

Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?

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ABSTRACT

Nonprofit hospitals receive favorable tax treatment in exchange for providing socially beneficial activities. Extending this rationale suggests that nonprofit hospital mergers should be evaluated differently than mergers of for-profit hospitals because suppression of competition may also allow nonprofits to cross-subsidize care for the poor. Using detailed California data, we find no evidence that nonprofit hospitals are more likely than for-profit hospitals to provide more charity care or offer unprofitable services in response to an increase in market power. Therefore, we find no empirical justification for different antitrust standards for nonprofit hospitals, as some courts have suggested.

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I. Introduction

The health care sector is characterized by extensive government regulation, prominence of insurance, product differentiation, information asymmetries, imperfect information, externalities, rapid technological change, dominance of nonprofit hospitals, and various moral issues. Although many of these characteristics are found in other areas of the economy, the fact that health care has all of them distinguishes it from other industries (Arrow, 1963). Antitrust law is based on the premise that competition maximizes society's welfare. However, considering the distinctiveness of the health care sector, it is not surprising that the application of antitrust doctrine to this industry has been debated. Although the debate continues as to whether or not competition in health care markets promotes welfare in the same way as it does in other markets, recent years have seen a shift away from regulatory policies and towards competition. Antitrust policy toward hospitals and other providers has become much more vigorous, especially in the last three decades (Gaynor and Vogt, 2000).

Nonprofit hospitals account for roughly 70% of all hospital beds in the U.S. A debate has arisen as to whether and how this characteristic should affect the application of antitrust to health care. Neither the Sherman Act nor the Clayton Act include statutory exemption for nonprofits and the Supreme Court has held that nonprofit organizations are not exempt from the antitrust laws.¹ There is also, however, case law that holds that though the antitrust laws apply to nonprofits, they should be applied in a way that accounts for the social goals of the nonprofit firms.²

The same antitrust standards should be applied to nonprofits as to for-profit firms if competition among nonprofits maximizes welfare. However, it is not clear that this is so and therefore the appropriate antitrust standards for, say, hospital mergers are not clear. Some commentators deem that

¹ See, for example, *NCAA v. Board of Regents*, 468 U.S. 85, 100 n. 22 (1984); *American Soc'y of Mechanical Eng'rs, Inc. v. Hydrolevel Corp.*, 456 U.S. 556, 576 (1982); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 786-87 (1975).

² See *United States v. Brown University, et al.*, 805 F.Supp. 288 (E.D.Pa.1992); *U.S. v. Brown University, et al.*, 5 F.3d 658 (3rd Cir. 1993).

mergers involving nonprofits should be treated in the same way as all other mergers (e.g. Simpson and Shin, 1998; Philipson and Posner, 2009). Others argue that traditional antitrust rules should not apply to mergers involving nonprofit hospitals because these institutions are not disposed to exercise market power in the form of higher prices (e.g. Lynk, 1994).

For the most part, empirical work investigating the effect of hospital mergers on pricing finds that hospital mergers that create market power do lead to higher prices, and that this is true for both for-profit and nonprofit hospitals (Keeler, Melnick, and Zwanziger, 1999; Dranove and Ludwick, 1999; Krishnan and Krishnan, 2003; Vita and Sacher, 2003; Capps and Dranove, 2004; Dafny, 2009).³ Empirical research on the cost effects of hospital mergers generally finds that most hospital mergers lead to either no cost savings or small cost savings.⁴ Empirical research on the quality effects of hospital mergers is less well developed, but the handful of studies on this topic typically find either no effect on quality, mixed effects on quality, or small reductions in quality from hospital mergers (Ho and Hamilton, 2000; Kessler and McClellan, 2000; Sari, 2002; Gowrisankaran and Town, 2003; Capps, 2005; Gaynor, 2006).

A key question relevant to assessing hospital mergers and market power that has received little formal study to date is whether nonprofit hospitals provide greater charity care when they earn higher profits (David and Helmchen, 2006)⁵. Generally, nonprofits may exercise market power in order to produce a socially desirable outcome, such as the redistribution of wealth among different segments of the population (Carlton et al., 1995). When this occurs, the relevant policy question emerges of whether

³ Lynk (1995) finds that nonprofits do not exercise market power by charging higher prices.

⁴ Connor, Feldman, and Dowd (1998), in a study based on 1986-1994 data, find the largest cost savings from hospital mergers, about 5%. Spang, Bazzo, and Arnould (2001) extend the Connor et al. framework by comparing cost changes at merging hospitals to the changes at their nonmerging rivals and find modest cost savings. Dranove and Lindrooth (2003) find that only full hospital "mergers," in which hospitals combine licenses and merge operations, generate significant cost savings; such full mergers are a small minority of all hospital mergers and acquisitions.

⁵ Garmon (2009) studies reported charity care and concentration in Florida and Texas using data from 1999-2002 and finds no evidence that increased competition leads to reductions in charity care. One notable exception is a study of religious nonprofit primary health care facilities in Uganda found to provide more care for the poor compared with for-profit facilities as a response to government subsidies (Reinikka and Svensson, 2010).

action that achieves this result should be given any consideration under the antitrust laws. Since there is no profit incentive for a for-profit hospital to provide charity care, this question relates primarily to the antitrust treatment of nonprofit entities.⁶

It is the outcome of a political bargaining game that leads to nonprofits being used to achieve social goals. For example, in health care, various political and economic factors combine to make it such that a significant portion of the population does not have health insurance. As a result, most hospitals provide uncompensated care to a nontrivial number of patients for whom care is not affordable. In recognition of this provision of community benefits, nonprofit hospitals are granted an exemption from paying income and other taxes. Given this outcome, it would be inconsistent with public policy as reflected in the tax code to apply the antitrust law in a way that ignores the benefit of achieving social goals.

The key underpinning of the argument for favorable antitrust treatment of nonprofits is that when nonprofits have the power to elevate price to some consumers, the resulting profits are used to provide services to consumers, such as the poor, who would otherwise have inefficiently low levels of service. Other possibilities, such as opportunistic behavior by nonprofit administrators, the dissipation of rents through non-price competition, and various forms of regulatory evasion, exist. If any of these factors dominate then granting favorable antitrust treatment to nonprofits may result in deadweight loss and lost tax revenue without creating the benefits that form the rationale for the nonprofit tax exemption.

In this paper, we develop a theoretical model that demonstrates that in contrast to competition among for-profit firms, competition among nonprofits can sometimes be undesirable, thereby justifying some previous courts' findings that consideration of nonprofit status is appropriate in an antitrust analysis of

⁶ In practice, for-profit hospitals in California accounted for more than 20% of all uncompensated care. Like their nonprofit counterparts, for-profit hospitals are legally required to treat patients who require immediate medical attention regardless of their ability to pay and also may treat patients who subsequently turn out either to lack insurance or to fail to pay the out-of-pocket portion of their medical bill. All such cases are classified as "uncompensated care".

nonprofits. This means that it is an empirical question whether a particular merger or action that increases a nonprofit's market power is undesirable. We analyze this empirical question for hospitals using seven years of data on competition and charity care provision by California hospitals. Should the empirical analysis verify the theoretical possibility that less competition leads to greater levels of charity care, there would be two direct antitrust implications. First, it would confirm the need to apply a rule of reason approach to analyzing coordination among independent nonprofit hospitals in cases that would otherwise be deemed *per se* Section 1 cartel cases (e.g., an agreement among for-profit hospitals as to which services each would offer). Second, it would justify the use of different standards for nonprofit merger cases. Specifically, even if nonprofit hospitals could gain market power by merging, a full antitrust analysis would need to consider the offsetting benefits of expanded charity care provision. Our empirical results, however, provide no support for special antitrust treatment of nonprofit hospitals.

The paper is organized as follows. In section II we discuss the application of antitrust to nonprofit firms and its reflection in the provision of community benefits through cross-subsidies in the hospital industry. In section III we develop a theoretical model of the effects of competition among nonprofit hospitals, charged with achieving social goals, on welfare. In section IV, we present an empirical analysis of the charity care provision by California hospitals from 2001 to 2007 that tests the hypotheses that nonprofit hospitals that face less competition provide higher levels of charity care. Section V concludes the paper.

II. Background

Antitrust and tax treatment of nonprofits

In this section we first address the policy question of how antitrust policy is applied to the nonprofit sector, and then discuss health care specifically. The policy question is how and whether antitrust analysis should consider nonprofit market power. A nonprofit firm receives 501(c)(3) status when its

purpose is to advance certain social goals (by providing a “benefit” to its community); in return, 501(c)(3) status provides certain tax advantages to the firm and allows it to raise funds through (tax deductible) donations. The fact that nonprofits are designed to achieve certain social goals requires that antitrust pay attention to those goals, and antitrust has done so. One of the leading cases involving nonprofits, from the early 1990s, is the MIT case, in which the Antitrust Division sued MIT and the eight schools in the Ivy League under Section 1 of the Sherman Act for engaging in a conspiracy to fix the prices that students pay. The Antitrust Division claimed that the schools conspired on financial aid policies in an effort to reduce aid and raise their revenues. While the District Court’s opinion found the schools guilty of a per se offense of price fixing, the Court of Appeals found it appropriate to consider nonprofit institutions’ justifications for collective action, such as to enable the poor to attend school, under a Rule of Reason. The court thus accepted the schools’ justification for their cooperative behavior—enabling them to concentrate aid on only those in need (Carlton et al., 1995)—but did not give schools unlimited ability to raise tuition to subsidize poor students.

Another recent case regarding nonprofits involves teaching hospitals. Medical school graduates enrolled in residency programs brought a class action charging universities, medical schools, foundations and hospitals with violating Section 1 of the Sherman Act. Plaintiffs alleged that the defendants contracted, combined, and conspired among themselves to limit competition in the market for resident services and to fix and stabilize residents’ wages. In this case, courts were preempted from ruling by legislation. In April 2004, Congress passed a provision to the Pension Funding Equity Act of 2004 entitled “Confirmation of Antitrust Status of Graduate Medical Resident Matching Programs,” creating a price-fixing exemption for a certain class of antitrust claims for graduate medical education residency matching programs.⁷ This exemption highlights the relative weight placed on the efficiency of the

⁷ At its core, the provision provides that “[it] shall not be unlawful under the antitrust laws to sponsor, conduct, or participate in a graduate medical education residency matching program, or to agree to sponsor, conduct, or participate in such a program.”

matching process, in this case through the National Resident Matching Program, a nonprofit corporation, over anticompetitive effects of collusion. Congress intended to protect the Match Program and its participants from the cost of defending antitrust actions that challenge the Match Program, with the rationale that the primary mission of teaching hospitals was patient care, physician training, and medical research as opposed to standard profit maximization objectives. Of course, a more cynical explanation is that the special interests of teaching hospitals have prevailed to allow them to exploit medical residents.

Under current regulation, private nonprofit hospitals are eligible for exemptions from property, sales, and income taxes, while for-profit hospitals are required to pay these taxes. Private nonprofit hospitals have access to capital financing through tax-exempt bonds, whereas this option is not available to for-profit hospitals. On the other hand, private nonprofit hospitals do not have access to equity financing. Tax exemptions for nonprofits are (or used to be) justified by a “bargain” that was “struck between the hospital and the community: a hospital would treat patients who were unable to pay, and the government would grant a tax exemption to the hospital” (Pellegrini, 1989). Originally the IRS code defined charity as “relief to the poor,” yet after the introduction of Medicare and Medicaid, with the bulk of hospital revenue coming from private insurance and public programs, the hospital industry pushed the IRS to revise its definition of “charitable services” (Seaton and Koob, 2009). Under current federal requirements, nonprofit hospitals are expected to provide “community benefits” in return for their 501(c)(3) tax-exempt status. While the definition of “community benefits” is broader (Nicholson et. al., 2000), the provision of charity care in the form of free or reduced price services remains at the heart of the justification for tax exemptions.⁸ To date, there is no convincing answer to the question of

⁸ In a recent case the Illinois Supreme Court ruled that Provena Covenant Medical Center in Urbana, Illinois did not meet the requirements for tax exemption. The court noted that the hospital waived just 0.7% of its revenue, far less than the tax benefits it stood to receive. The court also cited Provena’s small charity pool: only 302 of the hospital’s 10,000 inpatient and 100,000 outpatient admissions involved charitable care (Sataline, 2010). Senator Grassley and colleagues have also introduced federal legislation that would impose penalties on nonprofit hospitals that do not meet a minimum requirement

whether or not nonprofit hospitals are doing enough to justify their tax exempt status (David and Helmchen, 2006). Our theoretical analysis implies that competition may reduce “community benefits,” and therefore raises the policy question of whether alternative programs (e.g., competition plus transfers) would be superior and, if so, why they are politically infeasible.

Where there is evidence that nonprofit hospitals respond to competition in ways that benefit consumers and that such benefits will be lost if competition is eliminated, courts should anticipate the possible emergence of such benefits. Price increases that occur in the wake of hospital mergers highlight the ability of hospitals to exercise market power; however, market power may very well be used to attain a socially desirable objective, such as the provision of health care to the poor. The special tax treatment for nonprofits indicates not only that society places a value on the promotion of such care but also that, rightly or wrongly, society views nonprofits as the superior mechanism for attaining that goal (David and Helmchen, 2006).

Evidence on community benefits provided by nonprofit hospitals

Uncompensated care is just one form of community benefits reported by hospitals. As reported in a recent study by the IRS (IRS, 2009), “average and median percentages of total revenues reported as spent on community benefit expenditures were 9% and 6%.” As indicated by the divergence between the average and median, the distribution of community benefits is skewed, with a relatively small portion of hospitals studied providing high levels of community benefits. Uncompensated care is only one form of community benefit; other major categories of reported community benefits are medical education and training, research, and community programs.⁹ Uncompensated care accounts for 56% of total community benefits reported by nonprofit hospitals, and the average and median percentages of

for uncompensated care provision (“Grassley Targets Nonprofit Hospitals on Charity Care,” *Wall Street Journal*, December 18, 2008).

⁹ Education and training account for 23% of reported community benefits, medical research accounts for 15%, and community programs account for 6% (IRS, 2009).

revenue devoted to uncompensated care were 7% and 4%. These measures, however, are subject to manipulation; for example, the IRS study finds a great deal of variation in how hospitals measure and report uncompensated care.¹⁰

In our study, we focus on the component of community benefits that accrues directly to the direct customers of hospitals; namely, uncompensated care. If some action (e.g., a merger or coordination with rivals) allows a nonprofit hospital to charge higher prices to the insured and also to provide more uncompensated care, then the overall effect of that action on the hospital's patients will be ambiguous. In contrast, if higher prices fund research and teaching, then those higher prices would make patients unambiguously worse off, at least in the short run. Thus, by focusing on uncompensated care, we are analyzing the overall beneficial (short run) effects on patients. Our justification for excluding medical research and education is twofold. First, existing institutions, including universities, private corporations, and the National Institutes of Health, directly fund medical research and teaching. As a result, the policy rationale for funding research and teaching via permissive antitrust treatment of nonprofit hospitals is less compelling than the rationale for funding uncompensated care in that fashion. Second, it seems clear that, absent uncompensated care, a significant portion of the population would receive inefficiently low levels of hospital care. It is not clear that the same applies to medical research and teaching.

We pose and answer a number of questions of interest: What explains the *level* of uncompensated care provided by hospitals? Is that affected by the ownership status (for-profit/nonprofit)? Do the available

¹⁰ For example, the study reports that roughly one-fifth of hospitals include as uncompensated care each of the following: "the difference between hospital charges and the amount private insurance paid or allowed for services (private insurance shortfalls); the difference between hospital charges and the amount Medicare paid or allowed for services (Medicare shortfalls); the difference between hospital charges and the amount Medicaid allowed for services (Medicaid shortfalls); and the difference between hospital charges and the amount other public insurance programs allowed for services (other public program shortfalls)." Some of these measures appear questionable. For example, including "private insurance shortfalls" in uncompensated care is subject to ready manipulation: a hospital could increase its list charges, offer managed care organizations correspondingly larger discounts, and thereby report higher levels of uncompensated care.

data indicate that some hospitals exaggerate the degree of uncompensated care they provide? Does the presence of market power increase (or decrease) the level of uncompensated care provided by hospitals? And most importantly for informing the debate regarding different antitrust treatment for nonprofit hospitals - does the effect of market power on uncompensated care provision depend on whether the hospital is a nonprofit? All hospitals regardless of ownership type are legally required to treat patients who require immediate medical attention regardless of their ability to pay. Similarly, all hospitals are exposed to patients who eventually fail to pay the out-of-pocket portion of their medical bill. Therefore, for-profits represent a natural benchmark for the amount of “uncompensated care” in the absence of special privileges (e.g. tax exemptions) premised on the provision of community benefits.

Antitrust enforcement in the hospital industry

Hospital acquisitions and mergers in 2004 involved 130 U.S. hospitals and were valued at \$9.07 billion.¹¹ Since 1980, 37 antitrust cases were brought by the U.S. Department of Justice or the Federal Trade Commission against hospitals, 17 of which were against nonprofit hospitals (Philipson and Posner, 2009).¹² The Federal Trade Commission (FTC) and the Justice Department lost a combined six consecutive cases challenging proposed mergers of hospitals in the 1990s. In some cases the courts pointed to the hospitals' nonprofit status as a reason to let mergers go through.¹³

¹¹ Bernard Wysocki Jr. “FTC Targets Hospital Merger in Antitrust Case” *The Wall Street Journal*, January 17, 2005: uses data from Irving Levin Associates Inc., a publisher of health-care data based in New Canaan, Connecticut. (<http://www.karlloren.com/healthinsurance/p32.htm>)

¹² This figure appeared in a working paper version of Philipson and Posner (2009) paper, but is not in the final, published version. In any case, the DOJ and FTC have brought many cases against hospitals, both for profit and nonprofit. See, for example, Capps et al. (2002).

¹³ For example, in the mid-1990s, the FTC fought unsuccessfully to block a Grand Rapids, Mich., hospital merger. In that case, the judge placed great weight on the hospitals' nonprofit status.

In 2005 the FTC prevailed in a trial seeking to undo the January 2000 takeover of Highland Park Hospital, in suburban Chicago, by Evanston Northwestern Healthcare Corp.¹⁴ The FTC accused Evanston Northwestern, a nonprofit corporation, of antitrust violations, alleging that it used its post-merger market power to impose significant price increases on insurers and employers. Both the trial judge and, after a *de novo* review on appeal, the five commissioners of the FTC, concluded that the merger had created market power and that Evanston Northwestern had exercised that market power. The Commission, however, reversed the trial judge's order that Evanston Northwestern divest Highland Park Hospital. Instead, the Commissioners imposed a conduct remedy specifying that Evanston and Highland Park hospitals would have to negotiate separately with insurers; the Commissioners later added a provision allowing insurers to enter into binding arbitration in the event of an impasse in price negotiations.

Hospitals in merger cases often point to efficiencies from consolidated operations, improved patient management, better access to capital, and even slowing the pace of adopting expensive technology.¹⁵ Such efficiency gains, if present, are not unique to nonprofit hospitals. Merger among nonprofits may produce additional gains. For example, Gaynor and Vogt (2000) argue that “Hospitals, particularly not-for-profit hospitals, provide a lot of charity care to indigent patients. To the extent that such care is financed out of profits, increased competition may reduce charity care” and that “charity care which is lost due to increased competition may not be replaced, due to the vagaries of politics.”

A large part of the literature deals with the lack of incentives in nonprofits to exercise market power. Blackstone and Fuhr (1992) argue that incentives for profit maximization are inherently weaker for those who manage nonprofit organizations, as they do not stand to gain from price increases.

¹⁴ *In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315, File No. 011 0234, at <http://www.ftc.gov/os/adipro/d9315/index.htm> (Accessed March 21, 2009).

¹⁵ Hospital competition was deemed wasteful as it often led to “medical arms race”, where hospitals made strategic investment in costly technologies in order to compete for patients.

Identifying nonprofits as indifferent to profits led researchers to focus on the relationship between pricing behavior of nonprofits and concentration. Lynk (1995) argues that nonprofit hospitals charge lower prices in more concentrated markets than in less concentrated markets, while for-profit hospitals charge higher prices in more concentrated markets. While his study supports favorable antitrust treatment for nonprofits, a number of subsequent studies challenged Lynk's methodology and found that nonprofits do charge higher prices in more concentrated markets (Simpson and Shin 1998; Dranove and Ludwick 1999; Keeler et al. 1999; Young et al. 2000).¹⁶ We argue that while nonprofits may have markedly weaker incentives to maximize profits, the argument identifying the lack of profit motives with a departure from exercising market power is misleading. Objectives such as maximizing quality, providing charity care, and/or operating unprofitable services may all require the ability to exercise market power.

Courts, following the lead of economists, typically regard a reduction in competition as a result of a merger as undesirable. Yet, if competition interferes with nonprofits' ability to engage in socially desirable activities, such a general presumption would be inappropriate. The tension between the favored treatment of nonprofits under the tax code (presumably to achieve social objectives) and their treatment under antitrust laws creates a conceptual dichotomy, which is important to mend, one way or another. If indeed society assigns a value to the achievement of certain goals through the nonprofit sector and this value exceeds the loss of revenue from tax exemptions, courts ultimately have to face the complex and difficult task of evaluating the positive achievement of certain social goals against negative competitive effects of mergers where nonprofits are involved.

¹⁶ Dranove and Ludwick (1999) point to methodological flaws in Lynk's work, mainly the endogeneity of market share and the need to control for quality and severity, which can explain both high prices and high concentration.

III. Theory

A recent paper advanced a theory in which altruistic nonprofit producers exhibit some degree of “output preferences,” that is, they derive utility directly from output in addition to profits. The authors recognize the differences between the nonprofit organization’s utility and the utility in the absence of altruism, but show that competition still maximizes society’s surplus (Philipson and Posner, 2009). The authors recommend an antitrust doctrine that does not distinguish between the for-profit and the nonprofit sectors. We show that their result vanishes once one allows nonprofits to have a slightly more general objective function than the one postulated in their paper.

The key insight that Philipson and Posner identify is that if an altruist has an output preference, then competition among altruists, just like competition among profit-maximizing firms, will generate the “correct” marginal pricing conditions—if we assume that the social welfare function values consumption in the same way as the altruist. For example, if α represents the additional value that the altruist attaches to everyone’s health consumption, then $p = c - \alpha$ is the optimal pricing condition, where p is the price and c is marginal cost. But for this pricing condition to represent optimality, it must also be the case that such marginal pricing will lead to financial viability for the firm. However, even in the simplest constant returns to scale model, this cannot be true unless the altruist has a private source of wealth to subsidize the consumption of the poor, as Philipson and Posner assume. Conversely, if the sole source of funds must come from the revenue of the nonprofit firm rather than from the rich altruist, then it must be the case that the financing constraint will matter.¹⁷ Therefore the ability to exercise market power is a critical ingredient needed to provide funds to pay for health care. In addition, the altruist in the Philipson and Posner model values the health care consumption of everyone at α . A slight modification is to allow the altruist to value the health care consumption of different

¹⁷ In essence, we are ruling out the ability of the altruist to levy lump sum taxation on the public.

individuals differently. For illustration, suppose that the altruist thinks that rich people can afford a minimal level of health care consumption, but poor people cannot. Hence, the altruist values health care consumption of rich people at zero and that of poor people at α .¹⁸ These two changes to the Philipson and Posner model – the one involving the need to finance the hospital and the other the altruist’s differential valuation of health consumption of the rich and the poor - alter their conclusion.

Our point is not that our assumptions are necessarily superior to theirs but rather that their strong conclusion does not survive even minor changes to their model’s assumptions. Only an empirical analysis can resolve the issue of the proper role of antitrust in evaluating nonprofits.

Two implications follow from our modifications. First, if the financing constraint matters (as would be the case if the altruist is not the source of funds), then the creation of market power through merger may benefit society because the elimination of competition relaxes the financing constraint. Second, in order for the market power to be exercised so as to generate funds to be used to subsidize the health care consumption of the poor, the firm must be able to charge differential prices to the rich and the poor.¹⁹ Without this ability, the transfer from the rich to the poor could not occur. But competition makes such price discrimination difficult since with differential pricing, hospitals (even nonprofits) will want to poach its rivals’ profitable customers and this erodes the ability to exercise market power against profitable customers. Let us now turn to a model to illustrate these points.

Consider first the case of for-profit firms when there is no special value attached to the consumption of health care by the poor. Hence if α represents the additional value that society places on each unit of consumption by the poor, then $\alpha = 0$. In this case there is no reason to have nonprofit firms and no reason to use 501(c)(3) status. Let $\hat{c}(q_1, q_2)$ be the hospital’s cost function for providing q_1 units to the

¹⁸ By and large, the need to access charity care is discrete (patients either have insurance or they don’t)

¹⁹ While many of the uninsured are not poor, for simplicity, we use the terms “rich” and “poor” to denote the patients that are paying above competitive rates and the patients who are benefitting from cross-subsidization.

rich and the q_2 units to the poor. Assume for simplicity that $\hat{c}(q_1, q_2) = \hat{F} + \hat{c} \cdot (q_1 + q_2)$. Suppose $\hat{F} = 0$; in this case competition among firms will maximize social welfare, as usual. For $\hat{F} > 0$, if the firms play Bertrand, as Sutton has shown, there is no stable equilibrium if there is more than one hospital (Sutton, 1991). If instead competition is less intense than Bertrand (e.g. Cournot), there is a stable equilibrium with non-negative profits for a neighborhood of \hat{F} around 0, for any number of rivals. For this case, a merger that reduces the number of competitors definitely harms consumers because prices rise to both groups with no offsetting benefits. It is precisely for this reason that antitrust forbids mergers that only reduce competition.

Consider now a nonprofit hospital which receives 501(c)(3) status as a reflection of society's desire to increase health care among the poor (i.e., the involuntarily uninsured).²⁰ Hansmann (1987) finds that "tax exemption offers nonprofit firms a significant advantage in establishing market share vis-à-vis for-profit firms offering similar services." This is not surprising as the nonprofit status contains a subsidy that can be used to achieve such social goals. Similar to David (2009) we allow nonprofit hospitals access to lower costs, such that $c(q_1, q_2) = F + c \cdot (q_1 + q_2)$, where $\hat{F} > F$ and $\hat{c} > c$, which may be thought of as exemptions from property taxes and income taxes respectively. These cost advantages are assumed sufficient in our analysis for an "altruist" to always organize as a nonprofit.

Suppose that the social welfare function reflects that "society" values health care consumption by the poor above what the poor value it for themselves and the "altruist" hospital reflects the values of the social welfare function towards the poor. There is the entirely separate issue that the "altruist" may not faithfully represent society's values.²¹ An important distinction between our objective function and that

²⁰ This fits the original IRS definition of charity-care requirements, which state that a nonprofit hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered" (Seaton and Koob, 2009).

²¹ With no restrictions on raising funds the social planner could theoretically use non-distortionary lump sum taxes to support hospitals and charity care. In our analysis, the social planner is assumed realistically to face some limits on the use of

used by Philipson and Posner is that our altruist cares about only consumption by the poor, not total consumption. This seemingly minor change accounts for our different theoretical results. That social value is reflected by α , the additional value society places on consumption by the poor.²²

Suppose that competition between rival hospitals is Bertrand, with competition of even two hospitals guaranteeing that price reflects marginal social cost. It immediately follows under Bertrand competition between two altruists that

$$P_1 = \frac{\partial c}{\partial q} = c \quad \text{and} \quad P_2 = \frac{\partial c}{\partial q} - \alpha = c - \alpha,$$

where α is the assumed altruist's (and society's) extra benefit when the poor receive health care, and P_1 and P_2 are prices to the rich and poor respectively.

Since $c(q) = F + c \cdot q$ and $F > 0$ there is a natural monopoly element to hospital care as marginal cost pricing will not cover cost.²³ Moreover, even if $F = 0$, the optimality conditions related to the altruistic parameter α guarantee that profits are negative at the socially optimal pricing, since the price to the poor is below c . The following proposition states this result formally.

Proposition 1. With Bertrand competition between rival hospitals, the equilibrium cannot produce the socially optimal outcomes in which each hospital remains financially viable for $c(q) = F + c \cdot q$ and $F > 0$.

If competition is not as strong as Bertrand (e.g. Cournot), there would then be a positive margin earned on the rich and this could provide a source of financing for the poor. But the point is that competition for the rich limits the ability to finance healthcare for the poor.

lump sum taxation and therefore does face a hospital financing constraint, and hence restricts competition, allowing the price to the rich to rise in order to generate profits to provide medical care for the poor.

²² If nonprofits have no desire to subsidize care for the poor, allowing them the ability to set prices above marginal cost will not aid in achieving this desired social goal.

²³ In addition, when $c(q)$ is not homogenous of degree 1 in q , marginal cost pricing may not cover cost.

Now consider a merger to monopoly. The merger allows P_1 to be set above c , generating funds that can be used to subsidize the poor, subject to a zero-profit constraint. The nonprofit monopolist's altruist problem is

$$\begin{aligned}
 & \text{Max}_{P_1, P_2} \alpha \cdot \int_{P_2}^{\infty} q_2(x) dx \\
 (1) \quad & \text{s.t. } P_1 q_1 + P_2 q_2 - c \cdot (q_1 + q_2) - F = 0 \\
 & P_1, P_2 \geq 0
 \end{aligned}$$

where α again reflects society's (and the altruist's) valuation of health consumption by the poor. The altruist channels producer surplus generated in the rich market to maximize consumer surplus for the poor. The social planning problem is to maximize the social welfare function subject to zero-profits of the hospital and can be written as:

$$\begin{aligned}
 & \text{Max}_{P_1, P_2} \int_0^{q_1(P_1)} [P_1(x) - c] dx + \int_0^{q_2(P_2)} [P_2(x) - c + \alpha] dx \\
 (2) \quad & \text{s.t. } P_1 q_1 + P_2 q_2 - c \cdot (q_1 + q_2) - F = 0 \\
 & P_1, P_2 \geq 0
 \end{aligned}$$

The solution to the nonprofit altruist's problem (1) is:

$$\left(\frac{P_1 - c}{P_1} \right) = \frac{1}{\varepsilon_1} \text{ and } P_2 = \max \left\{ c - \frac{(P_1 - c) \cdot q_1 - F}{q_2}, 0 \right\}$$

This solution says that the altruist charges the monopoly price to the rich in order to maximize the funds (i.e. $(P_1 - c) \cdot q_1 - F$) that can subsidize the health consumption of the poor. Note that α does not enter the nonprofit monopolist's pricing rule. A unique price-quantity pair for the poor is determined solely by the funds generated in the rich consumers market. Note that our analysis is not altered by the presences of insurance, which ultimately weakens the relationship between prices and quantity demanded. The more generous the insurance coverage is, the more inelastic the demand for rich (insured) patients. Insurance, in essence, leads to less distortion from cross-subsidization. In the extreme case, with zero co-payment (i.e. full insurance), demand is perfectly inelastic. And while this would, in turn, imply no quantity effects for the insured, a merger to monopoly will still allow the

hospital to generate surplus that can then be used to cross-subsidize care for the uninsured. (This extreme case is equivalent to the case where the social planner can use lump sum taxation.)

The solution to the social planner's problem in (2) is a (modified) Ramsey pricing solution:

$$\left(\frac{P_1 - c}{P_1} \right) = \frac{\mu}{\varepsilon_1}, \quad \left(\frac{P_2 - (c - \alpha)}{P_2} \right) = \frac{\mu}{\varepsilon_2} - \frac{\mu \cdot \alpha}{P_2},$$

where $\mu = -\frac{\lambda}{1 + \lambda}$ and λ is the Lagrange multiplier related to zero profits and ε_i is the elasticity of demand for group i . Notice how the social planner pays attention not only to the transfer to the poor (i.e. the amount by which P_2 exceeds $c - \alpha$), but also to the markup on rich individuals (i.e. the amount by which P_1 exceeds c).

Assume for illustration purposes that the demand for health care by the poor is zero at a price of c . Comparing the nonprofit altruist monopoly problem to that of the social planner, it is clear that the (modified) Ramsey pricing solution to (2) will differ from (1). In (1), the nonprofit monopolist pays no attention to the distorting effects of a high P_1 on the health consumption of the rich, and therefore will raise P_1 above the socially optimal level.²⁴ For (1), the optimal solution is to set P_1 at the monopoly price and use all the profits to cover F and the remainder to subsidize consumption of the poor. In contrast, the social planner will trade off the negative deadweight loss caused by monopoly pricing to the rich against the social external gain associated with each additional unit of consumption by the poor. In general, the "altruist" harms the rich more than is socially desirable in order to serve the poor. This leads directly to proposition 2.

²⁴ Note that $\lambda > 0$ leads to $\mu < 1$, which in turn, means that the nonprofit altruist will charge the rich a price P_1 that exceeds the price set by the social planner.

Proposition 2. When $c(q) = F + cq$ and $F > 0$, the exercise of market power is necessary in order for the poor to consume health care. The rich subsidize the poor. The altruist, nonprofit monopolist, however, charges the rich too much and underprices health care to the poor relative to the social optimum.

Figure 1 illustrates this idea. $P_1^D = P_2^D = c$ is the single Bertrand duopoly price, which leads to the exclusion of the poor from receiving services. P_1^M and P_2^M are the prices set for the rich and the poor under the altruist monopoly. Positive profit margins in Market 1 (i.e. $q_1^M \cdot (P_1^M - c)$) are necessary for cross-subsidization across groups. Independent of any social weights, the altruist behaves as a monopoly in Market 1 and will set P_2^M below c , which leads to the delivery of services to the poor where the private value of their consumption is below marginal cost (when $q > q^*$ in the right hand-side panel of Figure 1).

The disadvantage of treating nonprofits like for-profits under the antitrust laws is that the poor are underserved if mergers that create market power are not allowed because market power is needed to generate funds to cross-subsidize the poor. The disadvantage of giving nonprofits an exemption from antitrust is that the rich are overcharged even relative to the social optimum, which recognizes the external benefit of consumption by the poor. In the extreme case, merger to monopoly may lead to a decrease in welfare when the loss in consumer surplus resulting from the price increase in Market 1 (area L) coupled with the deadweight loss due to underpricing services for the poor (area D) is greater than the surplus generated for consumers in Market 2 (area G). Since the choice to serve the poor does not by itself constitute a net increase in welfare, in order to justify a merger that suppresses competition from a social stand point, we need (1) sufficiently high value placed by society on consumption by the

poor and (2) sufficiently inelastic demand for healthcare services for the rich patients, which in turn, limits the distortion from cross subsidization.²⁵

The simple theme of this theoretical section, then, is that competition does not produce the socially desirable outcome even when a nonprofit altruist is ordered to follow a “social preferences” to favor the poor. The process of competition limits the ability to price discriminate and to cross-subsidize. Where cross-subsidization is necessary to achieve social optimality, as it typically is when one relies on 501(c)(3) organizations to achieve social goals, competition simply does not necessarily produce the socially desirable outcome.

Indeed, the acquisition of market power is a necessary (but *not* sufficient) condition for cross-subsidization to fund care for the poor. Further establishing that market power is, if not fully a sufficient condition, at least generally associated with greater provision of care to the poor by nonprofit hospitals, would constitute a compelling argument in favor of special antitrust treatment of nonprofits. With respect to non-merger matters, a "special antitrust treatment" would entail rule of reason analyses under which courts trade-off consumption by the rich and the poor (that is, conduct that would be condemned on a per se basis in the for-profit sector should be judged on a rule of reason basis in the nonprofit sector). With respect to mergers (which are never judged on a per se basis), a "special antitrust treatment" would, similarly, consider not just prices and surplus in the market for the rich but also trade-off consumption by the rich and the poor.

Appendix A provides a more detailed welfare analysis for the case of linear demand curves, illustrating how a merger of nonprofit hospitals can increase social welfare by suppressing competition.

²⁵ Note that moral hazard due to insurance coverage will contribute to lowering the demand elasticity for the rich patients.

IV. Empirical analysis of uncompensated care, nonprofit status, and market power

As noted above, market power is a necessary, but not sufficient, condition for the uninsured to receive care when nonprofit hospitals face a financing constraint. In general, the link between market power and uncompensated charity care will depend on the nonprofit hospital's objective function. While it is entirely possible that nonprofit hospitals will direct profits from insured patients towards care for the uninsured, other possibilities, such as opportunistic behavior by nonprofit administrators, the dissipation of rents through possibly inefficient non-price competition, and various forms of regulatory evasion, are also plausible.²⁶ Accordingly, whether and to what extent nonprofit hospitals with market power use profits from the insured to cross-subsidize care for the uninsured is an empirical question. This section studies the interrelationship between changes in charity care provision, within hospitals, and variation in market concentration and competition, for different types of hospitals.

We use a 7-year panel of data on California hospitals from 2001 through 2007. The data set combines financial information, including revenue, profit, and two dollar measures of uncompensated care provision from the California Office of Statewide Health Planning and Development (OSHPD) Hospital Financial Disclosure Reports with concentration measures derived from the OSHPD Patient Discharge data bases. We also use the discharge data to construct an alternative measure of uncompensated care based on the volume of care provided to uninsured patients.

Measuring charity care

Both for-profit and nonprofit hospitals provide substantial amounts of uncompensated care (CBO, 2006). When the hospital approves in advance free or discounted care, such care is considered charity

²⁶ In 2008, the *Wall Street Journal* published two critical articles questioning whether nonprofit hospitals were providing sufficient levels of uncompensated care or whether they were satisfying their nondistribution constraints via high compensation and excess capital spending. See Carreyrou (2008) and Carreyrou and Martinez (2008).

care, and will likely appear in a hospital's financial data as a deduction from revenue under the category of "charity care." In many cases, a hospital may realize after the fact that the care it provided was partially or entirely uncompensated care. Such care is also accounted for as a deduction from revenue (similar to the accounting treatment of contractual discounts), but is commonly allocated to "bad debt."²⁷ The majority of uncompensated care in California is actually accounted for as bad debt rather than charity care. More generally, hospitals and hospital systems vary in how they allocate uncompensated care into charity care and bad debt. As a result, the sum of charity care and bad debt is likely the more reliable dollar-denominated measure of uncompensated care (CBO, 2006; David and Helmchen, 2006). In the analysis below, we focus both on reported charity care and uncompensated care (charity care plus bad debt).

The value of uncompensated care reported in hospitals' financial statements may overstate the market value and the cost of uncompensated care. Charity care and bad debt are commonly computed using the list prices for services as reflected in each hospital's chargemaster. However, in practice, hospitals rarely if ever receive payment equal to their list charges. Private insurers commonly negotiate discounts under which actual payments may be 40-60% below list prices. Medicare payments are typically below private rates, and Medicaid rates are usually lower still. The uninsured are often billed full list charges, but they rarely actually pay those bills, which will be reflected in the high levels of bad debt.

This is likely to lead to biased estimates of charity care provision when inflation of and discounting from list charges are not constant across hospitals. As a result, hospitals that have higher list charges may appear to provide more uncompensated care than hospitals with lower list charges.²⁸ Cross-sectionally, the bias would be particularly severe if hospitals with more market power have a greater ability or propensity to inflate their list charges. Such tendencies, to the extent that they are time-

²⁷ See, for example, the discussion in Missouri Foundation for Health (2005).

²⁸ See note 10, above.

invariant, are diminished by the inclusion of hospital fixed-effects in the econometric analysis. Nevertheless, there still remains the concern that the within-hospital co-movement of charity volume and price is responsive to the dynamics of competition. For example, hospitals in markets experiencing consolidation may use their market power to raise list prices without allocating more resources to enhancing the volume and type of uncompensated care provided.

To focus on the effect on charity volume, we construct a third measure of charity care provision that is based on the *volume* of inpatient service provided to uninsured patients. Each year, the Centers for Medicare and Medicaid Services (CMS) computes and publishes DRG “weights.” From 2001 to 2007, the set of inpatient services hospitals offer were divided into roughly 550 Diagnosis Related Groups (DRGs). CMS determines weights for each DRG based upon regular surveys of hospitals for information on the cost of treating a typical patient in each DRG. The weights reflect the relative cost of treating patients in a particular DRG—for example, a patient in a DRG with a weight of 4 is four times as costly on average to treat as a patient in a DRG with a weight of 1. The volume based measure of care provided to various sets of patients that we analyzed below (e.g., Medicare, Medicaid, privately insured, uninsured. . .) is computed as the sum of the DRG weights for all patients in a given payer class. The three measures are defined in Table 1.

Figure 2 presents histograms describing the distributions of the three charity measures. Since larger hospitals are expected to provide higher nominal and physical rates of charity, measures of charity are divided by the number of staffed beds for each hospital. Charity measures, adjusted for size, appear to follow a log normal distribution.

Figure 3 presents statewide yearly trends in charity care, bad debt, and charity volume. Both charity care and uncompensated care (the sum of charity care and bad debt) doubled between 2001 and 2007.

Charity volume, on the other hand, grew by just 17.8% over the same period.²⁹ This indicates that the growth in charity care and uncompensated care is driven by increases in both charges and patient volume, but more so the former.

Measuring competition

Computing traditional concentration measures such as the HHI or four-firm concentration ratio requires pre-specifying the geographic areas within which to compute market shares. Commonly used geographic units of analysis, such as counties or metropolitan statistical areas (MSAs), are, in the context of hospitals, not based on market demand conditions and do not take into account the set of available choices or the actual choices of patients. As a result, imposing such arbitrary market definitions may overstate or understate the true size of the market and generate spurious conclusions about the degree of competition faced by hospitals or produce a measure of concentration that has so much measurement error that it would be impossible to identify any relationship between concentration and charity care or market power.

To avoid this problem, we use an alternative measure of competition that does not require specifying any geographic market or market boundaries (this measure is similar to that used in Kessler and McClellan (2000)). Our competition measure is constructed as follows. In the first step, we calculate the standard HHI based on observed patient shares within each unique zip code and Major Diagnostic Category (MDC) combination (which we call a “micromarket”) pair, taking joint ownership into account.³⁰ All hospitals that treat patients in a given MDC-zip code pair are part of this HHI

²⁹ Over this same period, the under-65 population of California grew by 3.4%, from 31.2 million to 32.3 million; the size of that group that is uninsured held steady at approximately 6.5 million (<http://www.census.gov/hhes/www/hlthins/historic/hihist6.xls>). The increase in measured charity volume exceeds the growth in the uninsured population.

³⁰ Because we focus on acute care hospitals, for the purpose of measuring competition, we exclude MDCs 19 (psychiatric care) and 20 (alcohol and drug related admissions), which are also provided by standalone psychiatric hospitals and addiction treatment centers, respectively. Additionally, these services are used disproportionately by the uninsured population and are considered unprofitable; therefore, they are not likely to contribute to or reflect the formation of market power. In order to avoid double-counting labor and delivery admissions, we also exclude DRG 391, the DRG for a normal newborn.

calculation, so we do not impose any market boundaries (except insofar as we use data only from the state of California). In the second step, each hospital's HHI is computed as the weighted sum of micromarket HHIs, where the weight is the share of that hospital's patients that originate from each zip code-MDC combination.

In general, hospitals that draw patients from more concentrated zip codes and more concentrated service lines will have higher hospital-level HHIs. The higher a hospital's HHI, the weaker is the competitive pressure that it faces. Therefore, not surprisingly, a number of studies have demonstrated that this modified HHI is a good predictor of hospital prices, indicating that it is also a good measure of a hospital's or hospital system's market power (Gruber, 1994; Keeler, Melnick, and Zwanzinger, 1999; Dranove and Ludwick, 1999; Capps and Dranove 2004).³¹

Formally, the measure of the degree of competition faced by each hospital, $Hosp-HHI_j$, is defined as follows:

$$(3) \quad Hosp-HHI_j = \sum_{z=1}^Z \sum_{m=1}^M \left(\frac{\text{Hosp. } j\text{'s patients from zip } z \text{ and MDC } m}{\text{Hosp. } j\text{'s total patients}} \right) (HHI_{z,m})$$

$HHI_{z,m}$ is the typical HHI, computed as the sum of squared market shares among patients from zip code z with a diagnosis in MDC m . $HHI_{z,m}$ is calculated after combining the shares of hospitals that are jointly owned.

Using this measure of competition addresses the problems raised by pre-specifying a geographic market within which to measure competition. However, the $Hosp-HHI$ is still theoretically subject to endogeneity (e.g., hospitals' prices determine their market share and thus the HHI, and prices may also

³¹ Kessler and McClellan (2000) noted, correctly, that this competition measure is likely endogenous and proposed constructing the hospital-level HHIs using the predicted values from a discrete choice model that includes only exogenous right hand side variables (rather than observed market shares) to compute the HHI in each micromarket. In practice, estimating 7 years of logit models for the state of California is impractical and, as noted, the simpler measure based on observed micromarket shares is an effective predictor of hospital pricing.

affect the provision of charity care). Kessler and McClellan address this issue by substituting for the observed shares within each microsegment the predicted shares from a choice model that uses only exogenous factors (e.g., distance and age) as predictors. This approach is less practical in the current setting because, while Kessler and McClellan compute their concentration measures for heart attack admissions only, we study all acute care inpatient admissions.³²

We view the concern as minimal. Primarily, this is because, due to the presence of insurance, the majority of the hospital population faces no variation or very modest variation in prices across in-network hospitals (the same is true of the uninsured, who typically do not pay their inpatient hospital bills). As a result, market shares and HHIs will be affected by prices only to the extent that variation of such prices in our data determine whether hospitals are included in or excluded from insurers' networks.

This distinction was discussed in detail in Vistnes (2000), who described hospital competition as a “two stage” process. In the first stage, hospitals and insurers negotiate pricing and determine network structure. In the second stage, hospitals compete for patients primarily on the basis of non-price factors.³³ Additionally, Capps, Dranove, and Satterthwaite (2003) show that insurers have an incentive to assemble expansive hospitals networks. Conversely, most hospitals have at least some excess capacity and would find it profitable at the margin to enter agreements with as many insurers as possible. This explains why, in practice, most managed care networks include most hospitals.³⁴ Price, therefore, serves primarily to divide the gains from trade between hospitals and insurers (and the insurers' customers).

³² Compared to the data in Kessler and McClellan, our data encompass roughly 20 times as many patients per year and span seven years rather than four.

³³ The trial judge in the Evanston case described above adopted this model of competition in reaching his decision that Evanston Northwestern Healthcare's acquisition of Highland Park Hospital had resulted in anticompetitive price increases. “Initial Decision of Chief Administrative Law Judge Stephen J. McGuire,” *In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, No. 9315 (Federal Trade Commission October 21, 2005).

³⁴ This was less true in the 1990s, when HMOs were both more common than PPOs and tended to feature narrower networks. By the end of the 1990s, consumers had largely rejected narrow networks, and HMOs began offering broader networks (which PPOs had always offered). See Draper et al. (2002) and Ginsberg (2005).

The direct effect of price on patients' choices of hospitals is minimal, so we do not think endogeneity poses a problem in this context. We also explore a sensitivity analysis that replaces the all-patient hospital-HHIs with the hospital-HHIs derived from just those patients in traditional Medicare. The hospitalization decisions of Medicare enrollees are unlikely to be affected by network restrictions (virtually all hospitals accept Medicare), pricing, or market power (Medicare prices are regulated).

Data overview

Table 2 presents summary statistics describing the time path of the number of hospitals, beds, utilization, financial information, and charity care provision from 2001-2007, separately for nonprofit, for-profit, and government hospitals. Over the sample period, the number of nonprofit hospitals declined by 10% and the number of for-profit hospitals declined by 24%. The bulk of this decline occurred after 2003 and was likely related to the requirement that hospitals complete seismic retrofitting by 2006 (some hospitals closed or converted to other uses rather than retrofit; Chang and Jacobson, 2008). Average net income among for-profit hospitals also began a marked decline in 2004. Average net income among nonprofit hospitals, however, increased steadily over the sample period.

Average discharges at the surviving hospitals increased over time, consistent with the decline in the number of hospitals. The average number of beds increased only slightly over time, since exiting hospitals were smaller than average; therefore the growth in discharges per hospital was primarily the result of higher utilization of existing beds rather than the addition of new beds.³⁵

The middle three rows in each panel contain the annual averages of three measures of charity care. The first row contains reported charity care; the second contains uncompensated care; and the third

³⁵ The average exiting hospital had 101.6 beds while the average surviving hospital (i.e. hospitals appearing in every year of our sample) had 194.2 beds.

contains the volume of service measure of charity care.³⁶ At nonprofit hospitals, all three measures grew rapidly over the sample period. Notably, as indicated in Figure 3, the volume-based measure of charity care grew at a much slower rate than either of the two dollar-based measures of charity care. This suggests that some portion of the increase in measured charity care reflects factors other than increasing levels of uncompensated inpatient care. As discussed above, this could result from increases in list charges, decreases in reimbursement for some types of insured patients, or accounting practices that incorporate expenditures not directly related to patient care, such as medical research and teaching, into the reported charity care measures. Government hospitals reported growing levels of charity care and bad debt, but did not provide an increasing volume of inpatient care to the uninsured and indigent (as we show below, however, the *level* of inpatient care government hospitals provide to the uninsured, is high relative to their scale and revenue).

Figure 4 charts average hospital trends by ownership type for each of the three measures of charity provision. The left hand-side panel includes row means while the right hand-side panel tracks measures of intensity by dividing each charity measure by the number of staffed beds and averaging it across hospitals within ownership type. All charity measures for the average nonprofit hospital in our sample have risen over time (left hand-side panel). When adjusting for hospital size, the growth among nonprofit hospitals is more modest. For-profit hospitals, due to their relatively smaller scale, have the highest rates of charity care and uncompensated care per bed. Government hospitals provide a disproportionately high amount of charity volume, both in absolute terms and per bed; however, government hospitals have been found to be less efficient compared to private ones (Douglas, Currie, and Simeonova 2010). Nonprofit hospitals provided only slightly more charity volume compared to their for-profit counterparts and that conclusion depends upon whether one adjusts for size.

³⁶ The patient discharge data contain 10 different payer categories. This measure is constructed as the sum of DRG case weights provided to patients for whom the expected payer is either “County Indigent Programs,” “Other Indigent,” or “Self Pay.”

Summary statistics for scale measures, concentration, and the three charity measures, are presented in Table 3. Three Hospital-HHI measures are also summarized: the first is derived from the full sample of patients, the second is based only on privately insured patients, and the third is calculated based only on Medicare patients. Our primary analysis relies on the first measure; results described in the sensitivity analysis below discuss reasons for considering these alternative measures and establish that our results are robust to alternative ways of computing our concentration measure.

The final column in Table 3 shows that over the full sample period, nonprofit hospitals actually account for a disproportionately *low* share of total charity care provision. Despite accounting for 65% of beds, 66% of discharges, and 69% of revenue, nonprofit hospitals account for 63% of charity care and bad debt and only 51% of the total volume of inpatient service provided to the uninsured. Perhaps surprisingly, for-profit hospitals actually account for a disproportionately large amount of charity care measured in dollars, though the same is not true for the volume measure. Relative to their overall scale, government hospitals provide a particularly large volume of inpatient care to the uninsured—over one-third of the total volume of care provided to the uninsured is provided by government hospitals. This finding is consistent with a 2006 CBO report that reported that the average cost of uncompensated care as a share of hospitals' operating expenses is much higher at government hospitals (13.0 percent) than at either nonprofit hospitals (4.7 percent) or for-profit hospitals (4.2 percent).

As suggested by the theoretical section above, the disproportionately low level of charity care provided by nonprofit hospitals could be the result of competitive pressures that preclude charging prices to insured patients that are sufficiently high to facilitate cross-subsidizing uncompensated care. However, Table 3 also shows that nonprofit hospitals on average face less competition than for-profit hospitals. Moreover, while the degree of competition faced by for-profit hospitals has increased slightly over time (the average hospital-HHI for for-profits fell from 2,807 in 2001 to 2,647 in 2007), the degree of competition faced by nonprofit hospitals remained roughly unchanged over the sample period.

Results

The basic regression model posits that charity care measure m is a function of the degree of competition faced by a hospital and other potential control variables $W_{j,t}$ such as patient mix (e.g., uninsured patients living near a given hospital) or local demographics (e.g., income, urban/rural area):

$$\ln(\text{Charity})_{j,t}^{(m)} = \alpha_0 + \alpha_j + \beta_{\text{Type}(j)} \text{Hospital_HHI}_{j,t} + \gamma W_{j,t} + D_t + \varepsilon_{jt}.$$

The coefficient on the measure of market power, $\beta_{\text{Type}(j)}$, captures the extent to which hospitals with more market power provide more (or less) charity care. To identify potentially differing propensities to provide more charity care for a given level of market power, we allow the coefficient on the concentration measure to vary according to the ownership status of hospital j . That is,

$\beta_{\text{Type}(j)} = \beta_{NFP} + \beta_{FP} * \mathbb{1}[FP_j = 1] + \beta_{Govt} * \mathbb{1}[Govt_j = 1]$ ($\mathbb{1}[\cdot]$ is the indicator function, which equals 1 if the argument is true.) Given this specification, the test of whether, relative to for-profit hospitals, nonprofit hospitals provide more charity care as they face less competition reduces to a test of whether $\beta_{FP} < 0$.

We explore two sets of models in the baseline analysis. The first is a set of cross-sectional and fixed effect models, presented in Table 4, which are robust to correlations between unobserved time-invariant hospital-specific factors and the error term. However, to the extent that the provision of charity care is related to time-invariant hospital characteristics (e.g., teaching status, ownership status, scale) or factors that are not available on an annual basis (e.g., income of the surrounding area), fixed effects regressions cannot identify potentially important determinants of the provision of charity care. Therefore, we also perform a set of cross-sectional regressions that include a wider set of hospital and area characteristics (presented in Table 5).

The hospital characteristics included in the full controls specifications include ownership type, teaching status, discharges, and an indicator for rural hospitals. Area characteristics are computed at the hospital service area (HSA) level and include the median income in each HSA, the 18-65 population, total population, the poverty rate, and the percentages of hospitalized residents that lack insurance and that have private insurance.³⁷ The variables describing the payer mix within each HSA are derived from the hospital discharge data and so vary over time; accordingly, these are included in both sets of models.

Our cross-sectional results are presented in the upper panel of Table 4. In the model without ownership interactions, the coefficient estimates on hospital-HHI are positive and statistically significant for all charity measures. Adding ownership interactions reveals our key finding, namely that there is no statistically significant difference between nonprofit and for-profit hospitals in terms of the relationship between concentration and charity care, uncompensated care, and charity volume. If anything, for-profit hospitals on average provide more charity care than nonprofit hospitals as they face less competition. Government hospitals provide less charity volume in more concentrated markets, but higher levels of charity and uncompensated care.

When hospital fixed-effects are included (lower panel of Table 4) the statistical significance of the relationship between the provision of charity care and concentration disappears. Importantly, just as before, there is no evidence that the effect is greater for for-profit hospitals than for nonprofit hospitals.

An intermediate case between the upper and lower panels of Table 4 is presented in Table 5, where instead of hospital fixed effects the regression is saturated with hospital-level and market-level characteristics. As in the less saturated cross-sectional specifications, there is a significant relationship

³⁷ HSAs are defined by the Dartmouth Atlas Project and are computed as collections of zip codes “whose residents receive most of their hospitalizations from the hospitals in that area.” See <http://www.dartmouthatlas.org/faq/data.shtml>. For demographic data from the Census, HSA averages are calculated as population-weighted averages of the zip code level means. There are 215 HSAs in California that contain hospitals.

between concentration and the charity volume. But there is, again, no statistically significant difference in the effect of concentration on the provision of charity care between for-profit and nonprofit hospitals.³⁸

In terms of levels of charity volume, when compared to nonprofit hospitals and controlling for size, for-profit hospitals provide lower charity volume, though the difference is not statistically significant.³⁹ This finding calls into question the special treatment that nonprofit hospitals receive under the tax code. Government hospitals provide substantially higher charity volume than both nonprofit and for-profit hospitals and the differences are statistically significant.

As highlighted in the theoretical model, cross-subsidization is achieved through increases in price for insured individuals. To evaluate this mechanism, and as a basic check of the reasonableness of the market power measure, we replace our dependent variable from Table 5 with price measures. We analyze two price measures: (1) a severity adjusted overall price and (2) a price index based on conditions (DRGs) treated at a broad set of hospitals. The results are presented in Table 6. We find that our concentration measure (Hosp-HHI) is positively related to prices, though the relationship is not significant when hospital fixed effects are included.⁴⁰

Teaching hospitals may provide slightly more charity care under the first two dollar-denominated measures and they provide significantly more charity volume than nonteaching hospitals. Rural

³⁸ Government hospitals' charity volume is either less sensitive to or negatively related to the degree of competition faced by the hospital. That is, government hospitals appear to provide less charity care in more concentrated markets. This is an interesting result that we leave for future research.

³⁹ The difference is statistically significant for *uncompensated care*, which is the sum of charity care and bad debt. As we note above, dollar measures of charity care will be inflated by higher list prices and also depend on idiosyncrasies in hospital's accounting practices.

⁴⁰ For details on the construction of the price indexes, see Appendix D.

hospitals have higher levels of charity and uncompensated care (after controlling for size), but provide less charity volume.⁴¹

Sensitivity analyses

One potential concern is that the measure of competition, the Hosp-HHI, may be endogenous. Kessler and McClellan (2000) noted, correctly, that this competition measure is likely endogenous and proposed constructing the hospital-level HHIs using the predicted values from a discrete choice model that includes only exogenous right hand side variables (rather than observed market shares) to compute the HHI in each micromarket. As noted above, this is impractical in the current analysis. As an alternative approach, we construct a version of the Hosp-HHI that is based solely on patients covered by Traditional Medicare (i.e., Fee-for-service Medicare). Medicare patients have essentially unfettered choice of hospitals and, because Medicare pays rates that are set administratively, Medicare patients also face little if any price variation across hospitals. Therefore, hospitals' shares among Medicare patients are very unlikely to be affected by hospital market power or pricing.⁴² As shown in Appendix B, the results under this alternative measure of concentration are very similar to those under the baseline concentration measure.⁴³

⁴¹ As expected, larger hospitals have higher levels of uncompensated care and charity volume but, as evidenced by the coefficient on the log of total discharges being close to 1, the effect is roughly proportional to scale. The coefficient on discharges is very close to 1 based for the charity volume measure and is further above 1 for the other two measures.

⁴² However, hospitals' shares of Medicare patients in various microsegments is an imperfect proxy for the preferences of privately insured patients.

⁴³ Potential omitted variables, such as unobserved hospital quality, raise concerns with regard to obtaining unbiased estimates of β_{FP} . If patients can observe changes in quality (even to a limited extent), hospitals with increasing quality are likely to attract more insured and uninsured patients, resulting in both greater market share and more uncompensated care. Therefore, not controlling for hospital quality could result in a bias towards finding a positive relationship between market power and uncompensated care, even when using hospital fixed effects. Similarly, consolidation that results in fewer hospitals would lead to an increase in the number of uninsured patients seen by all hospitals, especially those patients that require emergency care. This somewhat mechanical effect would again suggest finding a positive correlation between market power and uncompensated care. However, we find little or no evidence of such an effect. Moreover, since we are interested in whether the relationship varies by type of ownership, it is not obvious that our estimate of such variation would be biased even if quality is endogenous.

We also considered the possibility that some service lines may be intrinsically unprofitable and also highly concentrated, in which case the apparent “concentration” may in fact be the provision of a community benefit. As a first note, our analysis focuses on acute inpatient care and so our concentration measure excludes two services, psychiatric care and rehabilitation, often cited as unprofitable.⁴⁴ The acute care service lines most often cited as unprofitable include trauma care, burn care, the emergency department, neonatology, and, to a lesser extent, labor and delivery.⁴⁵ Even among these services, however, privately insured patients are likely to be profitable. To explore whether we may be conflating concentration in unprofitable service lines with market power, we also estimate versions of the same models using the Hosp-HHI as constructed only from privately insured patients. The results are very similar to those under the baseline concentration measure and the Medicare-derived measure.⁴⁶ (We revisit unprofitable services below.)

Finally, we also considered the possibility that the results are driven primarily by cross-sectional variation rather than within-hospital variation over time. To address this, we estimate the model using only hospitals that are in the bottom and top 25% of the distribution of changes in the Hosp-HHI from the beginning to the end of the sample.⁴⁷ As shown in Appendix C, the results under this restricted sample support our previous finding that nonprofit hospitals do not provide more charity volume as they face less competition. One distinction between these results and those based on all hospitals is that in the “large HHI change” specifications that include HRR fixed effects and that exclude rural hospitals, the baseline relationship between concentration and charity volume is not statistically significant. This suggests that the estimated positive relationship reported earlier between concentration and charity volume in the full sample is primarily driven by cross-sectional variation

⁴⁴ See McClellan 1997, Horwitz and Nichols 2009, and Lindrooth et al. 2010

⁴⁵ Note that visits to the emergency department (ED) are not recorded as inpatient care; only if an ED patient stays overnight, that patient would typically be admitted to the hospital and treated as an inpatient admission.

⁴⁶ These tables are omitted but are available upon request.

⁴⁷ 25% of hospitals had a decrease in the Hosp-HHI of 237 or more and 25% of hospitals had an increase in the HHI of more than 108. The former would correspond to a firm with a share of roughly 22% splitting into two firms; the latter would correspond to a merger of two firms with shares of roughly 7% each.

rather than time series variation. Accordingly, we are skeptical that increases in concentration will generally result in greater provision of charity care for either nonprofit or for-profit hospitals. And there is no evidence, in these or prior specifications, that charity care provision by nonprofit hospitals is more responsive to reductions in competition than provision by for-profit hospitals.

As a final check of our basic result that nonprofits do not increase charity volume as they face less competition, we examine changes in the travel patterns of insured and uninsured patients to hospitals that were in the top 25% of changes in the hospital-HHI. For these hospitals, the average travel time of privately insured patients increased by roughly 16% from 2001 to 2007 (from about 20.5 minutes in 2001 to 24 minutes in 2007). This indicates that hospitals that gained market power drew insured patients from a broader area (as opposed to business stealing from nearby rivals). However, there was no corresponding increase in the average travel time of uninsured patients, which remained at 23.5 minutes.⁴⁸ That increased market power does not lead to a hospital drawing uninsured patients from a broader area suggests that there is a relatively fixed volume of uninsured patients that hospitals tend to accept, irrespective of their market power.

Unprofitable Services

It is possible that nonprofit hospitals use their profits to provide services that are unprofitable, even if they are not disproportionately provided to uninsured patients. As noted above, hospital services commonly cited as unprofitable include psychiatric care, rehabilitation, the emergency department, trauma services, burn care, neonatology, and labor and delivery (McClellan, 1997; Horwitz and Nichols, 2009; Lindrooth et al., 2010). Offerings of these services by ownership type are presented in Table 7. It is clear from this table that nonprofit and government services are the most common providers of these services. However, as shown in the pattern of results relating concentration to the probability of a

⁴⁸ Similar findings emerge when looking at the upper tail of the travel time distribution. For example the 90th percentile of travel time increased by 27% (from 41.2 to 52.3 minutes) for privately insured patients and by less than 2% for the uninsured (from 48 to 48.9 minutes).

hospital offering each of these services (see Table 8), nonprofits are no more likely to offer these services as competition falls than are for-profit hospitals. Specifically, these services are generally more likely to be provided by hospitals in more concentrated markets. However, this effect is not confined to nonprofit hospitals and, for two services—trauma care and burn care—the effect of concentration on the probability of providing these unprofitable or less profitable services appears stronger for for-profit hospitals.

V. Conclusion

Our theoretical model suggests that the welfare implications of the suppression of competition through mergers will depend on the social value placed on increasing consumption of favored groups, industry profitability, and the link between market concentration and charity care provision. In particular, we show that cross-subsidization facilitated by market power may increase welfare. If the underlying premise—that nonprofit hospitals use profits from private paying patients to fund care for the uninsured—is borne out empirically, this would indicate a fundamental inconsistency between the tax laws, which offer nonprofits favorable treatment in exchange for community benefits, and the antitrust laws, which do not similarly favor nonprofits.

Our empirical analysis of 2001-2007 data on competition and charity care provision by California hospitals offers no support for this premise. We find no evidence that nonprofit hospitals are more likely than for-profit hospitals to provide more charity care in response to an increase in market concentration. We also test whether nonprofit hospitals facing less competition are more likely to offer unprofitable services and again find no significant differences between nonprofit and for-profit hospitals. Our results therefore provide no justification for applying a different antitrust standard to nonprofit hospitals than to for-profit hospitals.

Political pressures are emerging that could ultimately force nonprofit hospitals to provide more uncompensated care in order to retain their nonprofit status. Should such pressures prove effective, the potential benefit of higher pricing to some in order to subsidize care to the poor by nonprofit hospitals may need to be revisited. Even in that case, there may be more efficient ways of serving the indigent and uninsured than to rely on hospitals' local market power (e.g. expanded or universal health care coverage). Funding indigent care via local market power is a second best solution, at best.

Recent healthcare reform legislation is set to dramatically decrease the reliance on free care provision by hospitals to uninsured individuals, though that expansion is not scheduled to begin until 2014. This raises the broader issue of the role of nonprofit hospitals in providing benefits to their communities under near-universal health care coverage and, in particular, the diminished need to use tax exemptions to facilitate the delivery of care to the poor. While shortfalls from public payers could necessitate the use of cross-subsidization, the rationale for granting tax exemptions to nonprofit hospitals may grow even weaker should insurance coverage expand. In this paper, we focus on charity care, and find no basis for justifying the tax exemption of nonprofits since they appear not to provide any higher levels of charity care than for-profits. Nevertheless, charity care is one of potentially many dimensions of community benefit, and therefore, justification for tax exemption would have to rest on the provision of other community benefits.

If the goal is to resolve the tension between the tax laws and the antitrust laws, eliminating the tax exemption for nonprofit hospitals may be more appropriate than modifying antitrust policy.

References

- Almond, Douglas, Janet Currie, and Emilia Simeonova, "Public vs. Private Provision of Charity Care? Evidence from the Expiration of Hill-Burton Requirements in Florida" NBER Working Paper No. 15798, 2010
- Arrow, K. J., "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review*, 941-973, 1963.
- Blackstone E. A., and J.P. Fuhr. "An Antitrust Analysis on Non-Profit Hospital Mergers." *Review of Industrial Organization* 8(4): 473-490, 1992.
- Capps, C., "The Quality Effects of Hospital Mergers." Working Paper, 2005.
- Capps, C. and D. Dranove, "Hospital Consolidation and Negotiated PPO Prices." *Health Affairs* 23, no. 2 (2004): 175-181.
- Capps, C., D. Dranove, S. Greenstein, and M. Satterthwaite, "Antitrust Policy and Hospital Mergers: Recommendations for a New Approach." *Antitrust Bulletin*. 47(4): 677-704, 2002.
- Carreyrou, J. "Nonprofit Hospitals Flex Pricing Power". *Wall Street Journal*, August 28, 2008, <http://online.wsj.com/article/SB121986172394776997.html>, accessed March 21, 2009.
- Carreyrou, J. and B. Martinez, "Nonprofit Hospitals, Once For the Poor, Strike It Rich," *Wall Street Journal*, April 4, 2008, <http://online.wsj.com/article/SB120726201815287955.html>, accessed March 21, 2009.
- Carlton D. W., G. E. Bamberger, and R. J. Epstein, "Antitrust and Higher Education: Was There a Conspiracy to Restrict Financial Aid?" *The RAND Journal of Economics*, 26(1): 131-147, 1995.
- Chang Y., T. and M. Jacobson, "What is the Mission of a Not-for-Profit Hospital: Evidence from California's Seismic Retrofit Requirements." MIT, 2008.
- Congressional Budget Office (CBO), Nonprofit Hospitals and the Provision of Community Benefits. The congress of the United States, Congressional Budget Office, Publication No. 2707, December, 2006.
- Connor R. A.; Feldman R. D.; Dowd B. E., "The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices." *International Journal of the Economics of Business*, Volume 5, Number 2, 1 July 1998 , pp. 159-180(22).
- Dafny, Leemore, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *Journal of Law & Economics*, forthcoming.
- David, Guy "The Convergence between Nonprofit and For-Profit Hospitals in the United States." *International Journal of Health Care Finance and Economics*, Vol. 9(4), pp 403-428, December 2009.
- David, Guy and Lorens, A. Helmchen "Are Tax Exemptions for Nonprofit Hospitals an Efficient Way to Fund Indigent Care? An Uncertain Prescription" *Regulation* Vol. 29, No. 2, Summer 2006.
- Dranove, D. and R. Lindrooth, "Hospital consolidation and costs: another look at the evidence," *Journal of Health Economics* 22 (6): 983-997, 2003.
- Dranove D., and R. Ludwick, "Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis" *Journal of Health Economics* 18(1): 87-98, 1999.
- Draper, D. et al., "The Changing Face of Managed Care," *Health Affairs* 21(1): 11-23, 2002.
- Garmon, C. (2009), "Hospital Competition and Charity Care." *Frontiers in Health Policy Research*, forthcoming.

- Gaynor, M., "What Do We Know About Competition and Quality in Health Care Markets?" NBER Working Paper No. 12301, June 2006.
- Gaynor M, and W. B. Vogt, "Antitrust and Competition in Health Care Markets" 1406-43, in Newhouse, J. and A. Culyer, eds., Handbook of Health Economics, New York, NY: Elsevier Science, 2000.
- Ginsburg, P., "Competition in Health Care: Its Evolution over the Past Decade," *Health Affairs* 24(6): 1512–22, 2005.
- Gruber, J. (1994), "The Effect of Competitive Pressure on Charity: Hospital Responses to Price Shopping in California," *Journal of Health Economics*, v38, pp.183-212.
- Gowrisankaran G. and R. Town, "Competition, Payers, and Hospital Quality." *Health Services Research*. 38(6, part 1): 1403–21 (2003).
- Hansmann, H. "The effect of tax exemption and other factors on the market share of nonprofit versus for-profit firms." *National Tax Journal*, 40, 71–82, 1987.
- Ho V., and B. Hamilton, "Hospital mergers and acquisitions: does market consolidation harm patients?" *Journal of Health Economics*, 19(5): 767-791 (2000).
- Horwitz, Jill and Austin Nichols. "Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives." *Journal of Health Economics*, 28(5): 924-37, 2009.
- Internal Revenue Service, "IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report," at <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html> (Accessed March 21, 2009), 2009.
- Keeler, E. B., G. Melnick, and J. Zwanziger, "The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior" *Journal of Health Economics* 18(1): 69-86 1999.
- Kessler D, McClellan M., "Is Hospital Competition Socially Wasteful." *Quarterly Journal of Economics* 115(2): 577–615 (2000).
- Krishnan, R. and H. Krishnan, "Effects of hospital mergers and acquisitions on prices." *Journal of Business Research* 56(8): 647-656 (2003).
- Lindrooth, Richard C., Tamara Kontetzka, Jingsan Zhu, Wei Chen, and Kevin Volpp, "Trends in the Generosity of Medicare Hospital Payment: 1997-2005", working paper (2010)
- Lynk, W. J., "Property Rights and the Presumptions of Merger Analysis." *Antitrust Bulletin* 39: 363-383; 1994.
- Lynk, W. J., "Nonprofit Hospital Mergers and the Exercise of Market Power" *Journal of Law and Economics* , 38(2): 437-461, 1995.
- McClellan, Mark, "Hospital Reimbursement Incentives: An Empirical Analysis" *Journal of Economics and Management Strategy*, 6(1): 91-128, 1997.
- Nicholson, Sean, Mark V. Pauly, Lawton R. Burns, Agnieszka Baumritter, and David A. Asch, "Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals," *Health Affairs* 2000; November/December: 168-177.
- Pellegrini, D., "Hospital Tax exemption: A Municipal Perspective." *Frontier of Health Services Management*, Vol. 5: 44–46, Spring 1989.
- Philipson T. J., and R. A. Posner, "Antitrust in the Not-For-Profit Sector", *Journal of Law and Economics*, 52(1): 1-18, 2009.

- Reinikka, Ritva and Jakob Svensson, "Working for God? Evidence from a change in financing of not-for-profit health care providers in Uganda" *Journal of the European Economic Association* (forthcoming 2010)
- Sari, N., "Do Competition and Managed Care Improve Quality?" *Health Economics* 11(7): 571-584, 2002.
- Sataline, Suzanne, "Illinois High Court Rules Nonprofit Hospital Can Be Taxed" *Wall Street Journal* 03-19-2010
- Schmalensee, R., "Output and Welfare Implications of Monopolistic Third-Degree price Discrimination." *American Economic Review*, 71: 242-247, 1981.
- Simpson, J., and R. Shin, "Do Nonprofit Hospitals Exercise Market Power?" *International Journal of the Economics of Business* 5(2): 141-157, 1998.
- Seaton, Lynnore and Beth C. Koob, "Tax-exempt Hospitals and Community Benefit" *The Health Lawyer*, 21(5): 37-43, 2009.
- Stensland, Jeffrey, Zachary R. Gaumer, and Mark E. Miller, "Private-Payer Profits Can Induce Negative Medicare Margins" *Health Affairs* 29(5); 1-7, 2010.
- Sutton, J., Sunk costs and Market Structure. The MIT Press, Cambridge, Massachusetts, 27-43, 1991.
- Vita, M. and S. Sacher, "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study." *The Journal of Industrial Economics* (49(1): 63-84, 2003.
- Vistnes, G., "Hospitals, Mergers, and Two-Stage Competition." *Antitrust Law Journal*, 67: 671-692, 2000.
- Young, G., K. R. Desai, and F. J. Hellinger, "Community Control and Pricing Patterns of Nonprofit Hospitals: An Antitrust Analysis" *Journal of Health Politics, Policy and Law* 25(6); 1051-1081, 2000.

Figure 1: Graphical analysis of cross-subsidization: Bertrand duopoly versus monopoly

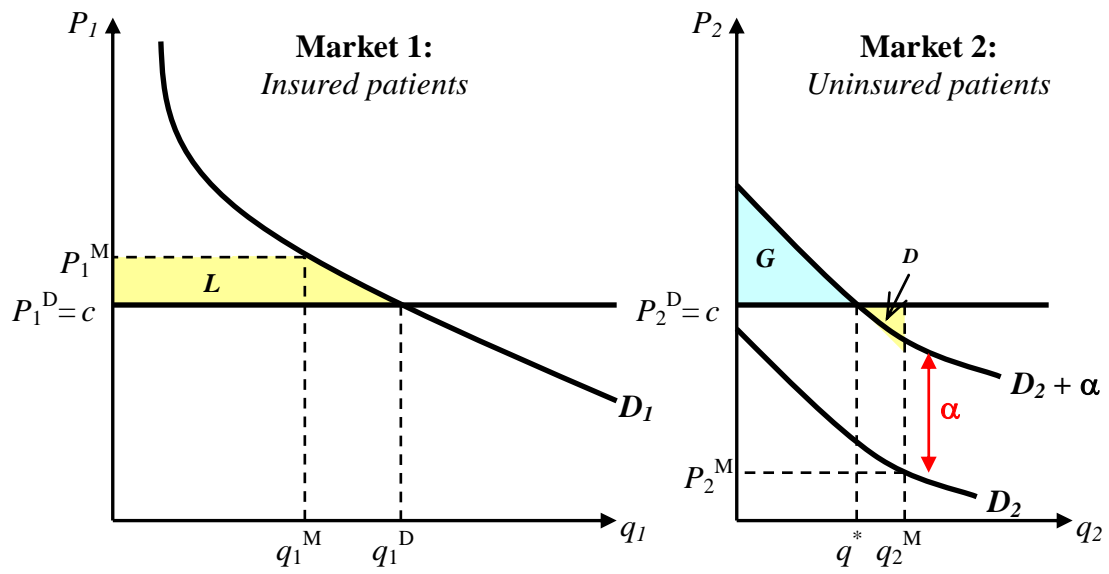
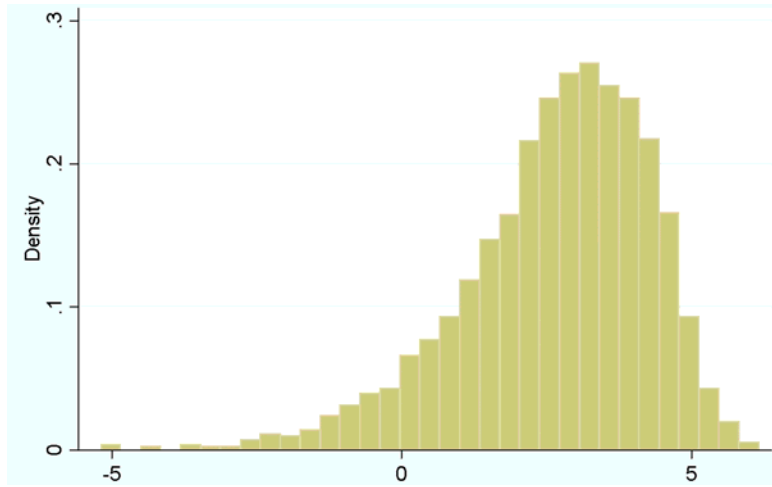
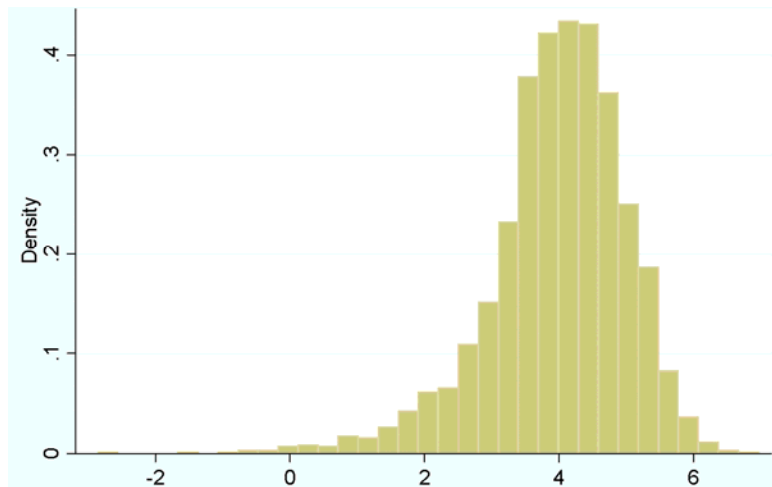


Figure 2: Histograms of Charity Measures (per number of staffed beds)

Ln (Dollars of Charity Care per staffed bed)



Ln (Dollars of Uncompensated Care per staffed bed)



Ln (Charity Volume per Staffed Bed)

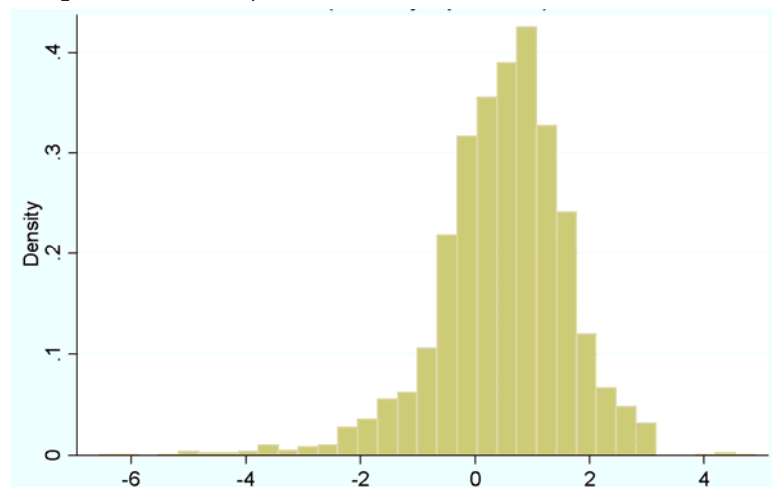


Figure 3: The Growth of Charity Care, Bad Debt, and Charity Volume, 2001 – 2007

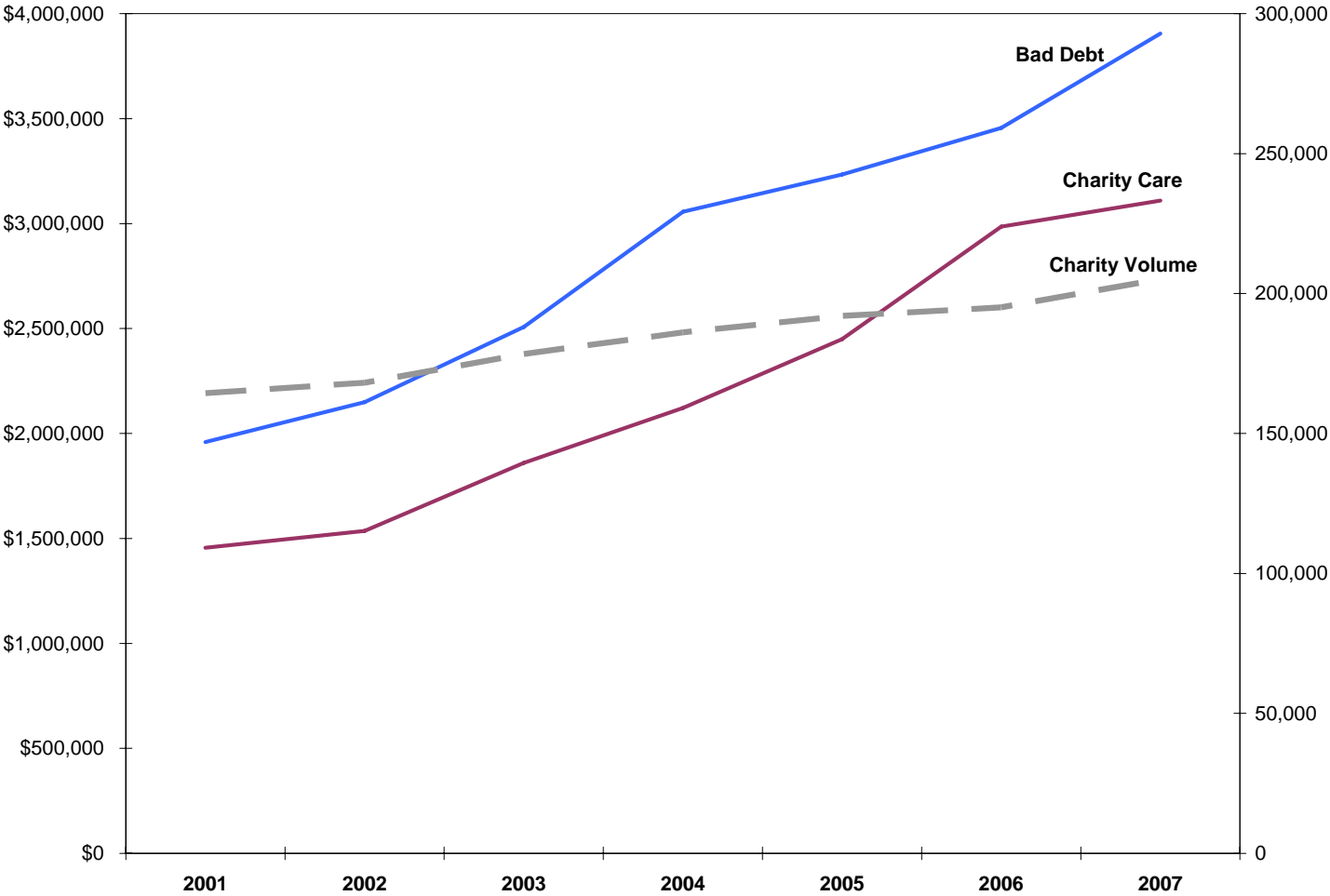


Figure 4: Average hospital trends for the three charity measures, 2001-2007

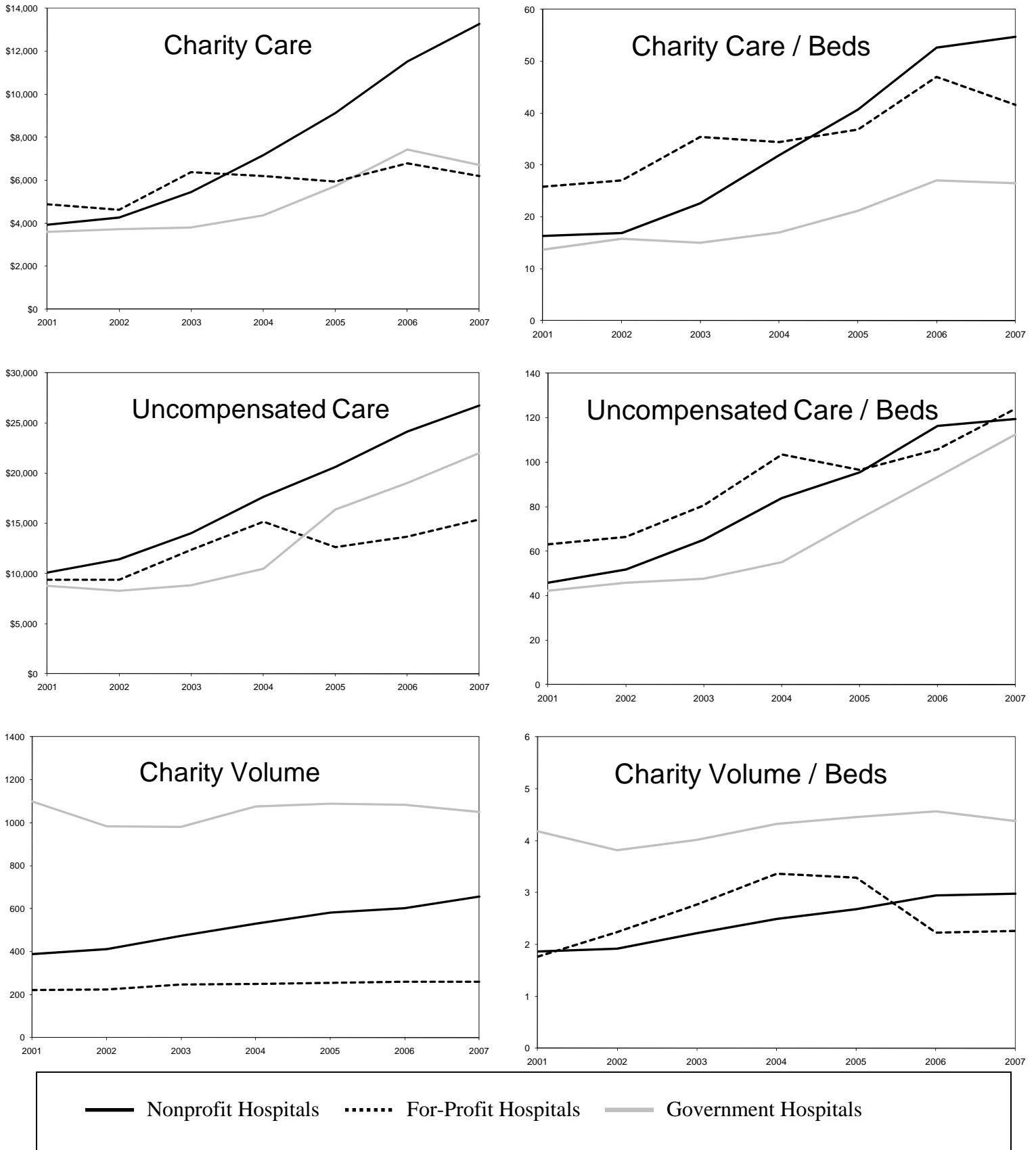


Table 1: Measures of Charity Care

Measure	Definition	Limitations
Charity Care	Reported Dollar amount for charity care	<ul style="list-style-type: none"> • Represents forgone charges, not incurred expenses or forgone revenue • Reporting variation across hospitals (some hospitals include only services for which the hospital does not expect to be compensated, while others include Medicare and Medicaid shortfalls, teaching and research, and even private payer shortfalls relative to list charges)
Uncompensated Care	Reported charity care + bad debt	<ul style="list-style-type: none"> • Represents forgone charges, not incurred expenses or forgone revenue • Reporting variation across hospitals • Bad debt may not indicate charitable intentions and could be a reflection of poor management practices • Bad debt may be generated from insured patients
Charity Volume	“DRG units” of care provided to uninsured/self-pay patients	<ul style="list-style-type: none"> • Does not reflect fixed investments in facilities • Based solely on inpatient data • Does not account for quality of care • Reflects cost of services, which is only a proxy for the quality of services

Table 2: Summary data for California hospitals by ownership type and year, 2001-2007

Control Variable		2001	2002	2003	2004	2005	2006	2007
Nonprofit	N	222	223	216	210	202	201	195
	Beds - staffed	207	212	216	218	223	218	224
	Discharges	9,686	9,608	10,272	10,696	11,223	11,235	11,582
	Gross IP Rev (\$1000s)	\$249,125	\$287,655	\$357,980	\$419,681	\$488,255	\$539,063	\$603,897
	Net income (\$1000s)	\$5,028	\$6,393	\$7,196	\$7,145	\$10,886	\$15,737	\$19,751
	Charity (\$1000s)	\$3,928	\$4,268	\$5,451	\$7,171	\$9,115	\$11,513	\$13,262
	Charity + Bad debt (\$1000s)	\$10,099	\$11,392	\$13,992	\$17,646	\$20,638	\$24,153	\$26,721
	Charity: DRG measure	387	413	475	530	583	602	656
	Hospital-HHI: Full sample	3,746	3,793	3,770	3,722	3,768	3,787	3,786
	Hospital-HHI: Private	3,823	3,849	3,790	3,708	3,718	3,764	3,768
	Hospital-HHI: Medicare	4,783	4,798	4,884	4,879	4,942	4,994	5,029
For-profit	N	92	95	93	87	81	75	70
	Beds - staffed	134	132	141	138	133	139	132
	Discharges	5,998	6,065	6,458	6,244	6,592	7,195	6,909
	Gross IP Rev (\$1000s)	\$208,330	\$251,399	\$310,400	\$308,008	\$325,405	\$361,742	\$362,401
	Net income (\$1000s)	\$6,952	\$7,710	\$8,290	(\$1,180)	\$910	\$718	\$762
	Charity (\$1000s)	\$4,892	\$4,618	\$6,366	\$6,198	\$5,930	\$6,785	\$6,204
	Charity + Bad debt (\$1000s)	\$9,377	\$9,357	\$12,327	\$15,142	\$12,653	\$13,675	\$15,388
	Charity: DRG measure	222	223	246	251	254	259	259
	Hospital-HHI: Full sample	2,850	2,828	2,800	2,828	2,726	2,713	2,639
	Hospital-HHI: Private	2,842	2,826	2,795	2,899	2,741	2,718	2,719
	Hospital-HHI: Medicare	3,698	3,650	3,618	3,660	3,548	3,582	3,473
Government	N	64	68	68	63	64	64	65
	Beds - staffed	148	140	143	155	156	152	153
	Discharges	6,726	6,236	6,485	7,042	7,160	7,256	7,314
	Gross IP Rev (\$1000s)	\$137,114	\$147,141	\$168,574	\$197,188	\$215,932	\$232,279	\$246,463
	Net income (\$1000s)	\$20,500	\$18,344	\$20,035	\$22,035	\$26,554	\$3,993	\$4,691
	Charity (\$1000s)	\$3,595	\$3,720	\$3,789	\$4,378	\$5,739	\$7,428	\$6,705
	Charity + Bad debt (\$1000s)	\$8,794	\$8,279	\$8,844	\$10,499	\$16,395	\$19,009	\$21,985
	Charity: DRG measure	1,099	982	980	1,075	1,088	1,084	1,051
	Hospital-HHI: Full sample	4,138	3,973	4,002	3,935	3,855	3,887	3,849
	Hospital-HHI: Private	4,148	4,087	4,133	4,022	4,033	3,986	3,950
	Hospital-HHI: Medicare	5,034	4,788	4,923	4,953	4,817	4,837	4,839
Medical care CPI (2001 = 100)		100	104.69	108.91	113.67	118.48	123.24	128.69

Table 3: Scale and charity provision by ownership type, full sample period

	Control Variable	Mean	S.D.	Min	Max	% of Total
Nonprofit (Hospital x Years = 1472)	Beds - staffed	217	158	12	911	65.20%
	Discharges	10,704	7,974	27	48,664	66.20%
	Net patient rev. (\$1000s)	\$170,003	\$189,012	\$1,810	\$1,467,459	69.10%
	Charity	\$7,695	\$13,728	\$ -	\$126,227	63.10%
	Charity + Bad debt	\$17,673	\$21,345	\$ -	\$183,617	62.60%
	Charity: Volume measure	520	677	-	4,778	51.50%
	Hospital-HHI: Full Sample	3,780	1,588	1,526	8,523	
	Hospital-HHI: Private	3,775	1,492	1,707	8,852	
	Hospital-HHI: Medicare	4,910	1,608	1,709	9,189	
For-profit (Hospital x Years = 587)	Beds - staffed	137	88	2	434	18.90%
	Discharges	6,509	4,450	134	20,065	18.60%
	Net patient rev. (\$1000s)	\$79,112	\$69,809	\$909	\$405,639	14.80%
	Charity	\$5,861	\$10,273	\$ -	\$82,052	22.20%
	Charity + Bad debt	\$12,478	\$14,872	(\$3,260)	\$118,556	20.40%
	Charity: Volume measure	245	256	-	1,741	11.20%
	Hospital-HHI: Full Sample	2,765	1,229	1,385	7,905	
	Hospital-HHI: Private	2,798	1,101	1,574	7,689	
	Hospital-HHI: Medicare	3,598	1,241	1,165	8,551	
Government (Hospital x Years = 446)	Beds - staffed	152	142	15	737	16.00%
	Discharges	7,019	8,244	51	44,559	15.20%
	Net patient rev. (\$1000s)	\$113,010	\$158,624	\$2,490	\$994,627	16.10%
	Charity	\$5,146	\$16,620	\$ -	\$173,952	14.80%
	Charity + Bad debt	\$13,631	\$31,028	\$ -	\$376,573	16.90%
	Charity: Volume measure	1,073	2,109	-	17,173	37.30%
	Hospital-HHI: Full Sample	3,950	1,321	1,628	7,320	
	Hospital-HHI: Private	4,054	1,501	1,979	10,000	
	Hospital-HHI: Medicare	4,896	1,341	1,930	8,750	

Table 4: Cross-sectional and fixed effects results, log-log specifications

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
	No ownership interactions [A]			Ownership interactions [A]			Payer mix controls [B]		
	Charity Care	Uncomp. Care	Charity Volume	Charity Care	Uncomp. Care	Charity Volume	Charity Care	Uncomp. Care	Charity Volume
Cross-Sectional									
Ln(Hosp-HHI)	0.608*** (0.1320)	0.126** (0.0593)	0.273*** (0.0456)	0.0414 (0.1330)	-0.0723 (0.0606)	0.424*** (0.0580)	0.0186 (0.1490)	-0.0138 (0.0692)	0.534*** (0.0595)
Ln(Hosp-HHI) * For-Profit				0.0731 (0.3450)	0.351** (0.1540)	0.104 (0.1100)	0.0769 (0.3510)	0.323** (0.1570)	0.0639 (0.1070)
Ln(Hosp-HHI) * Government				3.501*** (0.4670)	0.704*** (0.2150)	-1.130*** (0.1150)	3.545*** (0.4820)	0.619*** (0.2290)	-1.308*** (0.1180)
Observations	2,297	2,294	2,297	2,297	2,294	2,297	2,297	2,294	2,297
R-squared	0.397	0.617	0.699	0.422	0.621	0.71	0.422	0.622	0.716
Hospital Fixed-Effects									
Ln(Hosp-HHI)	0.874 (0.5740)	0.215 (0.2720)	0.168 (0.1910)	0.799 (0.5820)	0.218 (0.2730)	0.152 (0.1890)	0.791 (0.5880)	0.202 (0.2780)	0.16 (0.1900)
Ln(Hosp-HHI) * For-Profit				0.0605 (0.0528)	-0.000848 (0.0178)	0.0143 (0.0202)	0.0598 (0.0527)	-0.00125 (0.0180)	0.0144 (0.0203)
Ln(Hosp-HHI) * Government				0.0816 (0.0976)	-0.0277 (0.0315)	-0.01 (0.0227)	0.0829 (0.0976)	-0.0286 (0.0320)	-0.00919 (0.0231)
Observations	2,297	2,294	2,297	2,297	2,294	2,297	2,297	2,294	2,297
R-squared	0.826	0.858	0.946	0.826	0.858	0.946	0.827	0.858	0.946

[A] Specification also includes year dummies, For-profit and Government hospital dummies, Ln(Total Discharges)

[B] Specification also includes year dummies, For-profit and Government hospital dummies, Ln(Total Discharges), HSA % Privately insured, HSA % Self-pay

Notes: Heteroskedasticity-robust standard errors are reported in parentheses below the estimated coefficients. *, **, and *** indicate significance at the 10%, 5%, and 1% levels, respectively

Table 5: Full covariates results, log-log specification

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
	Full sample			Full sample, including HRR fixed effects			Excluding rural hospitals		
	Charity care	Uncomp. care	Charity volume	Charity care	Uncomp. care	Charity volume	Charity care	Uncomp. care	Charity volume
Ln (Hosp-HHI)	-0.14 (0.1580)	-0.114 (0.0730)	0.550*** (0.0637)	-0.279 (0.2580)	-0.289** (0.1170)	0.252*** (0.0908)	-0.172 (0.1780)	-0.067 (0.0793)	0.428*** (0.0784)
Ln (Hosp-HHI) x For-profit	0.0193 (0.3520)	0.324** (0.1590)	0.0262 (0.1080)	-0.0862 (0.3830)	0.335** (0.1420)	0.0997 (0.1210)	0.243 (0.3970)	0.377*** (0.1280)	0.172 (0.1320)
Ln (Hosp-HHI) x Government	3.622*** (0.4760)	0.636*** (0.2200)	-1.135*** (0.1130)	3.905*** (0.5580)	0.859*** (0.2490)	-1.138*** (0.1260)	6.843*** (0.7470)	1.684*** (0.3300)	-1.520*** (0.1740)
For-profit	-0.449 (2.8010)	-2.577** (1.2610)	-0.33 (0.8800)	0.484 (3.0420)	-2.605** (1.1290)	-0.938 (0.9780)	-1.94 (3.1570)	-2.836*** (1.0270)	-1.508 (1.0610)
Government	-31.50*** (3.9900)	-5.521*** (1.8440)	9.868*** (0.9480)	-33.70*** (4.6560)	-7.337*** (2.0640)	9.976*** (1.0460)	-58.20*** (6.1700)	-14.14*** (2.7490)	13.26*** (1.4460)
Teaching hospital	0.131 (0.2250)	0.0715 (0.1240)	0.589*** (0.0804)	-0.0667 (0.2290)	0.02 (0.1340)	0.551*** (0.0817)	0.568** (0.2200)	0.172 (0.1200)	0.481*** (0.0894)
Ln (Total discharges)	1.423*** (0.0641)	1.047*** (0.0373)	1.026*** (0.0266)	1.481*** (0.0660)	1.054*** (0.0431)	1.045*** (0.0290)	1.680*** (0.0756)	1.200*** (0.0452)	0.988*** (0.0379)
Rural hospital	0.444** (0.1890)	0.263*** (0.0767)	-0.309*** (0.0577)	0.705*** (0.1910)	0.306*** (0.0850)	-0.322*** (0.0616)			
Ln (HSA population)	-0.0423 (0.0567)	-0.0507* (0.0279)	-0.0526** (0.0210)	-0.0864 (0.0590)	-0.0736** (0.0296)	-0.0469** (0.0215)	-0.135** (0.0654)	-0.102*** (0.0283)	-0.0500* (0.0270)
HSA: Median income	-0.329 (0.2590)	0.217** (0.1040)	-0.331*** (0.0995)	-0.969*** (0.3200)	-0.0987 (0.1420)	-0.487*** (0.1130)	-0.271 (0.2760)	0.239** (0.1140)	-0.214* (0.1100)
HSA: % Uninsured	-1.997 (4.1230)	5.057** (1.9660)	7.679*** (1.3830)	5.165 (4.2010)	5.852*** (1.8440)	8.450*** (1.5100)	-0.143 (5.4140)	5.192** (2.4620)	7.885*** (1.7900)
HSA: % Privately insured	0.986 (0.7660)	-0.317 (0.3400)	0.449* (0.2530)	2.060*** (0.7830)	-0.12 (0.3330)	0.530** (0.2640)	1.244 (0.8590)	-0.511 (0.3840)	0.155 (0.2990)
year: 2002	0.0683 (0.1840)	0.116 (0.0784)	0.0337 (0.0637)	0.0815 (0.1800)	0.118 (0.0775)	0.0354 (0.0613)	0.0428 (0.2100)	0.0916 (0.0883)	0.0565 (0.0738)
year: 2003	0.29 (0.1830)	0.227*** (0.0810)	0.0741 (0.0654)	0.308* (0.1780)	0.231*** (0.0797)	0.0725 (0.0631)	0.273 (0.2070)	0.191** (0.0926)	0.0786 (0.0767)
year: 2004	0.546*** (0.1870)	0.445*** (0.0805)	0.112* (0.0676)	0.551*** (0.1820)	0.445*** (0.0796)	0.108* (0.0654)	0.461** (0.2120)	0.419*** (0.0928)	0.12 (0.0798)
year: 2005	0.927*** (0.1820)	0.562*** (0.0723)	0.176*** (0.0640)	0.944*** (0.1780)	0.567*** (0.0710)	0.166*** (0.0621)	0.817*** (0.2060)	0.528*** (0.0809)	0.184** (0.0749)
year: 2006	1.222*** (0.1780)	0.683*** (0.0738)	0.241*** (0.0618)	1.241*** (0.1750)	0.689*** (0.0721)	0.232*** (0.0601)	1.150*** (0.2010)	0.643*** (0.0781)	0.244*** (0.0720)
year: 2007	1.236*** (0.1820)	0.755*** (0.0740)	0.241*** (0.0618)	1.249*** (0.1780)	0.760*** (0.0724)	0.234*** (0.0604)	1.080*** (0.2040)	0.702*** (0.0810)	0.267*** (0.0718)
Constant	-0.871 (3.0890)	-1.414 (1.3330)	-4.312*** (1.2630)	6.480* (3.6300)	3.492** (1.7710)	-0.505 (1.3870)	-2.53 (3.5520)	-2.723* (1.6040)	-4.213*** (1.5240)
Observations	2,294	2,291	2,294	2,294	2,291	2,294	1,830	1,827	1,830
R-squared	0.421	0.623	0.723	0.459	0.641	0.741	0.365	0.534	0.615

Robust standard errors in parentheses, *** p<0.01, ** p<0.05, * p<0.1

Table 6: Price regressions

	Ln(Price per DRG unit)			Ln(Top DRG price index)		
	[1]	[2]	[3]	[1]	[2]	[3]
Ln (Hosp-HHI)	0.549*** (0.0418)	0.457*** (0.0584)	0.149 (0.1430)	0.549*** (0.0401)	0.402*** (0.0525)	0.0672 (0.1280)
Ln (Hosp-HHI) x For-profit	-0.161** (0.0679)	-0.0707 (0.0808)	0.00795 (0.0185)	-0.105* (0.0611)	-0.0076 (0.0720)	0.0183 (0.0128)
Ln (Hosp-HHI) x Government	-0.197*** (0.0741)	-0.275*** (0.0788)	-0.0362* (0.0196)	-0.225*** (0.0630)	-0.296*** (0.0683)	-0.0226 (0.0187)
For-profit	1.277** (0.5470)	0.592 (0.6460)		0.868* (0.4950)	0.142 (0.5770)	
Government	1.525** (0.6120)	2.183*** (0.6500)		1.760*** (0.5210)	2.342*** (0.5650)	
Teaching hospital	0.495*** (0.0333)	0.458*** (0.0333)		0.344*** (0.0306)	0.324*** (0.0310)	
Rural hospital	-0.0308 (0.0380)	-0.0638* (0.0386)		0.0372 (0.0331)	0.00298 (0.0314)	
Case Mix Index	0.214*** (0.0436)	0.213*** (0.0434)	0.128** (0.0551)	0.117*** (0.0386)	0.116*** (0.0365)	0.137** (0.0543)
Ln (HSA population)	0.0164 (0.0126)	0.0321** (0.0126)		0.011 (0.0095)	0.0213** (0.0096)	
HSA: Median income	0.377*** (0.0533)	0.312*** (0.0665)		0.322*** (0.0498)	0.335*** (0.0625)	
HSA: % Uninsured	1.519* (0.9210)	0.229 (0.9680)		1.266 (0.8000)	0.67 (0.8230)	
HSA: % Privately insured	-0.127 (0.1540)	-0.246 (0.1600)		0.00872 (0.1390)	-0.295** (0.1450)	
year: 2002	0.133*** (0.0426)	0.131*** (0.0412)	0.133*** (0.0311)	0.163*** (0.0388)	0.163*** (0.0373)	0.162*** (0.0296)
year: 2003	0.254*** (0.0389)	0.251*** (0.0374)	0.242*** (0.0285)	0.281*** (0.0360)	0.280*** (0.0346)	0.273*** (0.0273)
year: 2004	0.393*** (0.0381)	0.388*** (0.0365)	0.373*** (0.0283)	0.412*** (0.0353)	0.408*** (0.0337)	0.398*** (0.0267)
year: 2005	0.449*** (0.0382)	0.448*** (0.0366)	0.425*** (0.0288)	0.462*** (0.0348)	0.459*** (0.0332)	0.445*** (0.0272)
year: 2006	0.517*** (0.0384)	0.513*** (0.0366)	0.491*** (0.0291)	0.530*** (0.0359)	0.527*** (0.0342)	0.511*** (0.0274)
year: 2007	0.634*** (0.0383)	0.630*** (0.0366)	0.617*** (0.0303)	0.660*** (0.0352)	0.657*** (0.0335)	0.647*** (0.0282)
Constant	-0.31 (0.7030)	1.031 (0.8980)	7.342*** (1.1670)	0.322 (0.6620)	1.364* (0.8100)	7.863*** (1.0450)
Observations	2,278	2,278	2,279	2,267	2,267	2,268
R-squared	0.308	0.38	0.74	0.307	0.393	0.729
HRR Fixed Effects	YES			YES		
Hospital Fixed Effects	YES			YES		

Robust standard errors in parentheses; *** p<0.01, ** p<0.05, * p<0.1

Table 7: Summary statistics for unprofitable service offerings

Service	Nonprofit		For profit		Government	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
ER	92.9%	25.7%	79.5%	40.4%	93.1%	25.4%
Trauma	56.3%	49.6%	35.3%	47.8%	56.3%	49.7%
Psychiatric	31.2%	46.3%	28.6%	45.2%	31.0%	46.3%
OB	80.8%	39.4%	68.6%	46.4%	66.6%	47.2%
Neonatology	56.6%	49.6%	29.5%	45.6%	38.8%	48.8%
Burn ICU	4.9%	21.6%	3.1%	17.4%	5.3%	22.5%

Table 8: Probit regressions for unprofitable service offerings with HRR fixed effects

	[1]	[2]	[3]	[4]	[5]	[6]
Variables	ER	Trauma	Psychiatric	OB	Neonatology	Burn ICU
Ln (Hosp-HHI)	1.333*** (0.304)	0.136 (0.164)	0.145 (0.199)	1.751*** (0.207)	1.313*** (0.176)	0.128 (0.299)
Ln (Hosp-HHI) x For-profit	0.246 (0.306)	0.945*** (0.203)	0.234 (0.238)	-0.127 (0.213)	-0.0102 (0.209)	1.860*** (0.374)
Ln (Hosp-HHI) x Government	0.106 (0.491)	1.844*** (0.274)	0.731*** (0.281)	0.731** (0.293)	1.575*** (0.285)	-1.343** (0.603)
For-profit	-2.403 (2.398)	-7.703*** (1.607)	-2.188 (1.874)	0.641 (1.682)	-0.734 (1.658)	-15.26*** (2.990)
Government	-1.552 (3.977)	-15.12*** (2.246)	-5.625** (2.296)	-6.197*** (2.385)	-13.06*** (2.334)	10.82** (4.769)
Teaching hospital	0.952*** (0.169)	1.623*** (0.141)	1.142*** (0.128)	0.341** (0.146)	1.065*** (0.157)	0.828*** (0.163)
Rural hospital	-0.0744 (0.186)	-0.0975 (0.110)	-1.666*** (0.174)	-0.711*** (0.123)	-0.860*** (0.114)	
Case Mix Index	-0.278* (0.145)	-0.00494 (0.100)	-1.740*** (0.194)	-0.106 (0.119)	0.0481 (0.109)	-0.103 (0.183)
Ln (HSA population)	-0.348*** (0.053)	-0.0716** (0.032)	0.247*** (0.039)	0.127*** (0.034)	0.294*** (0.034)	0.137* (0.073)
HSA: Median income	-1.922*** (0.332)	-0.431** (0.197)	0.511** (0.239)	-0.655*** (0.225)	-0.355* (0.204)	-1.943*** (0.440)
HSA: % Uninsured	-16.56*** (4.179)	-7.027*** (2.689)	-16.79*** (3.967)	-12.39*** (3.079)	-15.76*** (3.006)	-2.788 (5.504)
HSA: % Privately insured	0.891 (0.651)	0.277 (0.517)	-0.362 (0.594)	2.036*** (0.604)	0.0898 (0.532)	4.603*** (0.932)
year: 2002	-0.00154 (0.151)	-0.00136 (0.104)	0.0318 (0.121)	0.0067 (0.114)	0.0065 (0.107)	0.0182 (0.217)
year: 2003	0.0369 (0.153)	0.0235 (0.104)	0.0402 (0.119)	0.0209 (0.114)	0.00805 (0.107)	0.00664 (0.217)
year: 2004	0.119 (0.156)	0.0398 (0.105)	0.121 (0.120)	0.0682 (0.115)	0.0479 (0.109)	0.0324 (0.218)
year: 2005	0.19 (0.158)	0.102 (0.106)	0.136 (0.120)	0.135 (0.116)	0.117 (0.110)	0.0852 (0.220)
year: 2006	0.189 (0.160)	0.0891 (0.107)	0.155 (0.121)	0.118 (0.117)	0.121 (0.109)	0.0619 (0.220)
year: 2007	0.204 (0.160)	0.0961 (0.108)	0.154 (0.121)	0.111 (0.119)	0.104 (0.111)	0.0367 (0.220)
Constant	16.49*** (4.285)	4.283* (2.450)	-7.429** (2.931)	-7.609*** (2.715)	-9.582*** (2.536)	15.59*** (5.517)
Observations	1,639	2,226	2,066	2,178	2,260	1,369

Appendix A: Welfare analysis for the case of linear demand curves

We now present an example to illustrate how a merger of nonprofit hospitals can increase social welfare by suppressing competition. Following our analysis above, suppose that a hospital monopolist produces a single service at a total cost of $c(q) = F + cq$, and that it is able to divide the aggregate demand into two groups: rich patients (Market 1) and poor patients (Market 2). These two groups have two distinct downward-sloping demand curves for hospital services, the demand curves are known to the monopolist, and there is no opportunity for arbitrage between groups, as medical care is “non-tradable” from the patient perspective. To illustrate our point simply, we assume that under uniform pricing Market 2 is not served profitably when price is set at marginal cost. This is important for our example because when demand curves are linear, price discrimination results in lower welfare and uniform price is favored (Schmalensee, 1981). In our model however, since the poor are excluded under a uniform price, the welfare implications of price discrimination are ambiguous.

The monopolist chooses a price for each group. Let $\{P_1, P_2\}$ denote the prices in Market 1 and Market 2 respectively. Assume that the demand curve in Market i is $q_i = a_i - b_i P_i$. Serving Market i is profitable if $P_i > c$, or $a_i > c \cdot b_i$ for $i = 1, 2$. If this condition is violated a for-profit monopoly will not engage in price discrimination. Instead, it will choose a uniform price (i.e. set price in both markets equal to the monopoly price for rich patients). Such pricing behavior excludes poor patients from receiving services. On the other hand, a nonprofit monopoly may serve markets in which this condition is violated. By relying on other segments of the population for whom they can price above cost (Market 1), the nonprofit firm will price below cost in Market 2 without violating its non-distribution constraint, which applies to the organization as a whole.

Under the assumption that $cb_2 - a_2 > 0$ a for-profit monopoly will always choose to exclude the poor ($q_2^F = 0$). On the other hand, a sufficient condition for a nonprofit monopoly to serve the poor is the ability to set P_1 above c . The monopoly will supply services to the poor even in the extreme case, where the social value of serving the poor (for every level of quantity) is lower than the social cost. As previously discussed, under these conditions, poor patients are served only if the hospital is nonprofit. However, this

does not imply that, for example, merger to monopoly will necessarily increase welfare. The change in welfare across groups is given by:

$$\Delta W = \left[\int_0^{q_2^M} [P_2(x) + \alpha - c] dx \right] - \left[\int_{P_1^D}^{P_1^M} q_1(x) dx \right]$$

The first term is the surplus generated in Market 2 as a result of such merger to monopoly and the second term is the loss of consumer surplus in Market 1. As expected the desirability of merger (i.e. suppression of competition) increases with α , the additional value that society places on each unit of the poor's consumption. While the nonprofit monopolist does not consider α when choosing the quantity of services to the poor, a greater α will increase the social benefits from eliminating competition. Subsequently this would raise the attractiveness of 501(c)(3) organizations as a vehicle for achieving social goals.

Following Proposition 2, the price for paying consumers chosen by the monopolist (problem (1)) is given by $P_1^M = \frac{a_1 + c \cdot b_1}{2 \cdot b_1}$, whereas, the price chosen by the social planner (problem (2)) is given by

$P_1^* = \frac{\lambda \cdot a_1 + (1 + \lambda) \cdot c \cdot b_1}{(1 + 2\lambda) \cdot b_1}$. The profit condition $a_1 > c \cdot b_1$ is necessary and sufficient for $P_1^M > P_1^*$.¹ Hence,

as in the general case, the altruistic nonprofit monopolist overprices healthcare to the rich and overprovides services to the poor.

¹ Proof: $a_1 > c \cdot b_1$

$$\begin{aligned} &\Rightarrow a_1 \cdot b_1 > c \cdot b_1^2 \Rightarrow a_1 \cdot b_1 + c \cdot b_1^2 > 2 \cdot c \cdot b_1^2 \\ &\Rightarrow a_1 \cdot b_1 + c \cdot b_1^2 + 2 \cdot \lambda \cdot (a_1 \cdot b_1 + c \cdot b_1^2) > 2 \cdot c \cdot b_1^2 + 2 \cdot \lambda \cdot (a_1 \cdot b_1 + c \cdot b_1^2) \\ &\Rightarrow (a_1 + c \cdot b_1) \cdot (1 + 2 \cdot \lambda) \cdot b_1 > 2 \cdot b_1 \cdot (\lambda \cdot a_1 + (1 + \lambda) \cdot c \cdot b_1) \Rightarrow \frac{a_1 + c \cdot b_1}{2 \cdot b_1} > \frac{\lambda \cdot a_1 + (1 + \lambda) \cdot c \cdot b_1}{(1 + 2 \cdot \lambda) \cdot b_1} \\ &\Rightarrow P_1^M > P_1^* \end{aligned}$$

Appendix B: Results based on Hosp-HHI constructed using only Medicare patients*

Table 9: Cross-sectional and fixed effects results, log-log specifications (Hosp-HHI based on Medicare patients only)

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
	No ownership interactions [A]			Ownership interactions [A]			Payer mix controls [B]		
	Charity Care	Uncomp. Care	Charity Volume	Charity Care	Uncomp. Care	Charity Volume	Charity Care	Uncomp. Care	Charity Volume
Cross-Sectional									
Ln(Hosp-HHI)	0.513*** (0.1640)	0.118* (0.0700)	0.224*** (0.0577)	-0.127 (0.1580)	-0.106 (0.0722)	0.337*** (0.0730)	-0.187 (0.1700)	-0.0345 (0.0785)	0.475*** (0.0722)
Ln(Hosp-HHI) * For-Profit				0.000274 (0.4010)	0.313* (0.1840)	0.331** (0.1430)	0.0311 (0.4050)	0.297 (0.1870)	0.319** (0.1390)
Ln(Hosp-HHI) * Government				4.024*** (0.5860)	0.905*** (0.2640)	-1.240*** (0.1400)	4.115*** (0.6030)	0.796*** (0.2800)	-1.450*** (0.1380)
Observations	2,283	2,280	2,283	2,283	2,280	2,283	2,283	2,280	2,283
R-squared	0.391	0.616	0.694	0.416	0.620	0.705	0.416	0.622	0.712
Hospital Fixed-Effects									
Ln(Hosp-HHI)	0.043 (0.5180)	-0.592** (0.2850)	0.145 (0.1390)	-0.0281 (0.5200)	-0.580** (0.2860)	0.134 (0.1370)	-0.0412 (0.5220)	-0.587** (0.2860)	0.134 (0.1370)
Ln(Hosp-HHI) * For-Profit				0.0664 (0.0500)	0.000527 (0.0180)	0.0173 (0.0191)	0.0657 (0.0500)	-0.0000988 (0.0182)	0.0175 (0.0192)
Ln(Hosp-HHI) * Government				0.0757 (0.0915)	-0.0318 (0.0297)	-0.0021 (0.0169)	0.0766 (0.0915)	-0.0327 (0.0302)	-0.00135 (0.0172)
Observations	2,283	2,280	2,283	2,283	2,280	2,283	2,283	2,280	2,283
R-squared	0.825	0.855	0.946	0.825	0.855	0.946	0.825	0.855	0.946
[A] Specification also includes year dummies, For-profit and Government hospital dummies, Ln(Total Discharges)									
[B] Specification also includes year dummies, For-profit and Government hospital dummies, Ln(Total Discharges), HSA % Privately insured, HSA % Self-pay									

Notes: Heteroskedasticity-robust standard errors are reported in parentheses below the estimated coefficients. *, **, and *** indicate significance at the 10%, 5%, and 1% levels, respectively

* Results based on Hosp-HHI constructed using only privately insured patients are available upon request from authors.

Table 10: Full covariates results, log-log specification (Hosp-HHI based on Medicare patients only)

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
	Full sample			Full sample, including HRR fixed effects			Excluding rural hospitals		
	Charity care	Uncomp. care	Charity volume	Charity care	Uncomp. care	Charity volume	Charity care	Uncomp. care	Charity volume
Ln (Hosp-HHI)	-0.348*	-0.118	0.500***	-0.596**	-0.305**	0.154	-0.382*	-0.0515	0.361***
	(0.1830)	(0.0841)	(0.0781)	(0.2710)	(0.1250)	(0.1040)	(0.2010)	(0.0905)	(0.0910)
Ln (Hosp-HHI) x For-profit	-0.12	0.259	0.293**	-0.217	0.275	0.462***	0.0672	0.280*	0.500***
	(0.4050)	(0.1870)	(0.1410)	(0.4320)	(0.1710)	(0.1560)	(0.4480)	(0.1620)	(0.1670)
Ln (Hosp-HHI) x Government	4.416***	0.897***	-1.200***	4.467***	0.943***	-1.199***	7.550***	1.834***	-1.718***
	(0.5950)	(0.2640)	(0.1380)	(0.6570)	(0.2850)	(0.1460)	(0.7350)	(0.3170)	(0.1720)
For-profit	0.665	-2.131	-2.529**	1.559	-2.214	-3.942***	-0.585	-2.148	-4.244***
	(3.3380)	(1.5320)	(1.1800)	(3.5520)	(1.4090)	(1.2940)	(3.6900)	(1.3350)	(1.3880)
Government	-39.12***	-7.892***	10.71***	-39.43***	-8.271***	10.78***	-66.15***	-15.89***	15.40***
	(5.1150)	(2.2740)	(1.1820)	(5.6140)	(2.4270)	(1.2490)	(6.3010)	(2.7450)	(1.4760)
Teaching hospital	0.274	0.114	0.556***	0.0321	0.0288	0.501***	0.791***	0.235**	0.405***
	(0.2130)	(0.1200)	(0.0837)	(0.2220)	(0.1300)	(0.0844)	(0.1970)	(0.1060)	(0.0921)
Ln (Total discharges)	1.426***	1.026***	1.014***	1.515***	1.038***	1.027***	1.721***	1.180***	0.960***
	(0.0673)	(0.0365)	(0.0273)	(0.0675)	(0.0411)	(0.0290)	(0.0781)	(0.0430)	(0.0382)
Rural hospital	0.564***	0.250***	-0.313***	0.818***	0.285***	-0.363***			
	(0.1910)	(0.0754)	(0.0584)	(0.1910)	(0.0818)	(0.0611)			
Ln (HSA population)	-0.0556	-0.037	-0.0467**	-0.102*	-0.0649**	-0.0428*	-0.166**	-0.0922***	-0.0416
	(0.0593)	(0.0274)	(0.0218)	(0.0616)	(0.0290)	(0.0222)	(0.0666)	(0.0282)	(0.0275)
HSA: Median income	-0.486*	0.155	-0.372***	-0.954***	-0.143	-0.499***	-0.402	0.171	-0.273**
	(0.2630)	(0.1030)	(0.0992)	(0.3220)	(0.1420)	(0.1150)	(0.2780)	(0.1120)	(0.1080)
HSA: % Uninsured	-3.868	4.929***	6.622***	5.446	6.170***	7.925***	-2.357	5.111**	6.839***
	(4.0520)	(1.9100)	(1.3470)	(4.1720)	(1.8370)	(1.5030)	(5.2360)	(2.3880)	(1.6740)
HSA: % Privately insured	1.095	-0.237	0.212	2.228***	-0.000262	0.384	0.913	-0.584	-0.00489
	(0.7650)	(0.3350)	(0.2500)	(0.7770)	(0.3240)	(0.2610)	(0.8600)	(0.3900)	(0.2940)
year: 2002	0.096	0.141*	0.0485	0.104	0.143*	0.0466	0.055	0.117	0.0715
	(0.1860)	(0.0780)	(0.0636)	(0.1810)	(0.0764)	(0.0608)	(0.2130)	(0.0882)	(0.0732)
year: 2003	0.325*	0.253***	0.0787	0.333*	0.257***	0.0782	0.264	0.209**	0.0952
	(0.1850)	(0.0799)	(0.0657)	(0.1800)	(0.0784)	(0.0631)	(0.2090)	(0.0915)	(0.0761)
year: 2004	0.551***	0.456***	0.112*	0.549***	0.458***	0.114*	0.436**	0.420***	0.129
	(0.1880)	(0.0812)	(0.0681)	(0.1830)	(0.0801)	(0.0657)	(0.2130)	(0.0938)	(0.0798)
year: 2005	0.942***	0.577***	0.174***	0.948***	0.585***	0.171***	0.782***	0.529***	0.196***
	(0.1830)	(0.0727)	(0.0647)	(0.1790)	(0.0713)	(0.0626)	(0.2060)	(0.0817)	(0.0752)
year: 2006	1.241***	0.697***	0.236***	1.252***	0.707***	0.235***	1.125***	0.643***	0.250***
	(0.1800)	(0.0744)	(0.0622)	(0.1760)	(0.0726)	(0.0603)	(0.2040)	(0.0792)	(0.0719)
year: 2007	1.253***	0.770***	0.239***	1.255***	0.778***	0.241***	1.055***	0.704***	0.277***
	(0.1840)	(0.0746)	(0.0622)	(0.1800)	(0.0732)	(0.0605)	(0.2050)	(0.0818)	(0.0716)
Constant	2.71	-0.697	-3.459***	8.847**	4.162**	0.555	0.842	-2.022	-2.910*
	(3.1890)	(1.3460)	(1.2740)	(3.7530)	(1.7890)	(1.4300)	(3.6290)	(1.5890)	(1.4950)
Observations	2,280	2,277	2,280	2,280	2,277	2,280	1,819	1,816	1,819
R-squared	0.418	0.621	0.718	0.455	0.64	0.739	0.367	0.524	0.61

Robust standard errors in parentheses, *** p<0.01, ** p<0.05, * p<0.1

Table 11: Price regressions, (Hosp-HHI based on Medicare patients only)

	Ln(Price per DRG unit)			Ln(Top DRG price index)		
	[1]	[2]	[3]	[1]	[2]	[3]
Ln (Hosp-HHI)	0.670*** (0.0483)	0.563*** (0.0631)	0.169 (0.1430)	0.675*** (0.0466)	0.550*** (0.0581)	0.206* (0.1130)
Ln (Hosp-HHI) x For-profit	-0.240*** (0.0810)	-0.13 (0.0922)	0.00647 (0.0177)	-0.145** (0.0735)	-0.0449 (0.0827)	0.0166 (0.0121)
Ln (Hosp-HHI) x Government	-0.248*** (0.0900)	-0.344*** (0.0919)	-0.0358* (0.0188)	-0.330*** (0.0785)	-0.415*** (0.0811)	-0.0235 (0.0179)
For-profit	2.010*** (0.6760)	1.13 (0.7640)		1.269** (0.6150)	0.485 (0.6870)	
Government	2.012*** (0.7680)	2.846*** (0.7860)		2.710*** (0.6670)	3.428*** (0.6920)	
Teaching hospital	0.520*** (0.0338)	0.470*** (0.0342)		0.365*** (0.0304)	0.333*** (0.0309)	
Rural hospital	0.00962 (0.0384)	-0.0363 (0.0393)		0.0697** (0.0334)	0.0254 (0.0320)	
Case Mix Index	0.192*** (0.0428)	0.192*** (0.0428)	0.127** (0.0545)	0.101*** (0.0381)	0.0995*** (0.0358)	0.134** (0.0538)
Ln (HSA population)	0.0285** (0.0123)	0.0447*** (0.0126)		0.0205** (0.0094)	0.0321*** (0.0097)	
HSA: Median income	0.295*** (0.0528)	0.245*** (0.0670)		0.234*** (0.0497)	0.262*** (0.0628)	
HSA: % Uninsured	0.763 (0.9000)	-0.0407 (0.9530)		0.597 (0.7810)	0.474 (0.8110)	
HSA: % Privately insured	-0.321** (0.1540)	-0.317** (0.1600)		-0.168 (0.1410)	-0.340** (0.1450)	
year: 2002	0.138*** (0.0425)	0.139*** (0.0411)	0.130*** (0.0311)	0.166*** (0.0388)	0.167*** (0.0372)	0.160*** (0.0297)
year: 2003	0.251*** (0.0389)	0.252*** (0.0374)	0.238*** (0.0285)	0.274*** (0.0361)	0.275*** (0.0346)	0.269*** (0.0274)
year: 2004	0.383*** (0.0383)	0.382*** (0.0367)	0.366*** (0.0281)	0.401*** (0.0354)	0.402*** (0.0337)	0.394*** (0.0267)
year: 2005	0.436*** (0.0383)	0.439*** (0.0366)	0.418*** (0.0284)	0.450*** (0.0350)	0.452*** (0.0330)	0.442*** (0.0269)
year: 2006	0.499*** (0.0385)	0.501*** (0.0367)	0.482*** (0.0288)	0.511*** (0.0359)	0.513*** (0.0340)	0.505*** (0.0271)
year: 2007	0.615*** (0.0385)	0.617*** (0.0367)	0.607*** (0.0299)	0.644*** (0.0353)	0.644*** (0.0334)	0.643*** (0.0279)
Constant	-0.641 (0.7170)	0.632 (0.8820)	7.150*** (1.1950)	0.0294 (0.6740)	0.704 (0.8050)	6.697*** (0.9580)
Observations	2,265	2,265	2,266	2,258	2,258	2,259
R-squared	0.312	0.386	0.741	0.317	0.405	0.73
HRR Fixed Effects		YES			YES	
Hospital Fixed Effects			YES			YES

Robust standard errors in parentheses; *** p<0.01, ** p<0.05, * p<0.1

Appendix C:

Results based on hospitals that experienced large changes in HHI

Table 12: Full covariates results, (Hosp-HHI based on all patients; hospitals in top and bottom 25% of change in Hosp-HHI)

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
	Full sample			Full sample, including HRR fixed effects			Excluding rural hospitals		
	Charity care	Uncomp. care	Charity volume	Charity care	Uncomp. care	Charity volume	Charity care	Uncomp. care	Charity volume
Ln (Hosp-HHI)	-0.319 (0.2330)	-0.391*** (0.1010)	0.257*** (0.0860)	-0.299 (0.3750)	-0.389*** (0.1470)	0.168 (0.1420)	-0.451* (0.2690)	-0.381*** (0.1080)	0.0731 (0.1060)
Ln (Hosp-HHI) x For-profit	-0.369 (0.5000)	0.463** (0.2250)	0.0921 (0.1360)	-0.762 (0.5550)	0.405** (0.1810)	0.139 (0.1610)	0.0894 (0.5700)	0.563*** (0.1460)	0.360** (0.1600)
Ln (Hosp-HHI) x Government	3.425*** (0.6560)	0.743*** (0.2800)	-0.367** (0.1480)	3.808*** (0.7310)	1.121*** (0.2910)	-0.289* (0.1580)	5.604*** (1.0490)	1.775*** (0.3660)	-0.309 (0.2160)
For-profit	2.653 (4.0150)	-3.759** (1.7930)	-0.868 (1.1160)	5.877 (4.4530)	-3.170** (1.4510)	-1.273 (1.3110)	-0.635 (4.5770)	-4.360*** (1.1850)	-3.012** (1.3030)
Government	-29.67*** (5.5030)	-6.413*** (2.3560)	3.257*** (1.2410)	-33.22*** (6.1300)	-9.541*** (2.4320)	2.650** (1.3260)	-47.63*** (8.6250)	-14.69*** (3.0740)	3.112* (1.8010)
Teaching hospital	-0.342 (0.5350)	-0.344 (0.3460)	1.389*** (0.1140)	-0.0134 (0.4920)	-0.146 (0.3550)	1.422*** (0.1090)	0.0806 (0.5210)	-0.266 (0.3200)	1.234*** (0.1330)
Ln (Total discharges)	1.392*** (0.0914)	0.947*** (0.0444)	1.008*** (0.0240)	1.479*** (0.0926)	0.933*** (0.0477)	0.977*** (0.0279)	1.760*** (0.1330)	1.185*** (0.0674)	0.964*** (0.0359)
Rural hospital	0.212 (0.2310)	0.108 (0.0872)	-0.309*** (0.0640)	0.985*** (0.2520)	0.245** (0.1060)	-0.342*** (0.0727)			
Ln (HSA population)	0.0203 (0.0832)	0.00764 (0.0362)	-0.0429** (0.0201)	0.00091 (0.0860)	0.00342 (0.0378)	-0.022 (0.0227)	-0.187* (0.1050)	-0.104** (0.0411)	-0.0334 (0.0280)
HSA: Median income	-1.333*** (0.3860)	-0.205 (0.1380)	-0.545*** (0.1220)	-2.674*** (0.4660)	-0.619*** (0.1860)	-0.937*** (0.1590)	-1.248*** (0.4100)	-0.238 (0.1560)	-0.320** (0.1460)
HSA: % Uninsured	-3.948 (5.0270)	0.126 (2.5660)	3.178* (1.6380)	3.927 (4.9830)	-1.838 (2.1630)	1.235 (1.7340)	0.143 (6.6860)	1.201 (3.0850)	1.888 (2.1130)
HSA: % Privately insured	3.824*** (1.0500)	0.261 (0.4310)	-0.119 (0.2640)	5.355*** (1.0260)	0.788* (0.4550)	0.354 (0.3130)	3.780*** (1.1460)	0.0117 (0.4880)	-0.47 (0.3030)
year: 2002	-0.0521 (0.2550)	-0.00127 (0.1150)	0.0317 (0.0745)	-0.0562 (0.2390)	-0.00515 (0.1100)	0.0359 (0.0707)	-0.069 (0.3080)	-0.0297 (0.1450)	0.0328 (0.0889)
year: 2003	0.134 (0.2510)	0.137 (0.1120)	0.089 (0.0778)	0.147 (0.2330)	0.143 (0.1050)	0.0967 (0.0743)	0.169 (0.3000)	0.0882 (0.1400)	0.0792 (0.0941)
year: 2004	0.493* (0.2540)	0.401*** (0.1090)	0.109 (0.0855)	0.473** (0.2350)	0.406*** (0.1030)	0.113 (0.0819)	0.406 (0.3040)	0.395*** (0.1370)	0.101 (0.1070)
year: 2005	0.935*** (0.2420)	0.525*** (0.0940)	0.196** (0.0766)	0.943*** (0.2280)	0.540*** (0.0875)	0.205*** (0.0736)	0.919*** (0.2860)	0.505*** (0.1100)	0.179* (0.0927)
year: 2006	1.158*** (0.2390)	0.605*** (0.1060)	0.234*** (0.0754)	1.172*** (0.2290)	0.616*** (0.1000)	0.237*** (0.0714)	1.237*** (0.2790)	0.583*** (0.1130)	0.208** (0.0905)
year: 2007	1.087*** (0.2490)	0.653*** (0.1030)	0.233*** (0.0749)	1.097*** (0.2370)	0.665*** (0.0979)	0.237*** (0.0715)	0.957*** (0.3030)	0.601*** (0.1160)	0.242*** (0.0907)
Constant	10.22** (4.3960)	5.674*** (1.7060)	0.776 (1.5540)	22.94*** (5.4070)	10.03*** (2.2650)	5.601*** (2.0810)	9.434* (5.0870)	5.175** (2.1320)	0.271 (2.0320)
Observations	1,148	1,147	1,148	1,148	1,147	1,148	829	828	829
R-squared	0.46	0.632	0.803	0.539	0.675	0.823	0.356	0.49	0.641

Robust standard errors in parentheses, *** p<0.01, ** p<0.05, * p<0.1

Table 13: Price regressions (Hosp-HHI based on all patients; hospitals in top and bottom 25% of change in Hosp-HHI)

	Ln(Price per DRG unit)			Ln(Top DRG price index)		
	[1]	[2]	[3]	[1]	[2]	[3]
Ln (Hosp-HHI)	0.418*** (0.0511)	0.281*** (0.0847)	0.146 (0.1570)	0.419*** (0.0475)	0.254*** (0.0692)	0.109 (0.1400)
Ln (Hosp-HHI) x For-profit	0.0685 (0.0952)	0.203* (0.1160)	0.0626** (0.0271)	0.0792 (0.0914)	0.219** (0.1080)	0.0487** (0.0194)
Ln (Hosp-HHI) x Government	-0.259*** (0.0990)	-0.165 (0.1070)	0.0339 (0.0343)	-0.259*** (0.0835)	-0.238*** (0.0917)	0.0202 (0.0276)
For-profit	-0.525 (0.7760)	-1.534 (0.9350)		-0.563 (0.7470)	-1.604* (0.8760)	
Government	2.062** (0.8180)	1.309 (0.8920)		2.083*** (0.6940)	1.899** (0.7660)	
Teaching hospital	0.641*** (0.0652)	0.673*** (0.0684)		0.392*** (0.0531)	0.447*** (0.0556)	
Rural hospital	-0.000619 (0.0523)	-0.049 (0.0549)		0.0799* (0.0426)	0.0257 (0.0397)	
Case Mix Index	0.307*** (0.0650)	0.291*** (0.0674)	0.162** (0.0631)	0.160*** (0.0525)	0.140*** (0.0488)	0.161*** (0.0612)
Ln (HSA population)	-0.0154 (0.0197)	0.000942 (0.0197)		-0.0173 (0.0131)	-0.0043 (0.0137)	
HSA: Median income	0.306*** (0.0827)	0.258** (0.1080)		0.280*** (0.0773)	0.355*** (0.0978)	
HSA: % Uninsured	-1.995* (1.1210)	-4.063*** (1.1800)		-1.341 (0.9490)	-2.845*** (0.9590)	
HSA: % Privately insured	-0.382* (0.2130)	-0.463* (0.2410)		-0.232 (0.1880)	-0.539** (0.2180)	
year: 2002	0.134** (0.0570)	0.134** (0.0558)	0.131*** (0.0462)	0.180*** (0.0489)	0.180*** (0.0472)	0.180*** (0.0409)
year: 2003	0.239*** (0.0529)	0.239*** (0.0512)	0.228*** (0.0427)	0.255*** (0.0498)	0.252*** (0.0476)	0.254*** (0.0389)
year: 2004	0.392*** (0.0516)	0.391*** (0.0494)	0.373*** (0.0417)	0.408*** (0.0470)	0.406*** (0.0444)	0.400*** (0.0376)
year: 2005	0.417*** (0.0517)	0.420*** (0.0500)	0.399*** (0.0435)	0.434*** (0.0463)	0.431*** (0.0441)	0.424*** (0.0389)
year: 2006	0.486*** (0.0532)	0.485*** (0.0508)	0.466*** (0.0434)	0.515*** (0.0487)	0.511*** (0.0460)	0.505*** (0.0390)
year: 2007	0.647*** (0.0529)	0.645*** (0.0508)	0.635*** (0.0449)	0.663*** (0.0472)	0.657*** (0.0450)	0.661*** (0.0402)
Constant	1.940* (1.0540)	3.476** (1.5070)	7.066*** (1.2830)	2.227** (0.9650)	2.793** (1.2600)	7.352*** (1.1470)
Observations	1,140	1,140	1,141	1,133	1,133	1,134
R-squared	0.313	0.408	0.707	0.314	0.442	0.706
HRR Fixed Effects	YES			YES		
Hospital Fixed Effects	YES			YES		

Robust standard errors in parentheses; *** p<0.01, ** p<0.05, * p<0.1

Appendix D: Construction of price measures

Both price measures analyzed in this paper are constructed using information on hospitals' actual revenue from private payers as a percentage of their total list charges to private payers. The percentages are derived from the OSHPD financial disclosure reports, which provide gross and net inpatient revenue from third party payers, separately for "traditional" insurance products (i.e., fee-for-service plans) and managed care insurance products. Individual patient records in the hospital discharge data identify (1) the list charges associated with the visit, (2) the payer category (private, Medicare, Medicaid, ...), and (3) whether the plan type is traditional or managed care. This facilitates matching the plan type discount factor to the patient's plan type.

The steps in computing the two price measures are as follows:

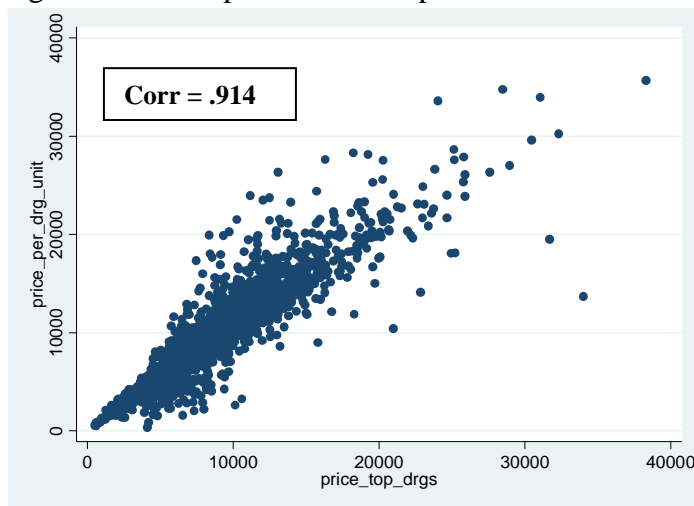
1. Compute the hospital-level ratio of net revenue to gross revenue in each year, separately for private traditional and private managed care products, using the following variables:
 - a. $\text{factor_tr} = \text{netrv_thrd_tr} / (\text{netrv_thrd_tr} + \text{c_adj_thrd_tr})$
 - b. $\text{factor_mc} = \text{netrv_thrd_mc} / (\text{netrv_thrd_mc} + \text{c_adj_thrd_mc})$
2. The resulting ratios are predominantly, but not universally between 0 and 1. Cap at the cross-hospital, within-year 5th and 95th percentiles of each "factor."
 - a. Drop Kaiser hospitals, which do not report financial data and generally do not treat non-Kaiser patients, before computing percentiles.
3. Use discharge level information on the payer category and plan type to estimate the net payment from the available patient-level data on list charges:
 - a. $\text{Payment} = 1[\text{Traditional}] * \text{factor_tr} * \text{charges} + 1[\text{MCO}] * \text{factor_mc} * \text{charges}$
4. Construct two price measures
 - a. Casemix adjusted price:
 - i. $\text{price_per_drg_unit} = \text{Sum}(\text{Payment}) / \text{Sum}(\text{DRG units})$
 - ii. "DRG units" are the case weights attached to DRGs; these weights indicate the national average relative cost of care (e.g., a patient in a DRG with a weight of 4 is twice as costly to treat on average as a patient in a DRG with a weight of 2.)
 - b. Basket of common DRGs price:
 - i. $\text{price_top_drgs} = \text{Average}(\text{Payment})$ in common DRGs (i.e., DRGs present at nearly all hospitals)

- ii. Impute, for a small number of hospital-years without all of the common DRGs, based on full sample averages.¹
 - iii. Table 14 lists the DRGs used in constructing the price index.
5. As shown in Figure 5, the two price measures are highly correlated and have similar magnitudes.

Table 14: Common DRGs used to construct the price index

DRG	MDC	Category	Description
88	4	M	Chronic Obstructive Pulmonary Disease
89	4	M	Simple Pneumonia & Pleurisy Age >17 w cc
97	4	M	Bronchitis & Asthma Age >17 w/o cc
127	5	M	Heart Failure & Shock
138	5	M	Cardiac Arrhythmia & Conduction Disorders w cc
ta	5	M	Cardiac Arrhythmia & Conduction Disorders w/o cc
143	5	M	Chest Pain
167	6	P	Appendectomy w/o Complicated Principal Diagnoses w/o cc
174	6	M	Gastrointestinal Hemorrhage w cc
182	6	M	Esophagitis, Gastroenteritis & Misc Digest Disorders Age >17 w cc
183	6	M	Esophagitis, Gastroenteritis/Misc Digest Disorders Age >17 w/o cc
204	7	M	Disorders of Pancreas except Malignancy
294	10	M	Diabetes Age >35
296	10	M	Nutritional & Misc Metabolic Disorders Age >17 w cc
320	11	M	Kidney & Urinary Tract Infections Age >17 w cc
359	13	P	Uterine & Adnexa Proc for Non-Malignancy w/o cc
416	18	M	Septicemia Age >17

Figure 5: Scatter plot of the two price measures



¹ It would likely be possible to obtain a better price index by regressing each component price in the index on the other prices and the casemix adjusted price (pric_per_drg_unit).