply the market, market share calculations should be made with attention to the individual facility's number of beds, inpatient days, and patient revenues or admissions. See Rule, supra note 47, at 127.
\item \textsuperscript{83} Merger Guidelines, supra note 11, §3.1.
\item \textsuperscript{84} Id. §3.11(c). Applying the DOJ's standards to the health care industry will yield an excessive HHI in virtually all cases. Even where an area has five hospitals, each having 20% of the market, the HHI figure (2000) would reveal a "highly concentrated" market. This computation seems to emphasize the inappropriateness of the HHI as a tool for measuring market concentration in this industry, where numerous communities have even fewer than five hospitals. Kopit & McCann, supra note 1, at 640. See also Merger Guidelines, supra note 11, §3.1 n.14 (providing another example of HHI calculation).
\item \textsuperscript{85} Merger Guidelines, supra note 11, §3.11(c).
\item \textsuperscript{86} Rule, supra note 47, at 127. Charles F. Rule is a former Assistant Attorney General, Antitrust Division, United States Department of Justice. Cf. Merger Guidelines, supra note 11, §5 (revealing that Rule's discussion of "special circumstances" represents a new found flexibility on the part of the DOJ not previously espoused by the Guidelines).
\item \textsuperscript{87} The failing firm defense is a long-established doctrine under which an anticompetitive merger may be allowed because one of the merging firms is "failing." However, DOJ policy is to construe the defense narrowly. The DOJ is unlikely to
\end{itemize}
efficiencies defenses are available under the 1984 Merger Guidelines. For example, a Portsmouth, Ohio, hospital merger was not enjoined although it gave U.S. Health monopolistic control over the market's three facilities. The DOJ claims that in that situation the acquired facility had deteriorated to such an extent that it no longer was a viable market competitor. The DOJ's decision not to sue, therefore, appears to be consistent with the well-established failing firm defense. Furthermore, recent statements made by a DOJ official suggest that this defense is available to hospitals that are merely "ailing."

1) the . . . failing firm probably would be unable to meet its financial obligations in the near future; 2) it probably would not be able to reorganize successfully under . . . the Bankruptcy Act; and 3) it has made unsuccessful good faith efforts to elicit reasonable alternative offers of acquisition . . . that would both keep it in the market and pose a less severe danger to competition than does the proposed merger. MERGER GUIDELINES, supra note 11, § 5.1 (footnotes omitted).

88. If the merging parties establish by clear and convincing evidence that the merger will achieve genuine significant efficiencies, the DOJ will consider those efficiencies in deciding whether to challenge the merger. Id. § 3.5.

Such efficiencies include, but are not limited to, achieving economies of scale, better integration of production facilities, and plant specialization. The DOJ also may consider claimed administrative efficiencies; however, these will be harder to prove. Additionally, efficiency claims will be rejected if comparable savings can be achieved through means other than merger. Id.

89. Rule, supra note 47, at 125. Portsmouth, Ohio, located in the nation's rust belt, is a city of 69,000 which faces chronic long-term unemployment and a projected substantial decrease in population. United States Health operated two of the city's three hospital facilities; one a 225-bed acute care hospital, and the other a 126-bed psychiatric and substance abuse/rehabilitation facility. Id.

90. Id.

91. See International Shoe Co. v. FTC, 280 U.S. 291, 292 (1930) (allowing competitor's acquisition of corporation facing "grave probability of a business failure"). Id.

92. See Rule, supra note 47, at 129.

Rule suggested that in analyzing a failing firm defense, the DOJ would consider the realistic prospects of the ailing hospital's survival as an indication that the facility's market share overestimates its true strength as a competitive force in the market. Id.

Rule's statement has lead some antitrust experts to believe that the DOJ is willing to allow merger intervention to take place much sooner than before. See generally Holthaus, Justice Dept. Outlines Merger Guidelines, Hosp., Mar. 20, 1988, at 54 (comments of attorney Edward Hirshfeld, of Gardner, Carton & Douglas in Chicago, who handled the Danville, Illinois merger discussed supra notes 93-95 and accompanying text).

The emergence of a more lenient application of a failing firm defense is closely related to a growing concern over the quality of medical care and a facility's
The DOJ also declined to contest the recent merger of Danville, Illinois' only two hospitals. The DOJ noted that both facilities were operating substantially below capacity and were having trouble generating enough surplus to ensure quality care. Although neither firm asserted a failing or ailing firm defense, the DOJ claims to have perceived genuine efficiencies in the merging hospitals' plans to consolidate the two facilities into one acute care hospital and one long-term inpatient care facility. Once again, the DOJ strayed from the strictures of the Merger Guidelines in accepting the efficiencies defense despite its belief that the efficiencies could have been achieved through means short of total merger.

IV. THE NONPROFIT HOSPITAL MERGER CONTESTS

A. The Roanoke Merger

The Roanoke, Virginia, transaction contested by the DOJ, involved the merger of Carilion Health System (Carilion) and Com-
munity Hospital of Roanoke Valley (Community). Carilion is a nonstock, nonprofit holding company which owns three nonprofit hospitals in Virginia and operates six others.

Carilion's largest facility is Roanoke Memorial Hospital (Roanoke, Memorial), a nonprofit teaching hospital in Roanoke, with 609 staffed hospital beds. Community is also a nonstock, nonprofit corporation, which operates 220 staffed beds at its facility of the same name in downtown Roanoke. A third facility in the Roanoke area, Lewis-Gale Hospital, in Salem, Virginia, would not be involved in the merger. Owned by Hospital Corporation of America, Lewis-Gale operates 335 hospital beds.

Roanoke Memorial and Community were both organized to provide hospital services to the general public, and both provide indigent care to the extent that funds are available. One major goal of the merger is to consolidate both hospitals' obstetrics and other clinical services at Community. Under the merger, Carilion acquires sole ownership of and sole membership in Community.

---

98. Id. Carilion also owns several for-profit subsidiaries including a helicopter ambulance service; an eye, ear, nose, and throat clinic; a health club; and an insurance company. Id.
99. Roanoke Memorial Hospital is affiliated with the University of Virginia School of Medicine in Charlottesville, Virginia. Id.
100. Id.
101. Shortly after the proposed merger was announced, Lewis-Gale began negotiating a joint venture with a nearby, 100-physician clinic. Attendant to this venture was the prospect of affiliation with a regional medical school in Winston-Salem, North Carolina. Lewis-Gale took this action in order to improve its own competitive posture. Id. at 746.
102. Id. at 842. Hospital Corporation of America is the nation's largest investor-owned hospital chain.
103. Id.
104. Id. at 845.
105. Id. Community hospitals traditionally have been organized as membership corporations pursuant to state nonprofit corporation laws. AHA Advisory Group, supra note 7, at 2. Membership in the corporation is granted either by virtue of one's position on the hospital board of trustees or through payment of membership dues. Id.

Members of a nonprofit corporation hold a position similar to that of shareholders in a for-profit corporation. Mulholland, supra note 7, at 365. Members typically include staff physicians, community religious leaders, and other members
while Community would retain minority representation on Carilion’s Board of Directors.106

The DOJ’s complaint against the Roanoke merger alleged violations of both section 1 of the Sherman Act and section 7 of the Clayton Act.107 However, the district court dismissed the section 7 claim,108 and the case proceeded to trial on the section 1 claim alone.

The Carilion court’s market analysis went in favor of the merger on all counts. First, the court’s product market included both inpatient and outpatient care.109 Next, the court defined a broad geographic market, which included twenty competing hospitals in the competitive scheme.110 Ultimately, the court was unconvinced that the affiliation of Carilion and Community would unreasonably restrain trade in the relevant product and geographic markets, and the government was denied injunctive relief under section 1 of the Sherman Act.111

B. The Rockford Merger

Three general acute care hospitals operate in the city of Rockford, Illinois. Rockford Memorial Corporation owns and operates

of the community. Even another corporation may be a member. Id.


Members of a hospital elect the board of directors (or trustees) which is responsible for the hospital corporation’s conduct. See supra notes 37-43 and accompanying text (discussing a hospital’s potential corporate liability). Nonprofit corporate laws usually prohibit the board of directors from enacting any fundamental corporate changes which would inhibit the rights of the members. See Pa. Cons. Stat. Ann. § 5504 (Purdon Supp. 1989).

Members in a nonprofit corporation have no proprietary interest in the corporation and have no rights to any profits. See Mulholland, supra note 7, at 356-58, 365-69.

106. Id. at 845.
107. Id. at 841.
108. See id. at 841 n.1.
109. Id. at 847.

110. Id. at 847-48. The court included in its geographic market any area from which the defendant hospitals drew 100 or more patients a year. Id.

111. Id. at 849.
Rockford Memorial Hospital, a nonprofit community hospital housing 400 staffed beds.\textsuperscript{112} SwedishAmerican Corporation owns and operates SwedishAmerican Hospital, also a nonprofit facility, which staffs a total of 363 beds.\textsuperscript{113} The third hospital, Saint Anthony Medical Center, has 258 staffed beds, and is owned and operated by the Sisters of the Third Order of St. Francis.\textsuperscript{114} The DOJ contested the proposed merger of Rockford Memorial Corporation and SwedishAmerican Corporation.\textsuperscript{115}

The Rockford court observed that the merger of Rockford Memorial Corporation and SwedishAmerican Corporation would reduce competition in the market by thirty-two percent, as opposed to a twelve percent reduction, which the FTC found to be unacceptable in Hospital Corp. of America.\textsuperscript{116} Moreover, the merger would give the merged entity alone seventy percent of the market as compared to the thirty percent figure deemed unduly concentrated by the Philadelphia National Bank court.\textsuperscript{117}

The court was unconvinced that the parties' nonprofit status alone extinguished any inclination to engage in anticompetitive behavior, stating that "decisionmakers [sic] need not be solely interested in the attainment of profit to act anticompetitively."\textsuperscript{118} The Rockford court concluded that although the merger made sense from a business standpoint, it was nonetheless inherently likely to lessen competition substantially and, therefore, must be enjoined.\textsuperscript{119}

V. Analysis

A. Does Section 7 Apply to Nonprofit Hospital Mergers?

The DOJ has long been in search of a case through which it could test the uncertain status of section 7's applicability to nonprofit,

\textsuperscript{112} Rockford, 717 F. Supp. at 1294.
\textsuperscript{113} Id. at 1295.
\textsuperscript{114} Id.

The Third Order, a religious congregation with a mission in health care, owns seven hospitals and one nursing home. \textit{Id.}
\textsuperscript{115} The merger purportedly will result in money-saving standardization of clinic practices and a substantial expansion of tertiary care services. \textit{Id.} at 1288.
\textsuperscript{116} Id. at 1281 (citing Hospital Corp. of Am., 807 F.2d at 1387).
\textsuperscript{117} Id. (citing Philadelphia Nat'l Bank, 374 U.S. at 364).
\textsuperscript{118} Id. at 1284.
\textsuperscript{119} Id. at 1292.
nonstock mergers.\textsuperscript{120} The \textit{Carilion} and \textit{Rockford} cases may ultimately accomplish this task.

The \textit{Carilion} court, in evaluating the section 7 issue, considered each of the section’s two relevant clauses in turn. First, the court held that the clause prohibiting certain acquisitions of “stock and other share capital” was not implicated in the merger of Carilion and Community because the defendants were both nonstock corporations.\textsuperscript{121}

In contrast, the \textit{Rockford} court held that section 7 did apply to the nonstock merger of Rockford Memorial Corporation and SwedishAmerican Corporation.\textsuperscript{122} The court primarily adopted the \textit{Philadelphia National Bank} court’s construction of section 7,\textsuperscript{123} but also cited with confidence \textit{United States v. Chelsea Savings Bank}, wherein a Connecticut district court enjoined the merger of nonstock mutual savings banks.\textsuperscript{124} The \textit{Rockford} court viewed \textit{Chelsea} as standing for the proposition that for section 7 purposes, the differences between stock and nonstock acquisitions are negligible.\textsuperscript{125} However, as the \textit{Carilion} court pointed out,\textsuperscript{126} the \textit{Chelsea} decision was based on a determination that the savings banks’ depositors “stood in the same shoes as shareholders of a regular bank in several ways.”\textsuperscript{127} Thus,

\begin{itemize}
\item 120. See supra note 96 and accompanying text.
\item 121. \textit{Carilion}, 707 F. Supp. at 841 n.1. The court noted that the government could point to no case where the acquisition of a nonstock, nonprofit corporation was designated an acquisition of share capital under the antitrust laws. \textit{Id.} See \textit{United States v. Carilion Health Sys.}, No. 88-0249-R, slip op. on Defendants Motion to Dismiss at 4-6 (W.D. Va. Sept. 30, 1988) (distinguishing \textit{Carilion} merger from \textit{Philadelphia Nat’l Bank} and \textit{Chelsea Savings Bank} mergers since Carilion and Community were privately owned and combination would not involve exchange of stock or share capital among owners).
\item 122. \textit{Rockford}, 717 F. Supp. at 1257.
\item 123. \textit{Id.} at 1255 (citing \textit{Philadelphia Nat’t Bank}, 374 U.S. at 346, 344 n.22).
\item 124. \textit{Id.} at 1255 (citing \textit{Philadelphia Nat’t Bank}, 374 U.S. at 346, 344 n.22).
\item 125. \textit{Rockford}, 717 F. Supp. at 1256.
\item 126. \textit{Carilion}, slip op. on Defendants’ Motion to Dismiss at 5.
\item 127. \textit{Chelsea}, 300 F. Supp. at 724 (citing Lippitt v. Ashley, 89 Conn. 451, 488, 94 A. 995, 1016 (1915)). Under Connecticut law, the depositors of a savings bank, like shareholders of other banks, have incidents of ownership in the bank’s capital, and upon liquidation take their ratable share only after third party creditors
\end{itemize}
the Chelsea court held that the little practical difference between the corporate form of a nonstock bank and a stock bank made it appropriate to define the depositors’ interest as “share capital” subject to section 7’s reach. Furthermore, the Chelsea court’s analysis is carefully framed within the context of nonstock bank mergers, and there is no indication that the decision was intended to extend further.

The Carilion court next considered the second clause of section 7, which embodies the 1950 amendment. The amendment was passed in response to a series of Supreme Court cases adhering to the “plain meaning” of the Clayton Act and refusing to apply the section to anything other than the sale of stock. Legislative history of the amendment clearly reveals a congressional purpose of extending section 7’s reach to asset acquisitions in order to halt the nationwide merger movement. However, as the Supreme Court noted in Philadelphia National Bank, the legislative history is silent on the ques-
tion "'why assets acquisitions by corporations not subject to FTC jurisdiction were not included.'"

The Philadelphia National Bank court suggested that the drafters had included the words "subject to F.T.C. jurisdiction" in order to reemphasize the FTC's role as its chief administrator of Clayton Act objectives. However, it is significant to note that the Federal Trade Commission Act, enacted the same year as the Clayton Act, expressly limits the FTC's jurisdiction to "for-profit" corporations. Presumably, Congress was aware of this limitation when it restricted

---


The language ["and no corporation subject to the jurisdiction of the Federal Trade Commission"] simply provides that provisions of the bill should not apply to corporations coming under the jurisdiction of certain agencies. These agencies already have jurisdiction over these corporations, and there is no disposition to change the present arrangement regarding them.

Id. This language may represent Congress' concession that those corporations not under the FTC's jurisdiction, e.g., nonprofit corporations, were already adequately policed by other regulatory agencies (in the case of nonprofit corporations, the DOJ), and therefore did not need the extra restraints provided under the proposed amendment. Cf. Rockford, 717 F. Supp. at 1257 ("[T]he fact that Congress did not want to eliminate the 'asset acquisition' exception for persons not under the FTC jurisdiction may be because there already existed the ability to challenge mergers by not-for-profit corporations and thus no broadening was needed.").


135. 15 U.S.C. §§ 41-77 (1982 (enacted 1914)). The Federal Trade Commission Act was designed to supplement and bolster the Sherman and Clayton Acts by enabling the FTC to stop, in their incipiency, acts which, when full blown, would violate these Acts. The FTC's powers are quasi-judicial and quasi-legislative in nature. See National Petroleum Refiners Ass'n v. FTC, 482 F.2d 672 (D.C. Cir. 1973), cert. denied, 415 U.S. 951 (1974); American Tobacco Co. v. FTC, 9 F.2d 570 (2d Cir. 1929), aff'd, 274 U.S. 543 (1927). See also Kopit & McCann, supra note 1, at 648.

136. The Federal Trade Commission Act defines "corporation," in relevant part, as "any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members . . . ." 15 U.S.C. § 44 (1982) (emphasis added).

"The only cases in which the FTC has successfully asserted jurisdiction over nonprofit organizations involved trade associations acting in the interest of their members' profits." Kopit & McCann, supra note 1, at 650 n.47. See, e.g., American Medical Ass'n v. FTC, 638 F.2d 443, 448 (2d Cir. 1980), aff'd per curiam, 455 U.S. 676 (1982).

the reach of the 1950 amendment in a similar manner.\textsuperscript{137} Furthermore, a congressional intent to limit the reach of section 7, as amended, to for-profit corporations is consistent with the amendment’s overwhelming focus on for-profit mergers and the excessive concentration of wealth such mergers caused.\textsuperscript{138}

Nevertheless, the \textit{Philadelphia Bank} court “inferred” from “the basic congressional design” of the amendment that Congress intended a narrow exception, excluding those corporations not under FTC jurisdiction only when they engage in acquisitions not accomplished by merger.\textsuperscript{139} From this exception, the court also inferred that Congress intended “explicitly [to] enlarge the FTC’s jurisdiction” to give it jurisdiction over merging parties even where the Federal Trade Commission Act did not grant such powers.\textsuperscript{140} Time has shown the court’s latter inference to be inaccurate.\textsuperscript{141} Thus, it is not unreasonable to conclude that the narrow exception from which that statement was drawn is also inaccurate in its application to nonprofit hospital mergers.

Furthermore, the \textit{Philadelphia National Bank} Court’s reasons for such a narrow interpretation of the amendment are unsupported in the health care context. First, the Court argued that there was no indication in the legislative history of the amendment that Congress

\begin{itemize}
  \item \textsuperscript{137} Kopit & McCann, \textit{supra} note 1, at 651.
  \item President Roosevelt explained his request for a study of the concentration of economic power in American industry: “It is a program to preserve private enterprise \textit{for profit} by keeping it free enough to be able to utilize all of our resources of capital and labor at a profit.” Message from President Franklin D. Roosevelt to Congress, S. Doc. No. 173, 75th Cong., 3d Sess. 1, at 10 (1938) (emphasis added). See also Temporary Nat’l Economic Comm., Investigation of Concentration of Economic Power (Final Report and Recommendations), S. Doc. No. 35, 77th Cong., 1st Sess. 3, at 9 (1941) (“We know that most of the wealth and income of the country is owned by a few large corporations ... and that the profits from the operation of these corporations go to a very small group ...”)). See Kopit & McCann, \textit{supra} note 1, at 651 n.52.
  \item \textsuperscript{139} \textit{Philadelphia Nat’l Bank}, 374 U.S. at 341-42.
  \item \textsuperscript{140} \textit{Id.} at 347-48.
  \item \textsuperscript{141} The DOJ concedes that the FTC does not have jurisdiction over nonprofit hospitals: “The [hospital] defendants are nonprofit corporations that do not issue stock, and the FTC has no jurisdiction over nonprofit corporations under Section 5 of the Federal Trade Commission Act.” Memorandum of the United States in Support of Its Motion for a Preliminary Injunction at 506, United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989) (No. 88-C-20186).
\end{itemize}
intended to confer a special exemption upon commercial banks.\textsuperscript{142} However, large classes of nonprofit corporations have received special treatment in numerous areas where federal legislation would otherwise be unduly burdensome. These areas include corporate income taxation,\textsuperscript{143} social security,\textsuperscript{144} unemployment insurance,\textsuperscript{145} the minimum wage,\textsuperscript{146} bankruptcy,\textsuperscript{147} copyright,\textsuperscript{148} and postal rates.\textsuperscript{149}

The \textit{Philadelphia National Bank} court also contended that any other construction of the amendment would create a loophole where Congress intended to close a loophole.\textsuperscript{150} However, courts have indicated that they are prepared to pierce the nonprofit shell and award the FTC jurisdiction where nonprofit status is merely a vehicle through which a pecuniary profit is realized.\textsuperscript{151} Moreover, the Eighth Circuit has held that the determination of whether a nonprofit corporation is subject to FTC jurisdiction should be made on an ad hoc basis.\textsuperscript{152}

The \textit{Carilion} court approached the question of section 7's applicability in terms of the section's plain meaning and concluded that nonprofit hospitals were excluded from section 7's reach.\textsuperscript{153} The \textit{Rockford} court, however, relied on longstanding Supreme Court authority in determining that Congress amended section 7 in order to

\textsuperscript{142} \textit{Philadelphia Nat'l Bank}, 374 U.S. at 348.
\textsuperscript{143} I.R.C. § 501(c)(3) (Supp. 1987).
\textsuperscript{145} I.R.C. § 3306(c)(8) (1982).
\textsuperscript{146} 29 C.F.R. § 779.214 (1988).
\textsuperscript{150} \textit{Philadelphia Nat'l Bank}, 374 U.S. at 343.
\textsuperscript{151} Community Blood Bank of Kan. v. FTC, 405 F.2d 1011, 1017, 1021 (8th Cir. 1969). \textit{See also} Benrus Watch Co. v. FTC, 352 F.2d 313 (8th Cir. 1965), \textit{cert. denied} 384 U.S. 939 (1966); Standard Distributrs., Inc. v. FTC, 211 F.2d 7 (2d Cir. 1954) (FTC was justified in enforcing its order against nonprofit corporations that were actually in business solely for the purpose of making money).


\textsuperscript{152} \textit{Community Blood Bank}, 405 F.2d at 1018.
\textsuperscript{153} \textit{Carilion}, 707 F. Supp. at 841 & n.1.
reach mergers "without qualification." The inherent weakness in each court's analysis is the absence of clearly defined congressional intent concerning nonprofit charitable hospital mergers. Thus, the decision of whether section 7, as amended, applies to nonprofit corporations is best left not to the courts but to the Congress.

B. The Struggle to Define an Appropriate Product Market

The dispute over what is a proper product market definition is not new to the health care industry. Hospital Corp. of America represents the prevailing view and is Seventh Circuit precedent to which the Rockford court willingly bowed. The Carilion court, however, has traveled an unbeaten path in hopes that the Fourth Circuit will follow.

The Carilion court reasoned that because providers of outpatient services competed with providers of inpatient services in a significant number of cases, the relevant product market must include 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 setting. Thus, the product market appropriately included both inpatient and outpatient services.

155. See supra note 133 and accompanying text.
156. Carilion defendants asserted, with apparent success, that if Congress believed that market concentration among nonprofit charitable hospitals was an evil requiring legislative relief, then Congress was free to amend the Clayton Act, just as it had in the past. Defendants insisted that for the courts to extend § 7 jurisdiction to nonprofit hospitals would be to usurp Congressional prerogatives and allow federal agencies to disregard statutory limitations. See Memorandum in Support of Defendants' Motion to Dismiss at 26-27, United States v. Carilion Health Sys., 717 F. Supp. 1251 (W.D. Va. 1988) (No. 88-0249-R).
158. 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).
159. See Rockford, 717 F. Supp. at 1260-61 (endorseing the "cluster of services" concept of Hospital Corp. of Am.).
161. Id.

Recently, major advances in medical technology have made it possible for services that were once safely performed only on an inpatient basis to be performed on an outpatient basis, in outpatient clinics, surgery centers, and doctors' offices. For example, treatment of kidney stones, once a strictly inpatient procedure, now can be done on an outpatient basis through the use of a lithotripsy, as well as on
However, it is the Rockford court's contention that despite some degree of substitutability between inpatient and outpatient care, the two, in reality, do not compete with one another. Specifically, the court argued that even where both types of services technically were available, the "cost containment" efforts of third party payors\textsuperscript{162} dictate that the invariably less expensive outpatient treatment must be chosen.\textsuperscript{163} The result of such practices is that only very "sick" patients, for whom no outpatient treatment is available, are admitted to inpatient care.\textsuperscript{164} The Rockford court further reasoned that the hospitals' "core" function of providing overnight care was a feature no outpatient facility could match.\textsuperscript{165}

The Rockford court's arguments seem to better mirror the health care market realities. It should be kept in mind that it has been only two years since the Supreme Court denied certiorari in Hospital Corporation of America, thus declining to consider the product market issue.\textsuperscript{166} Therefore, despite the continued growth of outpatient care providers, it seems unlikely that this growth has affected the competitive environment enough to make this issue any more compelling to the Supreme Court than it was in 1987.

That is not to say that the determination of the proper health care product market is a foregone conclusion. Neither the Carilion defendants nor the Rockford defendants alleged that they competed with outpatient providers for outpatient care. However, as hospitals

\textsuperscript{an inpatient basis through traditional kidney stone surgery. Furthermore, computerized tomography (CT) scanning and magnetic resonance imaging (MRI), both performed on outpatient basis, have antiquated many traditional forms of exploratory surgery. Hernia and cataract surgery, almost always performed on an inpatient basis only four or five years ago, now are performed almost exclusively on an outpatient basis. See Rockford, 717 F. Supp. at 1296-97.}

\textsuperscript{162. "Cost containment" is a term of art defining the way in which third party payors seek to keep down the amount a hospital spends. See Rockford, 717 F. Supp. at 1259, 1297.}

\textsuperscript{163. Id. at 1259.}

\textsuperscript{164. Id.}

\textsuperscript{While there may not be "reasonable interchangeability" under a Brown Shoe standard, it does not stand to reason that neither is there cross-elasticity of demand. On the contrary, if outpatient providers were to raise their prices in an exercise of their market power over the outpatient market, patients and third party insurers alike could and would turn to hospitals which offer their services and the attempt to exercise market power would be defeated. See Carilton, 707 F. Supp. at 848. See also supra note 63 and accompanying text (Brown Shoe standard).}

\textsuperscript{165. Rockford, 717 F. Supp. at 1260.}

\textsuperscript{166. See Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).}
are forced by advanced technology and patient "wellness" to increase outpatient services, outpatient care may develop into a viable sub-market of the hospital "service cluster."\(^{167}\) Thus, free-standing outpatient providers will be brought into the competitive picture for the purposes of antitrust merger analysis.

C. Reconciling the Carilion and Rockford Cases

At first glance, Carilion and Rockford appear to be conflicting opinions based upon strikingly similar facts. However, the cases are reconcilable on several bases. First, even if the Carilion court’s product market definition is inappropriate, its geographic market included enough inpatient providers to dilute the effects of any post-merger increase in market concentration.\(^ {168}\) In contrast, although the Rockford court defined a market broader than that proposed by the government, the merger of the market’s two largest competitors nonetheless concentrated an unacceptable percentage of the business into the hands of two potentially collusive firms.\(^ {169}\)

Second, while the Rockford court considered the Illinois CON law to present a "formidable" barrier, preventing would-be com-

\(^{167}\) See Groner, supra note 44, at 476-79. In Brown Shoe, the Supreme Court stated that within a broadly defined market, submarkets may exist which, in themselves, constitute product markets for antitrust purposes. Among other things, the Court looked to the product’s peculiar characteristics and uses, as well as unique production and distinct prices for proper delineation of a submarket. See Brown Shoe, 370 U.S. at 325.

\(^{168}\) The Carilion court’s geographic market included an area housing some 20 hospitals. Carilion, 707 F. Supp. at 847-48. With more hospitals in the market than were calculated by the government, the merged hospital’s piece of the pie was smaller. Recognizing that the merger would increase somewhat Carilion’s market share, the Carilion court nonetheless rejected the government’s estimation that the post-merger hospital would control 70% of the market. Id. at 848. Instead, the court noted that ""[t]he relative effect of percentage command of market varies with the setting in which that factor is placed,"" and indicated that the merged hospital would continue to compete vigorously because it would continue to rely on patients, who could easily go elsewhere, for revenues. Id. (quoting Columbia Steel Co., 334 U.S. at 528).

\(^{169}\) The Rockford court noted that although the reduction in competitors from six to five may appear benign, it not only would eliminate competition between the market’s two largest firms, but it would also give the two largest firms in the post-merger market control over 90% of the market. Rockford, 717 F. Supp. at 1280. The court noted, however, that "the elimination of a competitor is significant to anti-trust purposes only if it facilitates collusion among the remaining competitors." Id. The court then compared the 32% of competition eliminated in the Rockford case to the 12% figure deemed to promote collusion in Hospital Corp. of Am., and concluded that the merger may indeed facilitate collusion. Id. at 1281.
petitors from entering the health care market,\textsuperscript{170} the \textit{Carilion} court was persuaded that Virginia's impending repeal of certain CON regulations would facilitate a greater ease of entry into the Virginia health care market.\textsuperscript{171}

Third, the \textit{Carilion} court was persuaded by the testimony of certain Carilion Board members that the savings achieved through the merger would be funneled down to the consumers.\textsuperscript{172} In the \textit{Rockford} case, however, evidence of past collusion between the Rockford hospitals and Blue Cross was enough to convince the court that the alleged "consumer alignment" of the board was merely a facade.\textsuperscript{173}

Fourth, the \textit{Rockford} court noted that Saint Anthony's Medical Center opposed the Rockford Memorial Corporation/Swedish-American Corporation combination.\textsuperscript{174} The court stated that Saint

\textsuperscript{170} Id. at 1281.

\textsuperscript{171} \textit{Carilion}, 707 F. Supp. at 845. The inverse of barrier to entry is "ease of entry." Section 3.3 of the DOJ \textit{Merger Guidelines} states: "If entry into a market is so easy that existing competition could not succeed in raising price[s] for any significant period of time, the [DOJ] is unlikely to challenge mergers in that market." 

\textit{Merger Guidelines}, supra note 11, § 3.3.

The \textit{Guidelines} state that "entry' may occur as firms outside the market enter for the first time or as fringe firms currently in the market greatly expand their current capacity." \textit{Merger Guidelines}, supra note 11, § 3.3 n.20.

The \textit{Carilion} court relied upon the credible testimony of Virginia's Secretary of Health and Human Resources, Eva S. Teig, who expressed a firm belief that a state moratorium on the construction of new hospital beds would be lifted by July of 1989. This is important because, although the costs of building a new hospital can be financially prohibitive, the expansion of existing facilities, if permitted, costs substantially less. Thus, if CON caps were removed, Lewis-Gale and certain "fringe firms" would be able to expand their facilities to enhance their own competitive position. \textit{See Carilion}, 707 F. Supp. at 845.

Tieg's testimony was particularly convincing upon the government's cross-examination, during which she stated that not only did this merger make good common sense, but it also was just the sort of combination which the CON laws encouraged. Telephone interview with Robert W. McCann, Esquire, of Epstein, Becker & Green, P.C., Washington, D.C., counsel for the \textit{Carilion} defendants (Apr. 24, 1989).

\textsuperscript{172} \textit{Carilion}, 707 F. Supp. at 846.

\textsuperscript{173} \textit{Rockford}, 717 F. Supp. at 1286.

\textsuperscript{174} Id. at 1287. The defendants asserted that Saint Anthony's protestations were another indication that the merger would not be anticompetitive. Defendants explain that if a dominant firm exercises market power, the corresponding increase in price would benefit even non-colluding firms and, therefore, no logical competitor would contest such a merger likely to result in a cartel situation. The court discarded this argument, recalling Posner's statement in \textit{Hospital Corp. of Am.} that "such opposition to the merger is 'just one firm's opinion' not shared by the court." Id. (quoting \textit{Hospital Corp. of Am.}, 807 F.2d at 1392 (Posner, J.).
Anthony’s may have feared that the economic power of the merged entity would be exercised against it. In contrast, it is likely that the Carilion court believed that Lewis-Gale’s investor-owned parent corporation, Hospital Corporation of America, could easily provide any financial backing needed to ensure that spirited competition would continue between Lewis-Gale and the merged entity.

A pivotal difference in the cases was the Carilion defendant’s hard evidence disproving anticompetitive effects. Specifically, the Carilion court was persuaded by expert testimony that, in the Virginia health care market, prices were lower where there were fewer hospitals in an area. Furthermore, the Carilion defendants asserted economies that outweighed the conceivable anticompetitive effects. However, under the Rockford court’s section 7 analysis, evidence of past collusion, combined with the increased market concentration, was enough to merit injunctive relief.

Finally, the Rockford court modeled its analysis of the nonprofit hospital merger after the Seventh Circuit’s analysis of a proprietary hospital merger in Hospital Corp. of America. Similarly, the Carilion decision is consistent with Fourth Circuit precedent, which states that the special nature of the health care market compels the use of a special rule of reason analysis of allegedly anticompetitive behavior.

The facts seem to indicate that while the Roanoke merger could pass muster even under a section 7 analysis, the Rockford merger very well could fail even under a section 1 analysis. This differentiation reveals that the equitable disposition of hospital merger cases

---

175. Id.
176. See Carilion, 707 F. Supp. at 846 (court’s discussion of ways in which Lewis-Gale had already risen to the challenge and Hospital Corporation of America’s stake in other area hospitals).
179. Rockford, 717 F. Supp. at 1292.
180. Id. at 1260, 1277-87. See supra notes 68-72 and accompanying text (discussing Hospital Corp. of Am.).
181. See Hospital Bldg. Co. v. Trustees of Rex Hosp., 691 F.2d 678, 685 (4th Cir. 1982), cert. denied, 464 U.S. 890 (1983). The court held that actions violative of antitrust laws but undertaken in good faith may be “reasonable” if within the ambit of and furthering the objectives of health planning legislation. Id. at 686. Thus, the court hinted at an “implied repeal” exception, without saying as much. Groner, supra note 44, at 514-16 (an in-depth discussion of implied repeal). See Carilion, 707 F. Supp. at 846 (adopting “rule of reason” analysis).
requires careful scrutiny of all the facts and a copious market analysis.

D. Defending Nonprofit Hospital Mergers in the Future: Some Practical Suggestions

The strengths of the Carilion case, the weaknesses of the Rockford case, and the implications of other uncontested mergers provide some basic guidelines for defending nonprofit hospital mergers in the future.

1. Pre-merger Homework

Long before any merger agreement has been entered into, each prospective participant should take special care to preserve beyond question its nonprofit status. Where federal tax-exempt status is maintained, this requisite may be met. It is important to remember that only a truly nonprofit organization will be exempt from FTC jurisdiction and the low threshold of section 7 analysis.

Parties considering a merger should also assess precisely what business needs they seek to address through the merger. Are there less restrictive ways in which these needs could be met, i.e., something short of total merger? The parties must keep in mind that the court will most likely consider their needs as struggling competitors to be subordinate to the need to maintain healthy competition for the benefit of society. Thus, the needs to be accommodated by a merger ideally should mirror the needs of the community served.

2. Choosing a Partner

Choosing a partner is another crucial preliminary to creating a stalwart nonprofit hospital combination. It is essential that the acquired firm is a nonprofit, nonstock hospital. However, the inquiry

182. This can be done by keeping copious records of, for example: "(i) unreimbursed free care; (ii) discounts, including discounts for Medicare and Medicaid patients; (iii) unreimbursed community education; [and] (iv) unreimbursed public health measures (e.g., screening and testing programs)." Beautyman, Tax-Exempt Status Challenged, Soc'y of Health Care Attorneys of the Hospital Association of Pennsylvania Newsletter, Nov. 1988, at 1, 2.

183. See supra notes 120-57 and accompanying text.

184. Corporate reorganization could generate the capital requirements the merger seeks to provide, while at the same time solving expansion problems created by both the tax laws and the CON laws. AHA Advisory Group, supra note 7, at 3-4.

185. It is a well-settled principle that the antitrust laws were enacted for "the protection of competition, not competitors." Brown Shoe, 370 U.S. at 320.
should not stop there. Does the hospital have a history of collusive behavior at any level? Furthermore, is the focus on a large, affluent facility when there is an ailing firm available, which might better stack the cards in favor of the merger?

When choosing a partner, the hospital seeking a merger should also assess the strength of the individual competitors in the market after the merger. The choice of partner should leave firms remaining in the market that are likely to rise to the competitive challenge created by the merger, as did Lewis-Gale hospital in the Carilion scenario.

3. Market Analysis

Once the players have been designated, the market analysis should commence. At the outset, the importance of enlisting the aid of a knowledgeable health care economist cannot be minimized. The assistance of a competent economist will be indispensable to the preparation of a market analysis capable of countering the government’s attack of the merger. Recalling the Rockford court’s castigation of the defendant hospitals’ result-oriented analysis, the merging firms should also make a good faith attempt to ascertain the market realities. This is not to say that the data utilized may not seek to emphasize the appropriateness of a broadly defined market, but rather that data should not be created solely to obtain the desired result.

4. Efficiencies

Finally, the merger should be structured to create genuine efficiencies, the benefits of which outweigh any perceivable anticompetitive effects. It is increasingly clear that this type of balancing of

---

186. Collusion can take many forms in the health care industry. See, e.g., United States v. North Dakota Hosp. Ass’n, 640 F. Supp. 1028 (D.N.D. 1986) (United States claimed that defendants conspired to deny Indian Health Services a contractual price discount); Koefoot v. American College of Surgeons, 610 F. Supp. 1298 (N.D. Ill. 1985) (plaintiff, a surgeon, alleged that the American College of Surgeons and two of its executives had conspired in restraint of trade by maintaining a rule under which a surgeon could delegate post-operative care only to another surgeon).

187. The Carilion court’s emphasis on Lewis-Gale’s immediate response to the proposed merger underscores the benefits of leaving strong competitors in the market. See Carilion, 707 F. Supp. at 846.

188. See Rockford, 717 F. Supp. at 1267.
efficiencies and anticompetitive effects is the emerging threshold test in section 1 merger analysis.189

Innovative creation of services catering to the specific needs of the hospital community may also militate in favor of a hospital merger.190 Furthermore, while administrative efficiencies alone appear to be inadequate, significant projected savings, if substantiated, may tip the balance in favor of the merger where the court is satisfied that these savings will flow to the hospital’s constituency.191 Thus, the board of directors should be composed of community leaders and employers who previously have negotiated for lower health care prices and are likely to do so in the future.

VI. Conclusion

Nonprofit hospitals do not seek a broad exemption from antitrust law. They merely seek a level of scrutiny that recognizes the financial and economic constraints driving hospitals to combine. The rote application of present federal antitrust standards does not address any of these factors. Certainly, HHI has been maligned as an inappropriate tool for measuring market concentration in an industry in which one and two firm communities are commonplace.

Furthermore, it is evident from the legislative history of the 1950 amendment to section 7 that a congressional intent to exempt nonprofit corporations from the section is hardly inconceivable. The “plain meaning” of the statute bolsters this interpretation.

A section 7 exemption for nonprofit hospitals would leave the government with the heavier burden of proving actual anticompetitive restraint under section 1 of the Sherman Act. The Supreme Court’s development of the rule of reason analysis makes section 1 imminently qualified to serve as the proving ground for nonprofit hospital mergers. Some mergers will fail under section 1 analysis. Those that succeed will do so because they are likely not the type of combination

189. Rule, supra note 47, at 128-29. However, parties to a potential merger should be prepared to prove the asserted efficiencies will be achieved through the proposed transactions. Id. at 128.

190. For example, recall the Danville merger situation, which the DOJ did not contest. There the parties sought to convert the two acute care facilities into one acute care facility, and one long-term inpatient care facility. Although this plan created a monopoly, it directly pinpointed the needs of Danville’s aging population. See Rule, supra note 47, at 129-30.

that Congress sought to enjoin through application of the antitrust laws.

It has been said that the only legitimate goal of antitrust law is consumer welfare.192 Surely when a nonprofit hospital merger generates efficiencies that lower prices and increase quality, objective notions of “competition” and the market mechanism must cede to the welfare of the community of patients served by our country’s nonprofit hospitals.

Katherine Betz Kravitz