No. 11-1160

IN THE

Supreme Court of the United States

FEDERAL TRADE COMMISSION,

Petitioner,

v.

PHOEBE PUTNEY HEALTH SYSTEM, INC., *et al*.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* ECONOMICS PROFESSORS IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

Amici are professors and scholars who teach and conduct research in the areas of economics and indus-

[1] Pursuant to Rule 37.6 of the Rules of this Court, *Amici* state that this brief was not written in whole or in part by counsel for a party or any other entity. No person or entity other than *Amici* and their counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3, *Amici* state that Petitioners have granted blanket consent to the filing of briefs by *Amici* supporting either party and that Respondents have consented to the submission of this brief and their letter of consent has been filed with the Clerk of this Court.

trial organization, including, in particular, topics related to healthcare policy and competition in healthcare markets. *Amici* include David Dranove, Cory Capps, Martin Gaynor, and Robert Town, as well as Bernard Black, Timothy Bresnahan, David Cutler, Guy David, Alain Enthoven, Gautam Gowrisankaran, Deborah Haas-Wilson, Katherine Ho, Richard Lindrooth, Anthony LoSasso, Thomas McGuire, Aviv Nevo, Stephen Parente, Mark Pauly, Tomas Philipson, Uwe Reinhardt, Mark Satterthwaite, R. Lawrence Van Horn, William White, Dennis Yao, and Jack Zwanziger. A list that provides the titles and affiliations of each of these individuals appears in the Appendix. *Amici* file solely as individuals and not on behalf of any institutions with which they are affiliated. *Amici* have not been retained by any party with regard to this action.

BACKGROUND

Phoebe Putney Health System in Albany, Georgia, is operated by an independent not-for-profit company under a forty-year lease with the Hospital Authority of Albany-Dougherty County, a government entity (O.C.G.A. § 31-7-72). In 2011, Phoebe Putney Health System in Albany, Georgia, acquired its cross-town rival, Palmyra Medical Center. The Federal Trade Commission (FTC) challenged the acquisition on the grounds that it gave Phoebe Putney monopoly power that would result in consumer injury. The U.S. Court of Appeals for the Eleventh Circuit "agree[d] with the Commission that, on the facts alleged, the joint operation of [Phoebe Putney] Memorial and Palmyra would substantially lessen competition or tend to

create, if not create, a monopoly."[2] In its Brief in Opposition, Phoebe Putney did not contest the claim that the merger would give Phoebe Putney monopoly power. Instead, it argued, *inter alia*, that the merger would not injure consumers for two primary reasons:[3]

> (1) ". . . [Hospital] authority projects may not be operated for profit, and their prices must not exceed the amount necessary to cover costs and create reasonable reserves. O.C.G.A. § 31-7-77."
>
> (2) "Because of Phoebe Putney's non-profit structure and public mission, those savings would be passed on to local patients and their insurers and enable the provision of more services for elderly or indigent patients at the reimbursement rates fixed by Medicare and Medicaid." *See*, Dkt. 52-18, at 15, 18.

On June 24, 2012, the Court agreed to hear arguments from the FTC and Phoebe Putney.

THE QUESTION ADDRESSED BY THIS *AMICUS* BRIEF

In its Brief in Opposition, Phoebe Putney appears to call for special treatment under the antitrust laws because it is a nonprofit entity. This raises a simple question: should nonprofit hospitals be shielded from federal antitrust scrutiny?

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[2] *FTC v. Phoebe Putney Health Sys.*, No. 1:11-CV-58 (M.D. Ga.), 663 F.2d 1369 (11th Cir. 2011), *cert. granted*, No. 11-1160 (U.S. June 25, 2012).

[3] Brief in Opposition for Respondents Hospital Authority of Albany-Dougherty County, Phoebe Putney Health System, Inc., Phoebe Putney Memorial Hospital, Inc., and Phoebe North, Inc., at 8-9, 12.

The answer to this question is of great importance to the U.S. healthcare system. Hospital spending reached $814 billion in 2010, accounting for over 5 percent of the U.S. Gross Domestic Product, making it one of the largest industries in the U.S. economy.[4] Hospital services are sold and delivered in markets. On behalf of commercially insured patients, private health insurers paid hospitals approximately $286 billion in 2010; those patients made additional out-of-pocket payments to hospitals.[5] The prices paid for those services are determined in negotiations between hospitals and commercial health plans. That is, hospitals compete to be included in insurance provider networks and to attract privately insured patients.[6] The Medicare program fixes the prices it

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[4] U.S. Centers for Medicare & Medicaid Services, *National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010*, Table 1, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[5] U.S. Centers for Medicare & Medicaid Services, *National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010*, Table 4, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[6] *See, e.g.,* David Dranove, *The Economic Evolution of American Healthcare* (2000); DOJ & FTC, *Improving Health Care: A Dose of Competition* (2004), http://www.justice.gov/atr/public/health_care/204694.htm; Robert J. Town & William B. Vogt, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Robert Wood Johnson Found. Synthesis Project Research Rep. No. 9 (2006), http://www.rwjf.org/files/research/no9researchreport.pdf; Martin Gaynor & Robert J. Town, *The Impact of Hospital Consolidation–Update*, Robert Wood Johnson Found. Synthesis Project Research Rep. (2012), http://www.rwjf.org/pr/product.jsp?id=74582; Martin Gaynor &

pays hospitals, but Medicare beneficiaries have free choice among hospitals. Hospitals thus also compete for Medicare patients via non-price means, such as the quality of service.[7] The Patient Protection and Affordable Care Act promotes the creation of Accountable Care Organizations,[8] many of which will be organized by hospitals. It is envisioned that Accountable Care Organizations will compete for the business of both Medicare enrollees and privately insured individuals. In these and other ways, competition among hospitals is a central element of the U.S. healthcare system.

Nonprofits control approximately 69 percent of all general acute care hospitals and 78 percent of all hospital beds in the United States.[9] If the Court accepts Phoebe Putney's claims and shields nonprofits from federal antitrust scrutiny then most hospitals would be free to engage in anticompetitive conduct that would not be tolerated from for-profit firms, posing a

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Robert J. Town, *Competition in Health Care Markets*, in 2 *Handbook of Health Economics* 499-637 (2011), http://www.sciencedirect.com/science/article/pii/B9780444535924000098; Cory Capps & David Dranove, *Healthcare Provider and Payer Markets*, in *International Handbook of Antitrust Economics*, Oxford U. Press, forthcoming.

[7] Daniel P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful*, 115 Q. J. of Econ. 577-615 (2000); Martin Gaynor & Robert J. Town, *Competition in Health Care Markets*, in 2 *Handbook of Health Economics* 499-637 (2011), http://www.sciencedirect.com/science/article/pii/B9780444535924000098.

[8] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 *through* 124 Stat. 1025 (2010).

[9] American Hospital Association, Annual Survey Database for Fiscal Year 2010 (2010).

threat to the success of our market-based healthcare system.

OUTLINE OF ARGUMENTS

We make two distinct arguments. First, there is no compelling theoretical basis for an antitrust exemption for nonprofit hospitals. That is, economic theory provides no determinate conclusions regarding whether nonprofits will exploit market power if given the opportunity. As a consequence, whether there is an economic basis for more favorable treatment of nonprofit hospitals is an empirical matter. Second, there is a strong consensus in empirical research that, in general, nonprofit hospitals do exploit their market power by raising prices. This empirical evidence on the exercise of market power by nonprofit hospitals strongly suggests that they should not be exempt from antitrust scrutiny. Such an exemption would serve the private interests of nonprofit hospitals to the detriment of consumers and society as a whole.

ARGUMENT

1. THEORETICAL ARGUMENTS

Most economic analysis, including antitrust analysis, is based upon economic theory that assumes that firms maximize profits. This assumption, at first glance, seems less applicable to hospital markets, in which the majority of hospitals are owned by nonprofit entities. Indeed, some observers have questioned the application of antitrust law to nonprofit hospitals on this basis. Kopit and McCann (1998) argue that because nonprofit hospitals do not seek to maximize profits, and moreover, because nonprofits face oversight from boards of trustees drawn from the

local community, they would not increase price even if they could.[10] While Kopit and McCann make some valid points, they do not specify a complete model of nonprofit hospital behavior. They simply assume that hospitals will not take actions contrary to the interests of the community.

Economic theory only delivers such a result by assumption. Even early economic theories of nonprofit hospitals, which assumed that nonprofits do not care at all about profits, predict that nonprofit hospitals take advantage of opportunities to exercise market power. For example, Newhouse (1970) suggests that managers of nonprofits seek to maximize "prestige," which is loosely defined as some combination of size, complexity, and quality.[11] Prestige-maximizing hospitals will exploit market power by raising prices and using the resulting profits to fund facility growth and technology acquisitions. Thus, patients may be harmed if nonprofits obtain market power, particularly if the hospital's choice of size and technology is not aligned with the preferences of the community.

Philipson and Posner (2009) expand on Newhouse's model by assuming that nonprofit entities have some

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[10] Kopit and McCann also claim that "price typically is not an important element in the purchase of hospital services." To support this claim, they cite a textbook from 1983 and references therein. However, 1983 predates the explosive growth of managed care and selective contracting. William G. Kopit & Robert W. McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 20 J. of Health Pol., Pol'y and Law 137-69 (1988).

[11] Joseph Newhouse, *Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital*, 60 Amer. Econ. Rev. 64-74 (1970).

degree of "output preference"—that is, they assume that nonprofits maximize an objective function that is a weighted average of the institution's profits and its output.[12] Thus, nonprofits may care about how much service they provide to the community, but they also care about profits, because they use profits to pay for other things they care about, such as new facilities, research, and so forth.

Philipson and Posner show that competition among such nonprofit firms will only maximize social welfare if nonprofit firms have exactly the same preferences as the community. They also show that nonprofit firms will exploit increased market power by increasing prices, just as a for-profit firm would.[13] For these reasons, Philipson and Posner conclude that "the efficiency gains from antitrust policy may often be larger for nonprofit firms. Therefore, a policy of promoting competition has social value even when producers' motivations are altruistic."

Ultimately, economic theory provides no basis for any presumption that nonprofit hospitals will not exercise market power to the detriment of total or consumer welfare. In contrast, results from the empirical literature are much more definitive.

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[12] Thomas J. Philipson & Richard A. Posner, *Antitrust in the Not-for-Profit Sector*, 52 J. Law and Econ. 1-18 (2009).

[13] A nonprofit entity that values output will set a lower price than would an otherwise similar for-profit entity in order to deliver a greater quantity of services. Even so, the nonprofit will exploit market power, and the adverse effect of an *increase* in market power may well be greater for a nonprofit entity than for a for-profit entity.

2. THE EMPIRICAL EVIDENCE

There is a great deal of empirical evidence showing that hospital prices are substantially higher in concentrated markets.[14] Moreover, nearly all studies that account for ownership form find that nonprofit hospitals exercise market power by raising prices. We consider three types of evidence on nonprofit pricing.

First, there are a number of studies that directly examine the impacts of specific nonprofit hospital mergers on prices. Krishnan (2001) studies two mergers in Ohio and California and finds that prices at the merging hospitals increased more for those procedures in which the hospitals had the most market power.[15] Vita and Sacher (2001) find that prices increased subsequent to a merger of two hospitals in a concentrated market.[16] Economists retained by or working at the FTC recently produced several studies that examined price changes in the aftermath of three mergers that were not litigated (Haas-Wilson and Garmon, 2011; Thompson, 2011; Tenn, 2011).[17]

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[14] Robert J. Town & William B. Vogt, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Robert Wood Johnson Found. Synthesis Project Research Rep. No. 9 (2006), http://www.rwjf.org/files/research/no9researchreport.pdf; Martin Gaynor & Robert J. Town, *Competition in Health Care Markets*, in 2 *Handbook of Health Economics* 499-637 (2011), http://www.sciencedirect.com/science/article/pii/B9780444535924000098.

[15] Ranjani Krishnan, *Market Restructuring and Pricing in the Hospital Industry*, 20 J. Health Econ. 213-37 (2001).

[16] Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63-84 (2001).

[17] Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18

Prices unambiguously increased after two of the three mergers, and price changes after the third merger were mixed.

Second, the evidence presented in recent hospital merger cases is consistent with merging nonprofit hospitals using their increased post-merger bargaining leverage to raise prices. In retrospective analysis in the Evanston Northwestern Healthcare case, the FTC found that the merging hospitals—both nonprofits—significantly raised prices after the merger.[18] More recently, in the ProMedica case, the FTC upheld the administrative law judge's ruling that the merging nonprofit hospitals would likely raise prices post-merger.[19] This opinion, in large part, is based on historical pricing behavior of the hospitals and the testimony of managed care organizations with many years of market experience negotiating with both nonprofit and for-profit hospitals.[20] In another recent

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Int'l J. Econ. Bus. 17-32 (2011); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction*, 18 Int'l J. Econ. Bus. 91-101 (2011); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, 18 Int'l J. Econ. Bus. 65-82 (2011).

[18] *In re Evanston Northwestern Healthcare Corp.*, No. 9315, slip op. at 4-5 (F.T.C. Aug. 6, 2007), http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf ("There is no dispute that ENH substantially raised its prices shortly after the merging parties consummated the transaction . . . .")

[19] *In re ProMedica Health Sys.*, No. 9346, slip op. at 59 (F.T.C. Mar. 28, 2012), http://www.ftc.gov/os/adjpro/d9346/120625promedicaopinion.pdf ("[T]he Joinder of ProMedica Health System, Inc. and St. Luke's Hospital is likely to substantially lessen competition in the market for the sale of general acute-care inpatient hospital services to commercial health plan.")

[20] *Id*. at 35-51.

case, a federal district judge granted the FTC's request for a preliminary injunction to block the merger of two nonprofit hospitals in Rockford, Illinois.[21]

Third, a number of economic studies have constructed detailed models of competition in hospital markets and used those models to empirically examine whether nonprofits with more bargaining leverage charge higher prices. Three widely cited examples are Town and Vistnes (2001); Capps, Dranove, and Satterthwaite (2003); and Gaynor and Vogt (2003).[22] All three studies find no difference in the extent to which nonprofits and for-profits exploit their ability to raise prices. These analyses provide further, strong evidence against lax antitrust scrutiny of nonprofits.

The one exception to the finding that nonprofit hospitals exploit market power is an early study by Lynk (1995).[23] Lynk was an economist retained as an expert by the merging hospitals in a case in Grand Rapids, Michigan, *FTC v. Butterworth Health*.[24] In part, his testimony was based on a publication

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[21] *FTC v. OSF Healthcare Sys.*, No. 11 C 50344, at 44-45 (N.D. Ill. Apr. 5, 2012) ("[T]he FTC has shown that the merger would likely lead to higher prices.")

[22] Robert J. Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. Health Econ. 733-53 (2001); Cory Capps, David Dranove & Mark Satterthwaite, *Competition and Market Power in Option Demand Markets*, 34 RAND J. Econ. 737-63 (2003); Martin Gaynor & William B. Vogt, *Competition Among Hospitals*, 34 RAND J. Econ.764-85 (2003).

[23] William Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J. Law and Econ. 437-61 (1995).

[24] *FTC v. Butterworth Health Corp*., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd per curiam*, No. 96-2440 (6th Cir. July 8, 1997).

prepared in conjunction with that case that finds that prices were positively correlated with market concentration for for-profit hospitals but negatively correlated for nonprofits.

Lynk's findings, however, have been heavily criticized. Dranove and Ludwick (1999) find that Lynk's results hinged on several critical and questionable assumptions.[25] Keeler, Melnick, and Zwanziger (1999) note that the market for hospital services was evolving as a result of the growth of hospital/insurer contracting.[26] Specifically, by examining data from California spanning 1986-1994, they find that during the early years of their data, concentration and prices were negatively correlated for nonprofits, consistent with Lynk's finding. However, they find that this effect is reversed in later years: nonprofits charged higher prices in more concentrated markets.

3. EFFICIENCIES AND UNCOMPENSATED CARE

Phoebe Putney makes two specific arguments that are not directly addressed by the studies on nonprofit hospital pricing described above. First, it claims that the merger will lead to efficiencies.[27] This claim is made by nearly all merging hospitals. Yet, the empirical evidence on whether hospital consolidation

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[25] David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. Health Econ.87-98 (1995).

[26] Emmet Keeler, Glenn A. Melnick & Jack Zwanziger, *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. Health Econ. 69-86 (1999).

[27] Br. in Opp'n 12.

leads to cost savings is mixed at best.[28] The most convincing evidence shows that savings are only realized if there is true integration of functions, as opposed to simply consolidation of ownership.[29]

There is an important sense in which the evidence on cost savings is moot. The evidence on pricing presented above indicates that regardless of whether mergers lead to savings, those savings are not passed on to consumers. Therefore evidence on cost savings is irrelevant—the real question is whether nonprofit hospitals will raise prices when they gain market power through a merger. The evidence provides a clear answer of "yes" to that question—for both nonprofit hospitals and for-profit hospitals.

Second, Phoebe Putney has implied that the merger will allow it to provide more uncompensated care.[30] The empirical evidence is that this does not happen in any systematic fashion. Garmon (2009) studies hospital competition and charity care provision by hospitals in Texas and Florida from 1999 to

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[28] DOJ & FTC, *Improving Health Care: A Dose of Competition* (2004), http://www.justice.gov/atr/public/health_care/204694.htm; Robert J. Town & William B. Vogt, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Robert Wood Johnson Found. Synthesis Project Research Rep. No. 9 (2006), http://www.rwjf.org/files/research/no9researchreport.pdf. The research literature on merger efficiencies generally does not distinguish between for-profits and nonprofits. Because for-profits and nonprofits are operationally similar, it seems doubtful that one ownership structure would enjoy merger efficiencies while the other did not. Additionally, these review articles find that hospital mergers have mixed effects on quality.

[29] David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22 J. Health Econ. 983-97 (2003).

[30] Br. in Opp'n 5.

2002.[31] He finds no evidence that increased competition leads to reductions in charity care. Capps, Carlton, and David (2010) examine whether nonprofit hospitals are more likely than for-profit hospitals to offer more charity care or unprofitable services in response to a reduction in the degree of competition they face.[32] They examine data on California hospitals from 2000 to 2007 and find no difference: nonprofit hospitals do not provide more uncompensated care when they face less competition.

Even if it were the case that nonprofit hospitals with more market power both receive higher prices and provide greater levels of uncompensated care, that care would still come at the expense of other consumers who pay the higher prices directly and through reduced pay or benefits, including the possibility of losing insurance coverage entirely.[33] Moreover, in the wake of the Court's decision upholding key elements of the Patient Protection and Affordable Care Act, the number of uninsured persons is likely to shrink substantially in the relatively near future.[34] Given this, funding the provision of uncompensated

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[31] Chris Garmon, *Hospital Competition and Charity Care*, 12 F. for Health Econ. Pol'y Article 2 (2009).

[32] Cory Capps, Dennis Carlton & Guy David, *Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?* Stigler Center for the Study of the Economy and the State Working Paper No. 232 (2010).

[33] *See* Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. Labor Econ. 609, 629-31 (2006).

[34] *Natl. Fed'n of Indep. Bus.v. Sebelius*, Nos. 11-393, 11-398, and 11-400, 2012 BL 160004 (U.S. June 28, 2012), http://www2.bloomberglaw.com/public/document/Natl_Federation_of_Independent_Business_v_Sebelius_No_11393_US_Ju.

care, already a questionable rationale, is an even less compelling justification for lax antitrust scrutiny of nonprofit hospitals.

CONCLUSION

In its Brief in Opposition, Phoebe Putney essentially claims that nonprofit hospitals should receive special consideration in antitrust cases because (1) they will not use their market power to raise prices and (2) the savings that result from merger efficiencies will be used to provide additional community benefits such as uncompensated care. A review of economic theory suggests that nonprofits will not necessarily exploit their market power to benefit their community. A review of the empirical research is more sobering, leading to the following conclusions:

(1) Increases in market concentration are associated with increases in prices by nonprofit hospitals.

(2) Hospital mergers are not consistently associated with reductions in hospital costs.

(3) Nonprofit hospitals with more market power do not provide greater levels of uncompensated care.

In summary, economic analysis of Phoebe Putney's contentions offers neither a theoretical nor an empirical basis for any form of antitrust exemption or lax treatment for nonprofit hospitals. On the contrary, we conclude that a merger that gives a nonprofit hospital substantial market power is likely to harm consumers.

Respectfully submitted,

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