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Health Matrix: The Journal of Law-Medicine

Volume 31 | Issue 1 Article 7

2021

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McCarran-Ferguson is Protecting the Wrong Health Care Entities

R. Chad Nelson†

Abstract

Antitrust laws were established to promote and maintain a competitive marketplace by protecting competition itself; however, in regulating the health care industry, antitrust has missed its mark.

Despite the vast regulatory code keeping non-profit hospitals in check by protecting government and patient interests, antitrust laws do not provide substantial relief to these entities as they seek to ensure high level care for patients within their economic realities and the regulatory code. There are exceptions that acknowledge the realities of non-profit hospitals – such as a Robinson-Patman Act exception allowing non-profit hospitals to purchase pharmaceuticals at a discounted rate – but the bulk of relief is provided to profit-driven health insurers under the McCarran-Ferguson Act. In this way, the McCarran-Ferguson Act has truly missed its mark. True economic protection of patients would instead provide non-profit hospitals an antitrust exception in order to promote the highest quality health care within the regulatory code of the United States.

The Non-Profit Institutions Act, McCarran-Ferguson Act, and public utility exceptions could be used as a baseline for creating a non-profit hospital exception to the Sherman, Clayton, and FTC Acts. The exception would provide that in conducting the business of health care, non-profit hospitals may transact such business in any manner that is allowed by health care regulations and maintains the best interest of consumers.

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Introduction

Health care is a topic of constant conversation in the United States. How is it best managed? What system provides the most comprehensive coverage? Who should control that coverage? A less discussed, but no less important, part of the system, is how best to regulate and protect consumers while ensuring that hospitals are able to efficiently and effectively operate.

While hospitals are businesses, this classification fails to appreciate their importance to their respective communities. Providing health care is a necessity for any community to live and, hopefully, thrive. The industry's "consumers" are patients, a distinction that underlies the ultimate goal of a non-profit hospital – providing the best health services to the most people. This distinction sets it apart from profit-seeking industry.

While this distinction is important, it does not mean that non-profit hospitals are businesses that need to go unmonitored, unrestrained, and unchecked. Currently, non-profit hospitals are subject to a substantial regulatory code that restricts its business practices in order to protect consumers, the government, and taxpayers. These regulations are designed to protect these parties while acknowledging the ways in which hospitals need to operate through specific exceptions and safe harbors.

Antitrust laws also seek to protect consumers, but through the regulation of competition. Non-profit hospitals simply don't operate

under the principles championed by antitrust. Instead, they stand as an unnecessary obstacle to the non-profit hospital, even when operating within the health care code. A budgetary crisis among hospitals is complicated by antitrust laws that simply aren't built for health care. Courts have acknowledged this in various cases, but only very narrow exceptions have been established.

This paper will demonstrate that these existing exceptions can be brought together to build a workable antitrust exception for non-profit hospitals that allows for greater business decision making while continuing to operate in the best interest of the consumer, taxpayer, and the government. The exception would provide that in conducting the business of health care, non-profit hospitals may transact such business in any manner that is allowed by health care regulations and maintains the best interest of consumers.

I. The Rules and Regulations at Play

The purpose of antitrust laws is to protect a competitive market, thereby protecting the interests of market consumers, the government, and taxpayers. These ideals do not translate to non-profit hospitals and thereby miss their stated purpose within that industry. This misstep is not due to a perfectly competitive marketplace in health care, but rather a mis- categorization of non-profit hospitals. Non-profit hospitals account for a majority of hospitals within the United States – many of the most prestigious and largest hospitals, such as MD Anderson Cancer Center and Cleveland Clinic, operate as non-profits.[1] As with other non-profit institutions, hospitals are required to conduct business within a financial structure established and monitored by the IRS.[2] If the hospitals falls out of compliance with those rules, it loses its non-profit status.[3]

In addition to IRS rules, non-profit hospitals are subject to a complex regulatory code that seeks to protect consumer, government, and taxpayer. The contracts that make up the functioning hospital are all restricted by the terms of these regulations, requiring fair market value compensation and assurances that financial relationships will not result in fraudulent or unnecessary care that will be payable by Medicare and Medicaid.[4] At first glance, such terms may not appear

1. *Fast Facts on U.S. Hospitals, 2020,* AM. HOSP. ASS'N (2020), https://www.aha.org/statistics/fast-facts-us-hospitals [https://perma.cc/AT8M-9ECE].
2. In addition to the general requirements for non-profit organizations in I.R.C. § 501(c)(3), hospitals must also meet four additional requirements imposed by the Patient Protection and Affordable Care Act, as codified in I.R.C. § 501(r)(1).
3. *Id.*
4. *See* 42 U.S.C. §§ 1395nn, 1320a-7b(b) (2018).

cumbersome to the business of the hospital, but restrictions on compensation for real estate, physicians, and other various equipment hamstring what would be competitive aspects in other industries in order to maintain compliance with patient protection and non-referral laws.[5] Although cumbersome, these targeted regulations are important, keeping hospitals in check and protecting the best interests of consumers, the government, and taxpayers.

Antitrust laws do not provide substantial relief to non-profit hospitals as they seek to ensure high level care for patients within their economic realities and the regulatory code. Instead, non-profit hospitals are subject to the same antitrust laws as their profit-maximizing counterparts – even to a greater degree than some within their own industry such as insurance companies.[6] Hospitals are still subject to review of their mergers and acquisitions, market saturation tests, and pricing laws.[7] Such laws complicate and slow down the business decisions necessary for non-profit hospitals to continue operating efficiently. This is particularly true in the context of mergers and acquisitions, which have become increasingly popular as the fiscal burdens of hospital operations grows.[8] Although transactions often are allowed to proceed in the end, it does not mean that the same quality of treatment will continue. [9]

Currently, the majority of antitrust relief for health care entities is reserved for health insurers under the McCarran-Ferguson Act.[10] Non-profit hospitals only enjoy the benefits of the Non-Profit Institutions Act, which is primarily used by hospitals for purchasing

5. *See* Rachel V. Rose, *The Stark Law and Anti-Kickback Statute: What Are They and Why Do Health Care Industry Participants Need to Know?*, The Fed. Law., July 2016, at 12, 13.

6. Collin Z. Groebe, *The Evolution of Federal Courts' Healthcare Antitrust Analysis: Does the PPACA Spell the End to Hospital Mergers?*, 92 Wash. U. L. Rev. 1617, 1631 (2015); 15 U.S.C. §§ 1011–1015 (2018).

7. P. Dileep Kumar, *Antitrust Laws in Healthcare: Evolving Trends*, Am. Ass'n. for Physician Leadership (May 9, 2019), https://www.physicianleaders.org/news/antitrust-laws-health-care-evolving-trends [https://perma.cc/YZ6Q-4EJW].

8. *See* Brent Kendall, *Regulators See to Cool Hospital-Deal Fever*, Wall St. J. (Mar. 18, 2012), https://www.wsj.com/articles/SB1000142405270230 3863404577286071837740832[https://perma.cc/3QK5-P75Z].

9. Sara Heath, *How Do Healthcare Mergers and Acquisitions Impact Patients?*, Patient Engagement HIT (Aug. 7, 2018), https://patientengagementhit.com/news/how-do-healthcare-mergers-and-acquisitions-impact-patients [https://perma.cc/7UEL-Q9PT].

10. 15 U.S.C. §§ 1011–1015 (2018).

pharmaceuticals at a discount.[11] While this use is certainly helpful, it only covers one aspect of a business.

A. Health Care Regulations

Health care is one of the most highly regulated industries – protecting consumers (patients), the government, and taxpayers from unscrupulous practices that could compromise patient care and taxpayer/government dollars through Medicare. Pertinently, the federal government has enacted a complex code that prevents fraudulent or abusive practices that involve the federal health care programs, namely Medicare and Medicaid.[12] In 2013 (the last year data was available), Medicare and Medicaid made up 57.2% of patient revenue.[13] Further, failure to comply with any of these regulations results in settlements that can be in the multi-millions.[14] Accordingly, hospitals are very protective of their Medicare and Medicaid payments and are aware of their need to strictly comply with any regulatory scheme that threatens that.

Knowing this, the federal government uses Medicare and Medicaid as a tool to force compliant relationships. The five most common regulatory schemes are: 1) Stark Law, 2) Anti-Kickback Statute, 3) Emergency Medical Treatment and Labor Act, 4) False Claims Act, and 5) Civil Monetary Penalties. Each affects hospitals in a unique way that necessarily restricts their business capabilities.

1. Stark Law

The first important federal regulation that pervades every business decision made by a hospital system is the Physician Self-Referral Law, colloquially known as the Stark Law.[15] Pursuant to the Stark Law, physicians are prohibited from making referrals to any entity with which the physician has a financial relationship if the referral is for

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11. Stephen Barlas, *The Avenue to Discounts For Non-Profit Hospital Pharmacies: Meeting the Requirements of the Non-Profit Institutions Act,* 35 Pharmacy and Therapeutics 603 (2010).

12. *See* Rose, *supra* note 5.

13. *Hospitals Hit a Revenue Crunch,* Healthcare Fin. (Apr. 25, 2014), https://www.healthcarefinancenews.com/news/hospitals-hit-revenue-crunch [https://perma.cc/4H5C-JWX3].

14. *See* Press Release, U.S. Dep't of Just., Florida Hospital System Agrees to Pay the Government $85 Million to Settle Allegations of Improper Financial Relationship with Referring Physicians (Mar. 11, 2014); Press Release, U.S. Dep't of Just., Detroit Area Hospital System to Pay $84.5 Million to Settle False Claims Act Allegations Arising From Improper Payments to Referring Physicians (Aug.2, 2018); Press Release, U.S. Dep't of Just., United States Resolves $237 Million False Claims Act Judgment Against South Carolina Hospital That Made Illegal Payments to Referring Physicians (Oct. 16, 2015).

15. 42 U.S.C. § 1395nn.

certain designated health services payable by Medicare and Medicaid.[16] Entities are prohibited from presenting, or causing to be presented, claims to Medicare and Medicaid for those referred services.[17] These restrictions always apply to relationships between physicians and entities in which they have a financial interest unless an enumerated exception is met, such as the "bona fide employment" exception allowing employment for identifiable services at a fair market rate that does not take into account the volume or value of any referrals by the physician.[18] It is also important to note that the Stark Law is a strict liability statute – a showing of intent in the transaction is unnecessary – meaning that the only way to avoid liability under a referral relationship is by meeting an exception.[19]

2. Anti-Kickback Statute

Perhaps the most prevailing federal regulation of fraud and abuse affecting the health care industry is the Anti-Kickback Statute ("AKS").[20] A criminal law, the AKS prohibits knowing and willful payment of anything of value to induce or reward patient referrals or generate business payable by a federal health care program.[21] Importantly, the AKS is not limited to physicians and designated health services like the Stark Law, making it more pervasive in the business transactions and relationships of a health care system and requiring fair market value to avoid a violation.[22] In limited circumstances, an AKS violation can be avoided by falling within a safe harbor established and enumerated by the Office of the Inspector General.[23]

3. Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act ("EMTALA") states that anyone with an emergency medical condition, regardless of their ability to pay, presenting to an emergency department must be stabilized and treated.[24] In the event that the emergency department is incapable of stabilizing the patient due to a lack of specialized capabilities, an appropriate transfer must be arranged.[25] While the

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16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. 42 U.S.C. § 1320a-7b(b).
21. *Id.*
22. *Id.*
23. 42 C.F.R. § 1001.952 (2019).
24. 42 U.S.C. § 1395dd (2018).
25. *Id.*

scope may appear narrow, emergent cases, both involving physical and mental health issues, cost hospitals $4.2 billion each year.[26] This practice highlights the business model of the non-profit hospital – providing a service to as many patients as possible without regard for profits.

4. False Claims Act

To further protect the government from false or fraudulent reimbursement claims to Medicare and Medicaid, the False Claims Act ("FCA") makes it illegal to submit claims for payment to Medicare and Medicaid that the submitting party knows, or should know, are false or fraudulent.[27] There is no specific intent to defraud requirement and "knowing" includes deliberate ignorance or reckless disregard of the truth or falsity of the information.[28]

5. Civil Monetary Penalties Law

Under the Civil Money Penalties Law ("CMP"), the Secretary of Health and Human Services can impose civil money penalties, assessments, and program exclusions for fraud and abuse violations involving Medicare and Medicaid.[29] There are three specific violations under the CMP for submitting false or fraudulent claims, none of which requires a specific intent to defraud.

B. Antitrust Laws

Much like the health care regulations, antitrust laws are designed to protect consumers, the government, and taxpayers from fraud and abuse. Unlike the health care regulations, antitrust laws are designed to protect these interests through the competitive marketplace. Outside of the McCarran-Ferguson Act, the antitrust laws are not designed specifically for the health care industry, but they significantly impact the industry. The restrictions placed on market movement, firm size, and pricing affects the way that hospitals cope with the health care regulations in attempting to remain viable entities to serve their communities.[30] There is not a dollar figure to be placed on this harm, like the impact of the health care regulations; instead, the effect is a limited business mobility and increased costs of assessing and potentially fighting an antitrust challenge. Ultimately, this hurts the

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26. William (B.G.) TenBrink et al., *Emergency Medicine Advocacy Handbook*, EMRA, https://www.emra.org/books/advocacy-handbook/impact-of-emtala/ [https://perma.cc/4LHQ-VPHK].
27. 31 U.S.C. § 3729 (2018).
28. *Id.*
29. 42 U.S.C. §§ 1320a–7a (2018).
30. Jeffrey W. Brennan & Paul C. Cuomo, *The "Nonprofit Defense", in Hospital Merger Antitrust Litigation*, 13 Antitrust 13, 14 (1999).

consumer in the health care industry through a reduction of efficiency and access by disrupting business and increasing expenses for the hospitals in assessing, fighting, or being unable to follow through with business decisions.

There are five antitrust laws that impact the health care industry: 1) Sherman Act, 2) Clayton Act, 3) Federal Trade Commission Act, 4) Robinson-Patman Act, and 5) McCarran-Ferguson.

1. Sherman Act

The Sherman Antitrust Act of 1890 ("Sherman Act") seeks to protect consumers from abuse by preserving the competitive marketplace.[31] Toward this end, the Sherman Act prohibits anticompetitive agreements and conduct that monopolizes, or attempts to monopolize, a particular market.[32] The Sherman Act authorizes the Department of Justice ("DOJ") to bring suits to enjoin conduct in violation of the Sherman Act, as well as authorizing private parties injured by such illegal conduct to bring suits for treble damages.[33]

2. Clayton Act

Under Section 7 of the Clayton Antitrust Act of 1914 ("Clayton Act"), mergers and acquisitions are prohibited when they may substantially lessen competition or tend to create a monopoly.[34] When examining mergers and acquisitions – particularly mergers between direct competitors, called "horizontal mergers" – the agencies are primarily concerned with whether the proposed merger is likely to create or enhance market power or facilitate the exercise of such market power.[35] Like the Sherman Act, the Clayton Act authorizes the DOJ to bring suits to enjoin conduct in violation, as well as authorizing private parties injured by such illegal conduct to bring suits for treble damages.[36]

The Hart-Scott Rodino Act ("HSRA"), an amendment to the Clayton Act, allows for greater oversight of mergers that may lead to harmful effects on the market.[37] The HSRA requires notification to the antitrust agencies prior to merger if the potential merger meets certain

31. 15 U.S.C. §§ 1–7 (2018).

32. *Id.*

33. *Id.*

34. 15 U.S.C. §18 (2018).

35. *Horizontal Merger Guidelines,* U.S. Dep't of Just. & Fed. Trade Comm'n (Aug. 19, 2010), https://www.justice.gov/atr/horizontal-merger-guidelines-08192010 [https://perma.cc/89XR-XSJF].

36. 15 U.S.C. § 18.

37. 15 U.S.C. § 18a.

relevant market thresholds.[38] This effectively slows down mergers and acquisitions, as the parties cannot consummate the transaction until approval has been given by the agencies.[39]

3. The Federal Trade Commission Act

The Federal Trade Commission Act ("FTC Act") is primarily known for creating the Federal Trade Commission ("Commission') itself.[40] In doing so, the FTC Act empowers the Commission to, in pertinent part, prevent unfair methods of competition and unfair or deceptive acts or practices affecting commerce, as well as seek relief for conduct that injures consumers.[41]

The DOJ and Commission draft guidelines for when mergers and acquisitions are likely to be challenged.[42] The guidelines take into account geography and market, but do not account for non-profit status or an entity's objective – only its behavior.[43]

4. Robinson-Patman Act

The Robinson-Patman Act makes it illegal for "any person engaged in commerce, in the course of such commerce, knowingly to induce or receive a discrimination in price which is prohibited by this section."[44]

Non-profit hospitals do enjoy an exception to the Robinson-Patman Act under the Non-Profit Institutions Act. The exception applies to purchases of their supplies for their own use.[45] This exception is commonly used in the purchasing of pharmaceuticals.[46]

5. McCarran-Ferguson Act

The McCarran-Ferguson Act provides a limited exception to insurance companies from antitrust. To qualify for this exception, the activity must be part of the business of insurance and be authorized and regulated by the state.[47] The effect of this exception is that conduct that would normally violate the antitrust laws is exempted from action

38. *Id.*

39. *Id.*

40. 15 U.S.C. §§ 41–58 (2018).

41. *Id.*

42. U.S. Dep't of Just. & Fed. Trade Comm'n, *supra* note 35.

43. *Id.*

44. 15 U.S.C. § 13 (2018).

45. 15 U.S.C. § 13c.

46. *See* Barlas, *supra* note 11.

47. 15 U.S.C. §§ 1011–1015.

by the antitrust agencies if the conduct is within the scope authorized by the applicable state law.[48]

II. Obstacles Facing Hospitals

Health care is a unique business.[49] While it is a business, it does not operate under the same principles, assumptions, or models as other businesses.[50] Antitrust law concerns itself with protecting competition as a means of protecting consumers, the government, and taxpayers. Health care does not operate on the same plane in terms of competition and the best way to protect its stakeholders. Health care regulations take into account the ideals, purpose, and model of non-profit hospitals while still protecting consumers, the government, and taxpayers from fraudulent or unscrupulous practices.

Understanding this difference is more important than ever, as the landscape of health care, and non-profit hospitals in particular, shifts.[51] Non-profit hospitals are currently faced with declining reimbursement from Medicare and Medicaid and a growing compliance burden.[52] These challenges place significant financial strains on hospitals, which forces them to make business decisions in ways not previously common. For instance, the model has shifted toward favoring large hospital systems as a way of improving efficiencies and better providing services to a community.[53]

A. The Dichotomy of Health Care and Competition

Competition and the protection of consumers do not go hand-in-hand in the context of the health care industry like they do in other

48. *Id.*

49. *See* Molly Gamble, *How Much Should We Expect Healthcare to Mimic Other Industries?*, Becker's Hosp. Rev., (Aug. 19, 2013), https://www.beckershospitalreview.com/ hospital-management-administration/how-much-should-we-expect-healthcare-to-mimic- other-industries.html.

50. *Id.*

51. Jeff Lagasse, *Struggles will Continue for Nonproft Hospitals in 2019, Fitch Says*, Healthcare Fin. (Dec. 8, 2018), https://www.healthcarefinancenews.com/news/struggles-will-continue-nonprofit-hospitals-2019-fitch-says [https://perma.cc/CX93-J53J].

52. Meg Bryant, *Fitch: Worst may be over for nonprofit hospitals*, Heathcare Dive (Mar. 27, 2019), https://www.healthcaredive.com/ news/fitch-worst-may-be-over-for-nonprofit-hospitals/551382/ [https://perma.cc/5XB4-HNVT].

53. *See Kendall, supra note 8.*

industries.[54] Health care is complicated by the ultimately altruistic nature of the services provided and necessity of those services to a community. While they may appear similar – competition seeks to generate the best possible product at the best possible price and health care seeks to provide quality, affordable services to as many as possible – the ideals that feed them and their necessity to a community clash, highlighting the stark difference between them: profits.

1. Competition Ideals

Competition is at the heart of capitalism, at the heart of the American dream, and the very basis for the antitrust laws. The mantra of antitrust law, after all, is to protect competition, not competitors.[55] The purpose of competition, ideally, is to generate the best product for the best possible price – ultimately protecting the consumer.[56] The antitrust laws seek to protect these ideals by ensuring that competitors cannot transact in unsavory ways to monopolize a market.[57] Competition for market-share, and ultimately the competition for profits, creates perverse incentives for businesses to act in a predatory fashion toward competitors, harm consumers, and enter into business relationships that are not in the best interest of the consumer, but only in the best interest of the bottom line. [58]

2. Health Care Ideals

Non-profit hospitals are uniquely situated among American industry. They are differentiated by two primary factors: 1) they are not profit- seeking and 2) their entire business model is focused on an altruistic notion of providing quality health care to those who need it.[59] It is important to distinguish revenue from profit – revenue is important to non-profit hospitals, but only in order to cover the expenses necessary to provide the quality health care to members of the community.[60] Profit-seeking goes beyond the expenses and seeks to

54. Leemore S. Dafny & Thomas H. Lee, *Health Care Needs Real Competition*, Harv. Bus. Rev. (Dec. 2016), https://hbr.org/2016/12/health-care-needs-real-competition [https://perma.cc/843N-WCMG].

55. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977).*

56. *See* N. Pac. Ry. Co. v. United States, 356 U.S. 1, 4 (1958).

57. *See* 2B Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶402 (3rd ed. 2007).

58. *See* Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc., 784 F.2d 1325, 1338 (7th Cir. 1986).

59. Gamble, *supra* note 49.

60. Claire Boyte-White*, Revenue vs. Profit: What's the Difference?,* Investopedia (Nov. 24, 2018), https://www.investopedia.com/ask/answers/122214/what-difference-between-revenue-and-profit.asp [https://perma.cc/7TZN-3HQG].

generate more than enough revenue for services in order to enrich the beneficiaries of those profits.[61]

Those two factors put non-profit hospitals at odds with traditional profit-seeking business, even profit-seeking health care entities such as insurance companies. An example of these factors at play can be seen in the Mission & Values of one of the largest non-profit hospital systems in the Midwest:

> Through our participation in the healing ministry of Jesus Christ, communities, especially those that are economically, physically and socially marginalized, will experience improved health in mind, body, spirit and environment within the financial limits of the system.[62]

This mission echoes the ideals at the forefront of health care, particularly for non-profit hospitals. For all of the philanthropic good that American industry does in their respective communities, health care is built on the very function of caring for those who need help. The ideal of bettering the community is not just a part of the business – it is the business of non-profit hospitals. When a non-profit hospital is arguably operating at its peak performance, it *is* providing the widest variety of quality services to the most members of the community while simply covering the cost of providing those services.

Hospitals are big, with revenue streams in the billions.[63] Hospitals do compete to provide the best and most desirable services in their community; however, this is not a competitive market for profit, and the basis for all non-profit hospitals is providing the best possible care to the most community members possible within their economic realities. This is also what society wants – the best possible, affordable care. Such an efficiency aligns with the goals and ideals of all parties involved. While the ultimate purpose of competition, to deliver the best product at the lowest possible price, appears to align with this goal, the underlying product (health care services) distinguishes it from traditional business. Competition of that kind could yield unscrupulous results when health is the product and ultimately diverts from the goal of providing quality health care for as many in the community as possible.

61. *Id.*

62. *Our Mission & Values*, SSM HEALTH (2018), https://www.ssmhealth.com/resources/about/mission-values [https://perma.cc/4UBA-MRSW].

63. SUTTER HEALTH AND AFFILIATES INTERIM UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION (June 30, 2018), https://emma.msrb.org/ER1149213-ER898992-.pdf [https://perma.cc/XX3L-Y5FH].

Further distancing non-profit hospitals from American industry is a hospital's consumer base: patients seeking medical treatment.[64] Patients are protected from predatory, profit-motivated decisions by providers by the Stark Law, AKS, and the other rules and regulations discussed above which monitor financial relationships that could incentivize providers to administer care other than that which is in the best interest of the patient. The very financial relationships on which competitive advantage would be built are constrained by burdensome regulations in the name of protecting the patients. All of this is necessary in protecting patients, but it does distinguish non-profit hospitals from typical American industry and increases the burden of fulfilling health care's ideals.

B. The Changing Landscape of Hospitals

It is no secret that the landscape of health care in the United States has been changing in recent years.[65] For instance, the Patient Protection and Affordable Care Act fundamentally changed aspects of the way Americans are insured, how many people are covered under Medicare and Medicaid, increased the standards for non-profit status as a hospital, and decreased the standard of liability under the AKS from specific intent or actual knowledge to strict liability.[66] Also, while the Stark Law has been around since 1988, its implementation has taken shape as recently as 2007[67] when the Centers for Medicare and Medicaid Services ("CMS") rolled out their final implementation phase.[68] These changes and growing regulatory codes have placed resource and business strains on hospitals that are seeing slow growth and declining margins.[69] Further, hospitals have seen their reimbursements for Medicare and Medicaid fall as CMS has failed to keep their payment schedules in line with inflation.[70]

64. *See* Gamble, *supra* note 49.

65. *How We Can Expect the Healthcare Industry to Change in the Future,* George Wash. U. SCH. OF BUS. (Nov. 5, 2020), https://healthcaremba.gwu.edu/blog/how-we-can-expect-the-healthcare-industry-to-change-in-the-future/ [https://perma.cc/JKC5-6TXH].

66. *See* 42 U.S.C. § 300gg (2018).

67. 72 Fed. Reg. 51012 (Sept. 5, 2007).

68. The delayed roll out was due to an amendment in 1993 and an allowance for public comments through each phase of implementation. *See* Morey J. Kolber, *Stark Regulation: A Historical and Current Review of the Self-Referral Laws*, 18 HEC FORUM 61, 65 (2006).

69. *US NFP & Public Hospitals' Annual Medians Show Expense Growth Topping Revenues for Second Year*, MOODY'S (Aug. 28, 2018), https://www.moodys.com/research/Moodys-US-NFP-public-hospitals-annual-%20medians-show-expense-growth--PBM_1139331 [https://perma.cc/MV27-R3LB].

70. Bryant, *supra* note 52.

Hospitals have dealt with the burden of legislative changes, growing regulations, and declining Medicare and Medicaid reimbursements. These burdens have left non-profit hospitals struggling, with smaller hospitals fighting just to keep their doors open.[71] Left searching for larger systems to support them, some communities are losing their local access to quality health care.[72] Even larger systems are losing money, in some instances hand-over-fist.[73] Facing these issues, hospitals have moved away from simpler community models to large health care systems.

1. The Growing Compliance Burden

Given the penalties at stake when violations are discovered, hospitals must be more vigilant than ever to remain compliant. This is no small task – each transaction from a time-share, to on-call agreements, to pharmaceutical contracts, and each physician agreement must be examined for fair market value and any other potential violations.[74] Maintaining such compliance requires people with expertise in the industry, legal fees, and increased overall number of employees due to the inevitable rise in work load.[75] This burden becomes greater if a community hospital is found out of compliance and must pay fines or loses its ability to participate in Medicare or Medicaid.[76]

2. Diminishing Payments and the Growing Burden on Providers

Reimbursement rates for Medicare and Medicaid are established based on a "Physician Fee Schedule" posted by CMS.[77] In theory, these rates should adjust according to inflation in order to maintain proper reimbursement for providers; however, this has not been the case in the past several years.[78] Reimbursement rates have flatlined and failed to

71. *See* Paul Monies, *In Pauls Valley, a Rural Hospital Struggles Again to Survive*, Okla. Watch (Oct. 5, 2018), https://oklahomawatch.org/2018/10/05/cash-crunch-is-nothing-new-for-pauls-valley-hospital/ [https://perma.cc/2V2R-QRV6].

72. *Id.*

73. *See* Jeff Goldsmith, *How U.S. Hospitals and Health Systems Can Reverse Their Sliding Financial Performance*, Harv. Bus. Rev. (Oct. 5, 2017), https://hbr.org/2017/10/how-u-s-hospitals-and-health-systems-can-reverse-their-sliding-financial-performance [https://perma.cc/6LGD-ZJGS].

74. *Regulatory Overload Report,* Am. Hosp. Ass'n (2017), https://www.aha.org/guidesreports/2017-11-03-regulatory-overload-report [https://perma.cc/N32G-HSYL].

75. *Id.*

76. *Id.*

77. 42 C.F.R. §§ 405, 410, 414, 424–425 (2019).

78. Bryant, *supra* note 52.

keep up with inflation, leaving providers short large swaths of hospital income.[79] Another disturbing result is the impact this has on commercial insurance reimbursements.[80] Commercial insurers often model their schedules based on CMS, so while they are not identical, a CMS schedule that has not been adjusted for inflation can lead commercial insurers to follow suit.[81] This leads to even more catastrophic results for a hospital's income.

The issue of missing income is not limited to reimbursement rates. Hospitals large and small across the United States have reported striking operation losses. In fiscal year 2016, MD Anderson Cancer Center lost $266 million, Prestigious Partners HealthCare in Boston lost $108 million, and the Cleveland Clinic suffered a 71% decline in its operating income – these represent some of the most prestigious hospitals in the country.[82]

Rural hospitals have been hit even harder, given their shallower pockets and typically lower-income patients. For instance, in 2018 the Pauls Valley General Hospital in Pauls Valley, OK ("PVGH") resorted to a GoFundMe page in a desperate attempt to keep its doors open and continue serving its community.[83] PVGH attempted for months to find a larger system to join in order to stay afloat, but by that time there was too much debt to make an acquisition financially viable for even a large hospital network.[84] As a result, PVGH closed its doors in October 2018, and now its community members must drive as many as 20 miles to receive quality health care.[85]

3. Fiscal Sensibilities and Large Hospital Networks

Given the economic burdens placed on non-profit hospitals by dropping reimbursement and increased compliance issues, deeper coffers and larger revenues are necessary to continue providing quality health care to the community. Large hospital networks inherently have 1) a level of revenue that can sustain certain losses, 2) large in-house legal and compliance teams, and 3) the expertise to manage the general affairs of the hospital efficiently. Much like economies of scale theory

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79. *Id.*

80. *Id.*

81. *Id.*

82. Goldsmith, *supra* note 73.

83. Monies, *supra* note 71.

84. *See id.*

85. *Id;* Bill Miston, *Pauls Valley extends $361k to community hospital on brink of closure*, Okla.'s News (Sep. 5, 2018), https://kfor.com/news/pauls-valley-extends-361k-to-community-hospital-on-brink-of-closure/ [https://perma.cc/F3SN-7C84].

for products,[86] the cost of maintaining compliance and absorbing declining reimbursement can be better absorbed as the size (and therefore revenue) increases. The efficiencies of a large non-profit hospital system provide the best opportunity for quality care at the best possible price while the consumer, taxpayer, and government are protected by the more targeted health care regulations, large hospital systems.

III. The Solution: Antitrust Exception for Non-Profit Hospitals

In order to address the changing landscape of hospitals, a streamlining of the regulatory desires covering health care needs to occur. The business practices of non-profit hospitals are necessarily restricted and watched by health care regulations to keep the industry in check and their priorities in line for the consumer, government, and taxpayers. Where the industry could be positively affected is an exception from the antitrust laws, allowing for greater business decision making within the already thorough regulatory code, but without the inefficiencies created by the antitrust laws for this particular industry.

There are examples of industries that have been found to operate more efficiently or in the best interest of the government, taxpayers, and consumers outside of the burdens of antitrust. Utility companies and their services have proven most beneficial to their customers when efficiencies are maximized.[87] Another example hits especially close to hospitals, in the form of a profit-seeking sector of the health care industry – health insurance.[88] Non-profit hospitals have even been the beneficiary of one narrower exception – the Non-Profit Institutions Act.[89] Each exception provides a basis on which an exception for non-profit hospitals could be crafted.

A. The Utility of Health

Public utility companies, both public and private, have long been allowed to operate as natural monopolies.[90] This has been allowed for

86. Economies of scale is defined as "the reduction of production costs that is a result of making and selling goods in large quantities." *Economies of Scale*, Cambridge Dictionary, https://dictionary.cambridge.org/us/dictionary/english/economies-of-scale [https://perma.cc/YQK5-FBJN].

87. Andy Conigliaro et al., *Natural Monopolies: Benefits, Exceptions, and Ethics*, The Danger of Corp. Monopolies (June 10, 1996), https://cs.stanford.edu/people/eroberts/cs181/projects/corporate-monopolies/benefits_natural.html [https://perma.cc/BR7R-CMCW].

88. 15 U.S.C. §§ 1011–1015.

89. 15 U.S.C. § 13c.

90. Conigliaro et al., *supra* note 87.

the sake of efficiency, as "[a] natural monopoly exists when average costs continuously fall as the firm gets larger."[91] There are two primary characteristics inherent in utilities that separate them as a natural monopoly: 1) having only one set of electrical lines reduces capital costs and makes transmission of electricity more efficient and 2) maintaining this efficiency is essential to the public in avoiding blackouts and other disruptive electrical events.[92] To offset the potential harms of a monopoly to consumers and the economy as a whole, utility companies are heavily regulated on both the state and federal levels.[93]

Compare these characteristics with non-profit hospitals. Hospitals operate at their peak when they can provide the most quality services to their patients under one roof – while maintaining "roofs" in as many communities as possible. Hospitals also provide an essential service to the public as a whole – health and personal well-being.[94] Much like electricity, health and well-being are essential to a community's economy.[95] Unlike electricity, health and well-being are essential to the very basis that forms a community, as a community cannot exist without healthy people. These similarities allow for an initial comparison in crafting an exception for non- profit hospitals and understanding its underlying policy – an exception is not to bloat pocketbooks but rather to increase efficiency for a necessary service.

B. Learning from the McCarran-Ferguson Act

Protecting profit-maximizing institutions at the federal level has placed the McCarran-Ferguson Act in hot water with many politicians and various other critics in recent years.[96] McCarran-Ferguson has been wasted on a profit-maximizing industry, but its principles could lay the groundwork for advances in the most important aspect of the health care industry in non- profit hospitals. There are basic tenants of the McCarran-Ferguson Act that shed light on the viability of an antitrust exception for non-profit hospitals.

91. *Id.*

92. *See* Robert J. Michaels, *Electric Utility Regulations*, Libr. of Econ. and Liberty, https://www.econlib.org/library/Enc1/ElectricUtility Regulation.html [https://perma.cc/Y3R6-K55Y].

93. *Id.*

94. David M. Walker, U.S. Gov't Accountability Off., GAO-05,743T, Nonprofit, For-profit, and Government Hospitals: Uncompensated Care and Other Community Benefits (2005).

95. *Id.*

96. Michael G. Cowie, *Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action,* The Antitrust Source (Dec. 2009), https://www.kff.org/wp-content/uploads/sites/ 3/2011/09/dec09_cowie12_17f.authcheckdam.pdf [https://perma.cc/4DG9-PT39].

The two requirements to qualify for protection under the McCarran- Ferguson Act – 1) activity in the business of insurance and 2) activity authorized and regulated by the state – create a baseline from which to work.[97] In creating protection for non-profit hospitals, the "business of insurance", as used in McCarran-Ferguson, could be translated to the "business of health care" – this would protect stakeholder from hospitals stretching the exception to conduct other business in ways not intended. For instance, by limiting the conduct covered, hospitals could not acquire real estate not intended for medical practice. The exception would only cover the conduct intended, which consists of that which drives the efficiency of patient care.

Further, non-profit hospitals are heavily regulated by state and federal bodies that seek to protect patients from not only malpractice, but deceptive or otherwise unsavory business practices. These regulations are vast and monitor most all business conducted by a hospital.[98] Most importantly, these regulations are already in place and being followed – there would not need to be a major overhaul in operations that would disrupt the industry detrimentally.

C. The Promise of the Non-Profit Institutions Act

Carving out an antitrust exception for non-profit hospitals is not a new idea for lawmakers.[99] In 1938, Congress passed an exception – the Non- Profit Institutions Act – to the Robinson-Patman Act allowing non-profit hospitals to purchase supplies for their own use without availing themselves to liability under the Robinson-Patman Act.[100] The Non-Profit Institutions Act is limited in scope, allowing an exception only for "supplies" for the non-profit hospital's "own use."[101]Through its limiting language, the exception confronts the realities of operating a non-profit hospital and allows the hospital to save on its pharmaceuticals, but it prevents the hospital from engaging in anti-competitive behavior by shopping those pharmaceuticals to other hospitals at a price that undercuts the initial seller.[102]

D. The Non-Profit Institutions Act Beyond the Robinson-Patman Act

The health care industry, as it pertains to non-profit hospitals, can be distinguished from typical industry, not only in its non-profit-maximizing organization, but also its base mission, values, goals, and

97. 15 U.S.C. §§ 1011–1015.

98. *See* Rose, *supra* note 5.

99. 15 U.S.C. § 13c.

100. *Id.*

101. *Id.*

102. *Id.*

consumers.[103] The Sherman, Clayton, and FTC Acts seek to protect the market, and protect consumers from the ills of unhealthy acts. The argument is that the more players that are in a particular market, the better protected consumers are from such ills.[104] Non-profit hospitals do not function under that same mindset. Their purpose is to serve and better the community in the most efficient way possible. As health care becomes more complex, the focus needs to be on efficiency and creating better access to resources.

For decades, the courts have acknowledged what the merger guidelines have failed to take into account: allowing for a non-profit defense in antitrust.[105] It has even been argued that non-profit hospitals have been given a pass on antitrust challenges by the courts.[106] In 1995, *Butterworth Health Corporation* ostensibly opened the floodgates with its "non-profit defense" to a proposed merger with Blodgett Memorial Medical Center.[107] The non-profit defense – which was material but not dispositive – argued that the involvement of prominent community members on the boards of non-profit hospitals provided accountability against predatory price structuring and allowed for greater efficiencies.[108] The court agreed and acknowledged that "nonprofit hospitals operate differently in highly- concentrated markets than do profit-maximizing firms."[109] This defense has developed into five arguments enveloped in the "non-profit defense": 1) non-profit hospitals are not profit maximizers; 2) governing boards are benevolent; 3) community commitments will protect consumers; 4) price concentration data refute traditional assumptions; and 5) efficiencies will directly benefit consumers.[110]

Each of the arguments in the non-profit defense underscore the principles differentiating non-profit hospitals from the profit maximizing, non-altruistic, non-necessity-based industries that make up the intended targets of antitrust law. Because the expansion and streamlining of health care services through large networks of hospitals, healthplexes, and clinics provide purchasing power in negotiating

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103. *See* Gamble, *supra* note 49.

104. *Competition and Monopoly: Single-Firm Conduct Under Section 2 Of The Sherman Act: Chapter 1*, U.S. Dep't of Just. (2015), https://www.justice.gov/atr/competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-1#N_28_ [https://perma.cc/2L3E-TXPT].

105. *See* Groebe, *supra* note 6, at 1625–26.

106. *Id.*

107. *See* Fed. Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996).

108. *Id.*

109. *Id.*

110. Brennan & Cuomo, *supra* note 30, at 13.

discounts that can be used to pass savings along to patients, monopolization should be encouraged for the most capable non-profit hospitals.[111] Further, the essence of health care's purpose and its necessity to the community should provide non-profit hospitals the latitude to make the best possible business decisions to continue serving its community within the regulatory code. Patients are heavily protected by the health care regulations that restrain the manner in which hospitals conduct business, much like utility companies. The unique and complex fiscal challenges that face non-profit hospitals due to growing compliance burdens, dwindling reimbursement rates, and slowed growth demand a step toward allowing actions that would otherwise violate antitrust law, to the extent that they comply with the health care regulations.

To envelop these principles, the Non-Profit Institutions Act, McCarran- Ferguson Act, and public utility exceptions could be used as a baseline for creating this exception to the Sherman, Clayton, and FTC Acts. The exception would provide that in conducting the business of health care, non- profit hospitals may transact such business in any manner allowed by the health care regulations that amounts to the best interest of consumers. The "best interest of consumers" takes into account the impact of the transaction on the cost of patient care, the quality of patient care, and the availability of patient care. At the heart of any health care oversight must be the consumer. By taking the existing exceptions, existing health care regulations, and placing the interest of consumer patients at the forefront, health care business can operate more efficiently and ultimately provide better care to communities.

Conclusion

When looking at specific industries, it is important to understand who their consumers are, the necessity of their products or services, and how their products or services impact consumers. Health care becomes an obviously special industry when answering these three questions. Their consumers are patients and their products and services are of the greatest necessity on both an individual and community level.

In order to facilitate necessary service, the government always needs to be reviewing how those services are provided, monitored, and checked. Non-profit hospitals are among the most prevalent and most prestigious entities providing those services; not coincidentally, they are also some of the most regulated. These regulations are necessary to protect consumers, the government, and taxpayers from fraudulent or otherwise unscrupulous business dealings that would compromise services.

111. *Butterworth Health Corp.*, 946 F. Supp. at 1285.

While the health care regulations are necessary, they are burdensome to comply with, particularly given the dismal fiscal realities of non-profit hospitals. Given the fiscal burdens, certain business ventures have become necessary in order to survive and serve a community. Antitrust serves as an unnecessary obstacle toward this end. The complex health care regulatory code is already working to monitor the market – an idea that has been acknowledged by the courts. Changes are a necessary step to avoiding the closure of more hospitals like PVGH. Although there are certainly other obstacles, allowing for less regulation and more business freedom is a key step in the right direction.

Antitrust should expound upon its existing exceptions and those created by the courts to allow non-profit hospitals to act in a manner that allows for their survival and ultimately best serves their consumers, the government, and taxpayers. The Non-Profit Institutions Act, McCarran-Ferguson Act, and public utility exceptions could be used as a baseline for creating this exception to the Sherman, Clayton, and FTC Acts. The exception would provide that in conducting the business of health care, non-profit hospitals may transact such business in any manner that is allowed by health care regulations and maintains the best interest of consumers.