The interconnection between welfare services and the market in the United States with a focus on the elderly: the application of antitrust law to nonprofits

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1. BACKGROUND AND INTRODUCTION*

It is widely acknowledged that the US welfare system evolved differently from other industrialized countries' welfare regimes. From a neutral standpoint, scholarly works evidence that the US social service framework cannot be compared to the welfare states implemented in Western Europe over the 20th century−which remain in place. This is due to the different approaches to welfare objectives.[107] The prominent role of private organizations and nonprofits is one of the US system's defining features, although public authorities' action (or, better said, government intervention) has not been set aside completely.

The underlying rationale of the US welfare system largely relies on two premises: first, welfare benefits qualify as commodities that can be delivered by private entities (i) operating in the market; and thus (ii) able to meet the existing demand. Second, social service recipients or, where appropriate, welfare officials, have somewhat free choice to a certain extent regarding the services, which, also, would be available to anyone.

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[107] Reisch, M. (2009), Chapter 14, "United States: Social Welfare Policy and Privatization in Post-industrial Society" in Powell, J. L, Hendricks, J. *The Welfare State in Post-Industrial Society*, p. 253 – 270, p. 253.

However, note that these ideas regarding the efficient operation of social service markets might not be true in practice.[108] In fact, often there are market failures, i.e., the price, quantity or quality of the delivered social services may be unsuitable or simply not enough to meet society's needs. The most common market failures in the field of social services, although not the only ones, are the so-called "informational market failures" or information asymmetries.[109] If they lack information, welfare recipients can hardly assess the quality and value for money of welfare services. Ultimately, users are unable to choose correctly between services.[110] These and other market failures trigger government intervention, which relies on two instruments: (i) regulation; and (ii) antitrust law. As for (ii), it is worth noting that it qualifies as a paramount example of indirect economic regulation.[111] In the United States, the scope of antitrust law covers a wide range of social services, insofar as their provision is totally or partially subject to market conditions. By fining anticompetitive practices and behaviors, public authorities indirectly enhance the system, since the fines have a positive impact on the price and quality of services.

Within the field of US welfare, public action has been somewhat superseded by private entities' initiatives (including both companies and nonprofits) and market-based management. This poses several challenges and concerns. Does the protection provided by antitrust law cover the activity of non-profit organizations? We will answer this question below. This paper examines (i) the development of strictly assistance-based services or benefits in the US (section 2.1); (ii) their current legal framework (section 2.2) with regards to other social services, particularly those catering to older adults (section 2.3); and (iv) the positive and negative outcomes (section 3.1) and oversight (section 3.2) of private initiatives, including not-for-profit action (section 3.3).

2. OVERVIEW OF WELFARE SERVICES IN THE UNITED STATES AND THE PROVISION THEREOF BY PUBLIC AND PRIVATE ENTITIES

The history of welfare in the US is a tale of overlaps and supplementary relationships between government intervention and the private provision of social services to tackle socioeconomic issues, including elderly-related matters. From the outset, private initiatives seem to prevail over publicly delivered social services. The US welfare system has two additional distinct

[108] See a critical outlook on both the current context and prior stages in REISCH (2009: 253 *et seq.*).

[109] Wilder R. P. (2014) "Regulation and Antitrust Policy in Health Care," in Jacobs, P., Rapoport, J., *The Economics of health and Medical Care*. 5th Ed., p. 351.

[110] *Ibidem.*

[111] Indirect regulation refers to regulatory activities that affect price, quantity or quality by enforcing the competitive behavior of companies or by changing the market structure. Direct regulation refers to intervention in markets by regulatory agencies to control, *inter alia*, price, professional licensure requirements or professional qualifications, or the specific quality of services. Wilder (2014: 350 *et seq.*).

features: (i) decentralization,[112] i.e., public authority was successively devolved to lower level governments and private organizations; and (ii) non-universal nature, meaning that welfare is not universally provided; rather, it is made up of benefits specifically addressed to recipients in need of social care.

Political and administrative decentralization becomes evident particularly when discussed from a historical perspective. The close interdependencies between federal, state and local power in the provision of social benefits and services is highly noticeable.[113]

Scholarly works have recently reframed the history of welfare, discussing and chronicling the evolution of welfare in the United States from an unprecedented perspective.[114] Scholars highlight that the development of welfare benefits has been affected by the establishment of some kind of welfare-administrative state. This is evidenced by the implementation of an administrative framework at the three government levels, i.e., federal, state and local, as well as by steady (and major) social justice achievements. This progress becomes even more apparent considering that the starting point was lack of equity, discrimination and unreasonableness regarding welfare and social matters.

2.1. References to the historical development of social services

In the early American state, most social benefits and services were provided by local institutions in cooperation with charity organizations like churches, religious communities or the so-called benevolent societies. Subsequently, over the 19th century, privately initiated social movements (e.g., scientific charity and settlement houses) started to provide aid to the underprivileged.[115]

A public-administrative welfare system above local governments slowly gained ground throughout the 20th century. Taking care of children in need was the first priority, mostly through home relief. State legislation on the eligibility of mothers for pension schemes (i.e., the so-called "mothers' pension statutes") formed the basis for the first relief program enacted in 1935–the federal Aid to Dependent Children (ADC) program–later replaced by the 1960s AFWDC–Aid to Families With Dependent Children–and subsequently superseded by the currently applicable program called PRWORA (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996).

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[112]. Katz, M. B. (1996) *In the Shadow of the Poorhouse: a social history of Welfare in America* (10th ed. 1996), p. 247.

[113] Tani, K. (2016), *States of Dependency. Welfare, Rights, and American Governance, 1935-1972.*

[114] Tani, (2016: 189 *et seq.*).

[115] Estrin Gilman, M. (2001) "Legal accountability in an era of privatized Welfare," *California Law Review*, Volume 89, Issue 3, p. 581.

The first program for children in need (the ADC program) falls under the 1930s set of welfare reforms to address the 1929 stock market crash and the depression that followed, known as the New Deal. In order for the New Deal measures not to be temporary, the Social Security Act was passed in 1935, providing old-age insurance at federal level (i.e., social security in the strict sense), unemployment assistance provided through state and local authorities, and direct cash assistance for adults aged 65 and older,[116] dependent children in single-parent families, disabled children, and the blind.[117]

Social service developments during the early 20th century slowly but surely allowed to move towards a federal welfare system for those in need. Within this new system, resource allocation was increasingly more equal, fair, lawful, rational and objective. However, it was not all progress. After World War II, the economic reconstruction process gave rise to a boom, where some thought that poverty would be reduced almost automatically. Nonetheless, social assistance resources had to be increased at even higher rates than social security funds.[118] The need for public assistance and welfare benefits soared to the point that public authorities were forced to adopt many legal and administrative measures during the 1950s, aimed at reducing the growing number of welfare recipients. As a result, eligibility requirements and procedures became more stringent, thereby broadening states' scope of discretion in running their welfare programs and regulating eligibility.

The situation worsened in the 1960s. Demographic shifts–including the flow of rural populations into the cities–significantly increased the number of persons in need of public assistance. This scenario triggered a myriad of grassroots social, civil rights and human rights movements pushing for reforms across the board to mitigate poverty. Consequently, over the following decades, the American society became more aware of inequities and social justice issues. The prevailing strategy was based on reducing poverty by providing the poor with services to gain employment (i.e., encouraging people on public assistance to seek job opportunities). This "service strategy" was set forth in the Economic Opportunity Act of 1964, and the Federal Office of Economic Opportunity was entrusted the application and administrative implementation of this statutory provision. However, in line with US tradition, the actual enforcement of the Economic Opportunity Act was carried out by a vast network of private social service providers and local agencies. The funds came from the federal Government, but state and local authorities were responsible for administering these federal resources, which they did rather loosely. During this time period, the role of the federal

[116] According to the estimates, social security is the main source of income for retired workers (9 out of 10 adults aged 65 and older receive social security benefits, which account for at least 90% of the income for 23% of married older adults and 46% of single seniors. Brisk, W.J., Whitney A.A., (2013), "Exploring the future of Elder and special needs law," *NAELA (National Academy of Elder Law Attorneys) Journal*, No. 5, p. 16.
[117] Estrin Gilman, (2001: p. 584-585).
[118] Estrin Gilman, (2001: 585-586).

Government and private initiatives expanded greatly and simultaneously. Regarding the latter, private entities developed both as nonprofits and for-profit organizations and business-like entities.[119]

The lack of oversight, as well as budget cuts largely resulting from Vietnam War spending, shook the foundations of these programs, (i) fueling the social and civil rights movements; (ii) giving rise to a generation of pro-reform officials within government bodies;[120] and (iii) further consolidating the interdependence between government and administrative structures and private service providers, which remains in place nowadays.[121]

In spite of the prevailing anti-welfare political rhetoric, government spending on social welfare programs considerably increased and poverty decreased during the 1970s.[122]

During that time period, the importance of affording legal protection to welfare recipients became more apparent.[123] More specifically, welfare recipients were granted constitutional rights, namely due process rights, in case of due process violations and breaches of rights related to the delivery of welfare benefits and social services. Other fundamental rights were further secured. Courts began to find rights violations when the allocation and provision of welfare benefits failed to fulfill the principle of non-discrimination on grounds of territory, residence or race. In parallel, some legal principles were reinforced through measures fostering a more impartial, equitable and fair allocation of welfare benefits.

It is worth noting that this was not automatic. There was a lot of pressure and much political and legal struggle, often resulting in court proceedings and claims. There was also strong disagreement within benefit-providing bodies and authorities. All of these clashes arose from the regulation and exercise of public power in the various states and, particularly, from the development of administrative decision-making procedures. Keep in mind that administrative decisions often changed and evolved, not only as a result of amended state statutes, but also because administrative precedents kept changing and being reinterpreted in light of the state authorities' evolving interpretations subject to federal statutes that would remain applicable−and unchanged−for years.

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[119] *Ibidem.*

[120] Tani (2016: 190 *et seq.*).

[121] Estrin Gilman (2001: 588). As in any other field, a historical review underscoring positive aspects of welfare history is just one possible approach to the facts. Other scholars–e.g., Reisch (2009: 253)−see the glass as half empty and consider that New Deal welfare reforms or the post-World War II reconstruction measures were "modest." According to this approach, the few achievements in the field of social services result from the nation's Calvinist roots and emphasis on individualism, as well as from the absence of left-wing, socialist-leaning, working class political parties. Still under this critical outlook, all of this has led to the stigmatization of certain population segments, thereby rationalizing institutional racism and sexism and the effects thereof.

[122] Estrin Gilman (2001: 587).

[123] See Tani, (2016: 212 *et seq.*).

Throughout this historical evolution, there was a landmark conflict. In the summer of 1960, Louisiana amended its Aid to Dependent Children Law (ADCL) known as "The Louisiana suitable home." The debate revolved around whether this piece of legislation was compatible with federal law, specifically with the Social Security Act. Although there were serious concerns as to whether ADCL abided by federal law, it was neither repealed nor amended, stirring strong reactions and protests regarding its implementation and enforcement. Ultimately, the problem was that Louisiana amended its ADCL to prohibit payments to African-American women who had a child out of wedlock, excluding them in a rather *Scarlet Letter* fashion.[124]

After this welfare state blossoming, a small-government, more individualistic trend expanded in the late 20th century. Its advocates rejected government intervention and overreach. During this time period, a "big government" was considered a threat to individual freedom. This approach, along with the influence of prominent economists (Hayek, 1949; Friedman, 1962), gave rise to an alternative view of the welfare state that became mainstream, according to which the market had enough self-correcting or self-regulation mechanisms.[125] This neoliberal (small-government) outlook plainly underlined the market's ability to correct or make up for social gaps. As a result, the share of poor population increased again. There are various sociological reasons for this. Aside from demographic shifts and population increases, divorces and out-of-wedlock births grew significantly.[126]

The next major shift or, better said, backlash in welfare policy occurred in the 1980s with President Reagan. His term is famous for the cuts to social spending. As a result, the poverty rate began growing again, and in 1983 it was the highest it had been for decades. In 1988, the Family Support Act was enacted. This provision implemented the so-called Job Opportunities and Basic Skills (JOBS) program, although it was not very successful after its application at state level. In this context, welfare policymaking in the late 20th century linked welfare benefits to job promotion, as well as to specific achievements regarding social programs and targets. For instance, mothers would receive benefits if they married ("wedfare"), just like families with children who missed school or failed to get their vaccines would stop being eligible for aid.[127]

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[124] Tani (2016: 212 *et seq.*).

[125] REISCH (2009).

[126] Estrin Gilman (2001: 588). This social and political framework has also drawn strong criticism. See Reich, M. (2009), claiming that welfare public policies are disruptive, lacking and negative for business and entrepreneurial activities, since they discourage innovation, reduce the role of volunteer work and, generally, diminish civil society. Additionally, Reich argues that welfare policies make recipients highly dependent thereon.

[127] Estrin Gilman (2001: 588).

2.2. Defining current welfare regulation

During the last decades of the 20th century, welfare policies were mostly aimed at turning private entities into social service providers through the so-called "privatization of social services." This updated privatization process took place after President Clinton signed a major federal statute: the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or PRWORA.[128] Note that the PRWORA falls within a set of reforms including the Government Management Reform Act of 1994. These provisions set forth several measures encouraging the government to (i) adopt modern management methods and meaningful program performance indicators; and (ii) increase workforce incentives and flexibility increasing individual and corporate responsibility through accountability.[129] These new developments did not trigger heavy criticism in Congress of PRWORA's wording. Rather, the spotlight was on certain coercive measures included in this piece of legislation. It is worth recalling that American culture permeates welfare programs and the provision of welfare benefits, thus not being free for recipients. Therefore, benefits are provided "in exchange for consideration" by working-age recipients, who are required to work part time, to perform community service or, at least, to enroll in job placement programs.

There is no doubt that 1996 legislation, currently in force, implemented major reforms. In particular, it amended the welfare benefits that had been applicable so far. It set forth a program listing the various forms of assistance and benefits, i.e., the Temporary Assistance to Needy Families (TANF). Under the TANF, the federal Government guaranteed that, regardless of their place of residence, citizens receive minimum benefits. The purpose was to help families overcome the financial distress through direct cash payments, food benefits ("food stamps"), financial aid to pay for housing or utilities, child care benefits, as well as support regarding education or job training.[130]

As a result of PRWORA, states regained a prominent role in the field of social services. PRWORA had a clearly devolving or decentralizing effect, to the extent that states were

[128] Pub. *L. No. 104-93, 110 Stat. 2105 (1996).*

[129]Smith Nightingale, D. Pindus, N.M. (1997), *Privatization of Public Social Services*. *A Background Paper*. Urban Institute for U.S. Department of Labor, Office of the Assistant Secretary for Policy.

[130] As stated by Reisch, M. (2009), it is commonly believed that the Temporary Assistance to Needy Families (TANF) program was fairly successful at first, since it increased the number of recipients first and then gave rise to a drop in the nation's welfare caseload, tying welfare to job search and economic independence. The main criticism of this program is twofold (i) TANF recipients mostly concentrated in urban areas and had specific racial origins (thus preventing other racial groups from receiving TANF benefits); and (ii) despite the quantitative indicators of success, little attention was paid to the program's impact on the living standards of low income households.

entitled to make spending and resource allocation decisions as long as they met the requirements laid down by federal law (42 US Code, Sec 602, 603 (a) (1)).[131]

The applicable legal framework does not provide for exclusive powers in the field of welfare benefits. Both the US Congress and state legislatures have lawmaking powers in this regard. The federal Government first held exclusive powers solely regarding social security. Over time, we witnessed a slowly expanding federal role, providing for new benefits and thereby extending its lawmaking powers. This increasingly prominent role ran parallel to increased federal funding for welfare benefits.[132]

In contrast, states have been given flexibility to fashion their own welfare policy, operate their own programs and increase or upgrade the benefits that could be received by social service users, as long as they do not spend state dollars (42 U.S.C. Sec. 666(f) and Sec. 601).[133] In fact, after the enactment of the 1996 federal piece of legislation, states had to timely submit their own assistance programs. State assistance programs had to meet the relevant federal requirements, aimed at reducing welfare spending. These requirements include, *inter alia*, that recipients engage in "work activity" within 2 years of getting benefits, and that such assistance have a five-year lifetime limit on the receipt of benefits. On top of that, the federal Government requires, e.g., that state programs (i) increase marital stability and reduce domestic violence and child abuse; (ii) provide for an effective system to collect food benefits received by non-custodial parents; and (iii) promote the financial independence of low income families through job placement measures for adults (42 US Code, sec 602, 603).

Having fulfilled the relevant federal requirements, states enjoy broad discretion to determine eligibility requirements within the TANF program.[134] Accordingly, states have rulemaking powers to supplement, interpret or clarify federal regulations.[135] Also, much of the authority over administering welfare and implementing and delivering benefits is devolved from the federal Government to the states.

In a nutshell: since the 1990s, the federal Government has devolved much of the power in the field of welfare services to the states, i.e., there has been a decentralization. Even more important than this federal-to-state devolution of powers is the discretion granted to states to delegate authority to local governments and private entities (whether profit-seeking or

[131] After the passage of the federal legislation, states had to submit their assistance program within a given time limit.

[132] O'Neill Murray, K. Gesiriech, S. (2004) *A Brief Legislative History of the Child Welfare System,* THE PEW CHARITABLE TRUSTS 1.

[133] Gais, T., Weaver, R. K. (2002), "State Policy Choices Under Welfare Reform," *Policy Brief* No. 21, April . *Welfare Reform and Beyond*, The Brooklings institution, Washington, DC.

[134] Estrin Gilman (2001: 578).

[135] *Ibidem.*

nonprofits). If welfare administration is placed in the hands of public authorities, they can manage welfare benefits through local bodies, like California counties.

The California model is useful, since it (i) is one of the states with the most welfare benefits in the US (having the largest share of adults and seniors)[136]–although the age average is a lot lower than other states'–and (ii) has high immigration rates.[137]

The most remarkable welfare benefit is the cash aid from the California Work Opportunity and Responsibility to Kids (CalWORKS) program. This program falls under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and it provides cash aid, food stamps, employment services and health insurance to qualified families in need with children under 18 when one or both parents is absent, disabled, deceased or unemployed. Only children that are 17 or younger or adults enrolled in job placement or welfare-to-work programs are eligible, and adults will only be entitled to temporary benefits. CalWORKS also includes "Temporary Homeless Assistance" and "Permanent Homeless Assistance." The latter program provides cash aid to pay (i) for a hotel or similar forms of temporary shelter while recipients find permanent accommodation; and (ii) last month's rent and security deposits if these payments are reasonable conditions of securing a residence.

California also adopted a state General Assistance program regulated, funded and administered by the counties. It is a county-funded loan program for eligible or potentially qualified persons for a social security disability pension, although unemployed or low income adults (below certain thresholds) are also eligible. CalWORKS also includes a Supplemental Nutrition Assistance Program.

As for elderly care and assistance, most benefits solely include social security pensions under the US Department of Health and Human Services or DHHS. It is worth highlighting the disability and retirement pensions (see section 2.3 below). Supplementing these pensions there are General Assistance programs for recipients aged 64 and older who are not entitled to a retirement pension. See also the Refugee Cash Assistance Program for eligible refugees and humanitarian immigrants over 64, the Cash Assistance Program for Immigrants covering adults aged 64 and older, as well as the Supplemental Nutrition Assistance Program for recipients over 60. All of these programs, in contrast with other ones, have less stringent financial eligibility requirements. Working-age, non-disabled recipients must work for a minimum number of hours on a monthly basis or should be actively looking for a job.

[136] https://datosmacro.expansion.com/demografia/poblacion/usa-estados

[137] Due to its high immigration rates, California has implemented two programs addressed to foreigners. First, see the Refugee Cash Assistance Program, providing cash assistance to eligible refugees and other humanitarian immigrants; both individual adults and refugees' families can be eligible. Second, see the Cash Assistance Program for Immigrants, involving cash benefits to aged, blind, and disabled non-citizens over 64 years old, legally residing in California, who are otherwise ineligible for pensions due to their immigrant status. It is a county-administered program, implemented, funded and regulated by the State of California.

However, there are certain exceptions subject to time limits or extraordinary economic circumstances.

2.3. Regulation of elderly care: figures and references

Regarding the provision of social services for the elderly, note that private providers and market dynamics are involved. However, government intervention has intensified lately. First, the United States is experiencing a "Silver Tsunami." According to some studies and projections, the share of adults over 65 increases and will increase (at least until 2030) at a daily rate of 10,000.[138] Also, keep in mind that publicly managed welfare services are focused on caring for the elderly. In fact, some federal welfare programs are specifically addressed to senior citizens. See, for instance, the welfare benefits laid down in the federal Social Security Act. These are publicly funded and privately provided services including two types of health care (discussed in detail in section 2.3.1 below). First, services for low income and needy population under Medicaid (a joint federal and state program providing health coverage to low income individuals, including seniors).[139] Second, there is Medicare,[140] a publicly funded program providing health insurance for Americans aged 65 and older. Finally, it is worth examining certain affordable or social housing programs (see section 2.3.2 below).

With regards to demographic data (according to the United States Census Bureau), note that the US population aged 65 and older amounts to 54 million, i.e., 16.5% of the total population.[141] In 2016,[142] some studies found that long-term care service providers served over 8.3 million people in the United States by means of 4.600 adult day service centers (half of them managed by nonprofits[143]), 12,200 home health agencies, 4,300 hospices, 15,600 nursing homes and 28,900 assisted living and similar residential care communities, many of which are established as retirement communities (see a more detailed analysis in section 2.3.4 below).

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[138] Pew researcher Center, *Baby boomers Retire* (29 December 2010) https://www.pewresearch.org/fact-tank/2010/12/29/baby-boomers-retire/, last accessed on 20 June 2020.

[139] This program, along with Medicare, was passed by Congress in 1965. Fogg, R. (2011) *Introduction to Federal Nursing Home Regulations. Nursing home Regulations Manual.*

[140] https://www.medicare.gov/

[141] https://www.census.gov/

[142] Harris-Kojetin L., Sengupta M., Lendon J.P., Rome V., Valverde R., Caffrey C. (2019) Long-term care providers and services users in the United States, 2015–2016." National Center for Health Statistics. *Vital Health Stat 3*(43).

[143] Harris-Kojetin L., Sengupta M., Lendon J.P., Rome V., Valverde R., Caffrey, C (2019:8).

2.3.1. Health care services

Health care services in the US are mostly privately provided. Since there is no universal health coverage, health care is, to a large extent, privately funded (54% of the overall spending comes from private dollars according to data from financial year 2018).[144] Health care is provided by companies (through health insurance plans for employees) and families. There is also public funding, where federal expenditure amounts to 28% and state and local governments' expenditure equals 17%.[145]

Commonly, scholars argue that the United States does not have universal health coverage due to cultural reasons. Compared to Europeans, the American society can be thought to be more diverse, individualistic and pro-small government.[146] There are also political and economic reasons involved: certain interest groups are against universal health care, blocking the various political attempts in this direction.[147] On top of that, the US Constitution fails to provide for the right to health, neither as an individual right nor as a governing principle.[148]

Public funding relies on (i) Medicare which, as noted above, is a federal program providing health coverage to adults aged 65 and older; and (ii) Medicaid, a federally funded health care program for low income individuals. They are publicly funded programs including private insurance and private service providers. All of this helps to establish a market-oriented system where government intervention regulates access to the market by setting forth (i) licensing requirements for health care professionals; and (ii) the Food and Drug Administration (FDA) approval requirements for drugs and medical products. Hospitals are also subject to a somewhat stringent regulation[149] via a policing or law enforcement approach. Among others, there are certification requirements regarding hospitals' ability to set up an infrastructure covering certain population groups and cities. Price and quality standards are regulated indirectly, subject to antitrust law. According to OECD information,[150] the United States has the highest *per capita* health expenditure among all

[144] *National Health Expenditures 2018 Highlights. Center for Medicare and Medicaid Services.* Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical

[145] *Ibidem*

[146] Mitra, M. (2018) "Free universal health care system in United States," Vol I, I, *Journal of Political Science and International Relation*, Volume 1 Issue, p. 16-17.

[147] Mitra, M. (2018:16-17).

[148] On the effects of legally or constitutionally acknowledging this right on the quality of health worldwide, see Kavanagh M. (2016) "The Right to Health: Institutional Effects of Constitutional Provisions on Health Outcomes," *Studies in Comparative International Development* Vol, 51, p. 364 *et seq.*

[149] Phelan, M.E. (2019), *Nonprofit Organizations: Law and Taxation, Chapter § 21: Hospitals.*

[150] *Health at a Glance 2019 OECD Indicators*.

OECD countries[151] (health spending amounts to 18% of the US GDP).[152] However, this does not entail that health care is better or that spending is efficiently allocated.[153] In fact, 2013 data[154] evidence that roughly 7% of Americans (22.3 million people) did not receive health care benefits due to the excessive cost.

2.3.2. Access to affordable housing

Affordable or social housing development, construction and rehabilitation in the US mainly relies on public policies, and particularly on federal financial aid.[155] This type of financial aid is ultimately addressed to low income households that are otherwise unable to afford housing in the private market (i.e., who cannot purchase or rent a house at market prices). There are numerous programs pursuing this objective,[156] seeking to fill the gap between income and housing prices.[157] Low income housing markets' dynamics are shaped by these subsidies and financial aid, which are determined based on the average income of residents qualifying for affordable housing.[158]

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[151] On average, health spending in the US represented roughly USD 4,000 *per capita* (at purchasing power parities). The United States spends more on health care than any other OECD country, by a significant difference of over USD 10,000 per resident, as provided in *Health at a Glance 2019 OECD Indicators*.

[152] Mitra (2018:16).

[153] Mitra (2018:16).

[154] *National Health Interview Survey, 2014* data. http://www.cdc.gov/nchs/nhis.htm.

[155] A different issue altogether is promoting access to housing through urban planning or territorial development policies. In this regard, the greatest barrier to providing fair housing is the local governments' use of zoning policies to contain or restrict high density and urban developments providing housing for multiple families. Admittedly, many governments since the 1970s have required developers to include affordable units. *Cfr.* Salsich, P. (2011) "State sources of housing finance," CHAPTER 10, in Iglesias, T., Lento, R.E. (Eds.) *The legal Guide to Affordable Housing Development*. 2nd Ed.

[156] See an overview of these programs in Salsich, P. (2011).

[157] These are diverse federal programs revolving around debt structuring instruments such as tax-exempt bonds, tax increment financing or low income tax credit. There are additional available resources, like the federal Community Development Block Grant (CDBG) and the formula grants provided by the HOME Investment Partnerships Program (HOME) given to state and local agencies for them to subsequently contribute additional funds and allocate them all. Charitable contributions are also an option. These are complex programs that sometimes provide households in need with financial aid to meet their housing needs. SALSICH (2011).

[158] Salsich (2011). Based on the information provided by this scholar, the housing affordability formula is based on the household income–e.g., think of a household made up of two full-time workers with a minimum income of USD 15,000 each and USD 30,000 overall where income be lower than 50% of the metropolitan area's median income. For most public housing affordability programs, households spending 30% or more of their pre-tax income on housing are viewed as having an excessive housing cost burden. In the above example, this would amount to USD 500 per month. If we add further spending on furniture, appliances, utilities, and other expenses for household operation, the available income for housing would be USD 200 per month. Accordingly, from the developer's perspective, the mortgage would be USD 40,000 to 50,000, depending on interest rates

2.3.2.1. The federal Low income Housing Tax Credit program (LIHTC)

The most significant and stable affordable housing program is the federal Low income Housing Tax Credit program (LIHTC) created in 1986.[159] It has been modified several times since its entry into force.[160] The LIHTC is the primary tool to impact the affordable rental market.

This program's annual application revolves around indirect economic aid to access affordable housing, encouraging investment and development of affordable rental units. It is meant for developers, providing them with funds through a competitive tender where the awarding authority is a state body. Developers may (i) use the tax credits to offset construction costs or (ii) sell them to outside investors in exchange for equity as long as the latter use them for development projects reserving a fraction of units that are rent-restricted and for lower-income households. This allows to reduce the financing developers would otherwise have to secure, increasing the funds (upfront financing) for the construction and rehabilitation of housing units addressed to lower-income households.[161]

The program's execution begins at the federal level with each state receiving an annual LIHTC allocation in accordance with federal law.[162] Each state's housing finance agency (HFA) allocates credits to developers of rental housing according to federally required, but state-created, allocation plans. The developers applying for the credits range from companies,

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and other expenses. If the actual cost of each housing unit ranges between USD 75,000 and 100,000, there is a major gap between the actual cost and the housing expenses affordable in each case.

[159] Through the Tax Reform Act of 1986 (P.L. 99514). The LIHTC database, created by the Department of Housing and Urban Development (HUD) and available to the public since 1997, contains information on 48,672 projects and 3.23 million housing units placed in service between 1987 and 2018. LIHTC program gives State and local LIHTC-allocating agencies the equivalent of approximately USD 8 billion in annual budget authority to issue tax credits for the acquisition, rehabilitation, or new construction of rental housing targeted to lower-income households. The database shows the territorial distribution and the characteristics of households residing in LIHTC properties. See https://www.huduser.gov/portal/datasets/lihtc.html.

[160] It is worth highlighting the legal reforms implemented by the Bush (2008) and Obama (2009) Administrations: the Housing an Economic Recovery Act of 2008 (HERA) and the American Recovery and Reinvestment Act of 2009 (ARRA). In late 2017 the Internal Revenue Code (P.L. 115-97) was amended. Although it did not have a direct impact on the program, it did significantly affect the federal tax system. See the Congressional Research Service, (2019), *An introduction to the Low income Housing Tax Credi*t, p. 2.

[161] See a comprehensive explanation of the LIHTC program in Lento, R. E. Graceffa, D. (2011) "Federal sources of Financing," CHAPTER 9, in Iglesias, T., Lento, R.E. (Eds.) *The legal Guide to Affordable Housing Development.* 2nd Ed., p. 249 *et seq*.

[162] Federal law requires to prioritize any projects that serve the lowest-income households and that remain affordable for the longest time.

corporations, associations or even nonprofits. In order to be awarded LIHTC, owners or developers must pass an income test regarding future tenants.[163]

LIHTCs or tax credits are granted to projects expected to last up to 10 years. Also, the property must remain occupied by low income households for at least 15 years.[164] Any LIHTCs not allocated by states after a 2-year period are added to a national pool and then redistributed to states that apply for the excess credits. This is a nudge for states to allocate all their credits among their applicants right away.

Federal law restricts the types of housing units eligible for LIHTC. These tax credits cannot be allocated for student residences, nursing homes or any other housing units other than the main residence. However, a given project may still use its housing units for a specific demographic segment, e.g., the elderly.[165]

There are additional financial instruments regarding affordable housing other than LIHTCs, like the Community Development Block Grant program (CDBG). The CDBG is aimed at preventing or eliminating slums or blight that can pose a serious threat to a community's well-being and suitable living environment. The CDBG allows for more diverse uses, since it can be applied to enhancing urban areas, by providing decent housing but also by enhancing street lighting, sidewalks, etc. There are also tax-exempt bonds issued by state or local governments aimed at funding projects subject to the same eligibility requirements as the LIHTC program. These bonds supplement LIHTCs.[166]

2.3.2.2. Housing for the elderly

Section 202 of the 1959 Housing Act provides funds for elderly housing. The US Department of Housing and Urban Development (HUD) makes capital grants (i.e., provides capital in advance) to non-profit developers or groups of sponsors or consumers within the framework of a Project Rental Assistance Contrat or PRAC concluded between the HUD and the owner. The capital advances are secured through a mortgage with HUD and they do not (i) accrue

[163] First, at least 20% of the project's units should be occupied by tenants with an income of 50% or less of the area's median income adjusted for family size (AMI). Second, at least 40% of the units must be occupied by tenants with an income of 60% or less of AMI. Over the last few years, there have been some additional eligibility requirements for these credits. See HousingFinance.com, "Corporate Investment and the Future of Tax Credits: What Should You Expect," at http://www.housingfinance.com/news/corporate-investment-and-the-future-of-tax-credits-what-should-you-expect_o, 1 January, 2011.

[164] *Ibidem.*

[165] Lento, Graceffa (2011:259 *et seq.*).

[166] Lento, Graceffa (2011:271 *et seq.*).

interest or (ii) require repayment as long as the properties are made available to very low income elderly households for at least 40 years.[167]

The advance funds granted by the HUD can be used to build and rehabilitate properties under the Federal Deposit Insurance Corporation (FDIC). The FDIC is an independent agency created by Congress due to the impact of the Great Depression to maintain stability and public confidence in the nation's financial system. To accomplish this mission, the FDIC insures deposits guaranteeing that no depositors lose a penny in case of bankruptcy.

2.3.3. Nursing homes

In spite of the steady ageing process in the US, the nursing home resident rate has decreased.[168] Between 1990 and 2000, the share of older adults living in care facilities increased by 3 percentage points (from 5% to 8%). However, in the early 21st century, the nursing home population fell significantly. Unsurprisingly, most residents are older than 80.[169] Also, according to the estimates, in 2006 there were 1.8 million licensed beds available nationwide only serving 1.5 million residents.[170] By 2011, many of the older adults living in nursing homes were dependent and required intensive care.[171] Almost all facilities are privately owned, and 23.3% are held by nonprofits.[172] Approximately 95% of the existing care facilities are Medicare-and-Medicaid-approved or licensed.[173]

The Centers for Medicare and Medicaid Services (CMS) are under the US Department of Health and Human Services (DHHS), which is responsible for monitoring nursing home services. CMS provide funding to nursing homes, since these care facilities actually serve older adults and persons with disabilities qualifying as Medicare or Medicaid beneficiaries.[174] Furthermore, state agencies enter into agreements with CMS to identify, survey, and inspect provider and supplier facilities and institutions providing publicly funded services. In order to deliver these services, nursing homes must apply for a state license or certification. Federal Congress lays down the eligibility requirements, generally set forth in the Social Security Act. According to this Act, the DHHS Secretary is responsible for monitoring compliance with and applying these requirements. The aforesaid Centers for Medicare and Medicaid

[167] For further information on these programs, see HUD's website: www.hud.gov.
[168] Brisk, Whitney (2013:10).
[169] Brisk, Whitney (2013:17).
[170] According to the American Health Care Association (2006) "The State Long-Term Health Care Sector 2005: Characteristics, Utilization, and Government Funding."
[171] According to the findings from the first nationally representative survey of assisted living/residential care facilities. National Center for Assisted Living, *Assisted Living State Regulatory Review 2012*.
[172] Harris-Kojetin, Sengupta, Lendon, Rome, Valverde, Caffrey (2019:8).
[173] Fogg, (2011).
[174] www.medicare.gov.

Services (CMS) are entitled to develop regulations and protocols to enforce these requirements.[175] In fact, this regulatory and enforcement approach is somewhat recent. It can be traced back to the 1990s, following the passage of the landmark Nursing home Reform Act in 1987.[176] This legislative provision was enacted after a heated debate on the shortcomings of public supervision of care facilities and residents' rights, shifting federal oversight of nursing home quality. After 2000, given the continuing issues, the abovementioned CMS[177] were put in place.

2.3.4. Continuing care retirement communities or CCRCs

Continuing care retirement communities (CCRCs), also known as life plan communities, are a long-term care option for older adults in the US, i.e., a specific type of retirement community. CCRCs provide a wide range of services to residents, including housing, health and social care, allowing them to live independently (to the extent possible) increasing social engagement with other seniors. As necessary, CCRCs enable a subsequent transition to assisted living, providing medical care and daily assistance. Residents live in an area with various residential options with approximately 100 people. Whereas in the mid-1980s the US had roughly 275 CCRCs,[178] in 2014 there were more than 2,000.[179] Almost half of them are in Western states,[180] and 17.7% of the entities administering these CCRCs are not-for-profit organizations.[181]

Each of these CCRCs has distinct features, offering diverse leisure activities, services, quality standards or arrangements. Most of them allow residents to engage in leisure activities, as well as to have lunch and dinner together and to receive care according to their preferences and needs. These life plan communities or CCRCs are self-financed through users' fees,[182]

[175] www.medicare.gov.

[176] Fogg, (2011).

[177] *Ibidem.*

[178] Winklevoss, H.E. Powell, A.V. (1984) Continu*ing Care Retirement Communities. An Empirical, Financial, and Legal Analysis Pension* Research Council of the Wharton School University of Pennsylvania.

[179] Span P. (2014) "In many states, few legal rights for C.C.R.C. Residents," published on the New York Times online edition on 21 March 2014. See mylifesite.net (a specialized website providing comprehensive information) for a comparison between the existing communities in terms of occupancy rates, services and prices: mylifesite.net

[180] Harris-Kojetin, Sengupta, Lendon, Rome, Valverde, Caffrey, (2019: p. 7-8).

[181] Harris-Kojetin, Sengupta, Lendon, Rome, Valverde, Caffrey, (2019: p. 8).

[182] Winklevoss, Powell, (1984:XI).

paid by users themselves or through insurance plans (65.7%), including Medicare insurance (22.6%), Medicaid (29.6%) or private insurance plans (10.1%).[183]

CCRCs are often organizations managed by private companies or nonprofits operating subject to state legislation. There being no consistency from state to state, and in the absence of harmonizing federal legislation, the varying degree of assurance of residents' rights has given rise to certain concerns. Depending on where the CCRC would be located, residents' rights would be more or less secured. This has given rise to various claims and to a national residents' "bill of rights" for CCRCs.

Some could argue that these senior facilities could be considered as some sort of segregated area. In addition to that, CCRCs raise financial concerns. The 2008 economic crisis had a very significant impact on them. Many CCRCs faced economic hardship and were shut down. As a result, the affected residents did not receive their upfront and monthly fees back.

3. PRIVATE PROVISION OF WELFARE IN THE UNITED STATES

As noted above, private organizations have often provided social services in the United States.[184] It is also worth noting that private provision of welfare has continued to increase after the most recent reforms of the US welfare state.

As for assistance and care services, up until 1960 private entities had solely provided discrete services such as job training or child care. Subject to 1990s legislation, private organizations steadily gained a much more prominent role, which they still have nowadays. Private entities are even allowed to run entire welfare offices, i.e., public offices responsible for administering the services. Thus, these entities can draft the local and state governments' welfare programs, thereby performing eligibility determinations and sanctioning recipients for non-compliance with program requirements.[185]

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[183] These data also include information from nursing care facilities: Table 15- Nursing care facilities and Continuing Care retirement Communities Expenditures; levels, percent change, and percent distribution, by source of funds: Selected Calendar Years 1970-2018. Harris-Kojetin, Sengupta, Lendon, Rome, Valverde, Caffrey, (2019).

[184] Nilsen, S. R. (2002) "Welfare Reform: Federal Oversight of State and Local Contracting Can Be Strengthened. Report to Congressional Requesters." *General Accounting Office, Washington*, DC-Welfare Reform McConnell, S., Burnwick, A, Perez-Johnson, I. and Winston, P. (2003), "Privatization in Practice: Case Studies of Contracting for TANF Case Management," *Final Report prepared by Mathematica Policy Research Inc. for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services*, Washington DC. See also, Sanger, M. B. (2001) "When the Private Sector Competes," *Reform Watch,* No. 3, The Brookings Institution, Washington DC.

[185] Estrin Gilman, (2001: 670).

Currently, the provision of social services through public authorities, usually local bodies, does not prevent public authorities from contracting out their welfare services to private entities (42 US Code, sec 604a). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) allows for contracting out all social services to nonprofits if they fulfill certain general interest requirements (charities).[186] The available information, however, shows that there were few states that chose to contract out "all" social services. This remains true considering both actual service delivery and the drafting and administration of welfare programs. Within the Spanish legal system, these "drafting and administration" activities (i.e., shaping the welfare services) would be considered the "public dimension" of welfare, i.e., the dimension of services where public bodies actually exercise public authority (within the meaning of Article 85(3) of the Spanish Local Government Act, which bans "indirect administration of welfare" thereby preventing private entities to administer these services[187]). Examining this dimension of welfare, privatization would be more limited, both in California and in most states. Government authorities do not remain responsible for actually providing the service, but they do retain decision-making powers regarding the shaping and administration of welfare and social assistance. Many counties (although not all) often contract out the training programs for welfare officials to private entities.[188]

As discussed before, after the amendments to assistance services by the aforesaid 1996 federal piece of legislation (PRWORA), the role of private organizations has even increased with respect to previous time periods (see sections 2.1 and 2.2 above). In addition to the increasingly prominent role of private initiatives regarding welfare, there was a noteworthy federal-to-state devolution of powers and states vastly increased their discretion to award social benefits. The provision of welfare assistance does not solely depend on the fulfillment of the objective eligibility requirements, but also on the recipients' willingness to work and cease to be dependent. Accordingly, the provision of benefits also depends−to a certain extent−on the outcomes expected by the benefit providers, after the relevant assessment to be conducted by their workers and welfare officials.

By (i) broadening the scope of discretion in the provision and award of social assistance; and (ii) devolving to entities (some of which are private) eligibility determinations, it becomes increasingly important to decide on welfare planning: how is welfare going to be provided? what about its scope or coverage? Therefore, it also becomes essential to come up with new

[186] See Finn, D. (2007) "Contracting out welfare to work in the USA: delivery lessons." *Department for Work and Pensions. Research Report* No. 466, and the bibliography therein.

[187] Article 85(3) of the Spanish Local Government Act: "Any public services that entail the exercise of *public authority* shall not be contracted out or otherwise provided through indirect means or by a company even if its entire share capital is held by local government authorities."

[188] Finn (2007).

control and accountability mechanisms applicable to these entities, regardless if they are nonprofits or profit-seeking organizations.[189]

As discussed before (see section 2.3 above), the role and presence of private entities and nonprofits regarding social services for the elderly (including health care and housing, whether private, nursing homes or retirement communities) is even greater than in the field of social assistance.

3.1. Advantages and disadvantages of private provision of welfare

Scholarly works emphasize the challenges posed by the role of private organizations, businesses and nonprofits in welfare provision. Moreover, scholars warn of the risk that recipients fail to receive the social service appropriately (considering that recipients are already seen as "clients") or that the recipients' rights be breached within the provision of benefits.[190] Consequently, it is probably a top priority to implement the necessary legal mechanisms to hold private welfare providers accountable.

The main arguments in favor of privatizing and contracting out the provision of welfare relate to cost savings and maximizing efficiency and flexibility.

Some authors reject this stance,[191] claiming that such approach ignores the many ways in which the government bears the social costs of private enterprises and the efficiency of government bureaucracy, like the social security administration. According to Reisch, these "privatization advocates" also seem to ignore the historic role played by the government in (i) supporting the efficiency (i.e., profitability) of the for-profit sector through capital formation, grants, and contracts for research; and (ii) expanding and protecting markets through antitrust law.

Reisch concludes by saying that the said stance also disregards that the goods produced by government services have qualitative characteristics that are not easily subjected to standard cost-benefit analysis. Also, this approach overlooks the fact that most of the efficiencies achieved by privatization have occurred by lowering workers' wages, reducing services, or diminishing the quality, quantity and accessibility thereof.[192]

In sum: keep in mind that privatization is not inherently good or bad. Rather, it depends on the actors involved. There is no clear evidence as to whether private services are more

[189] Estrin Gilman, (2001: 569).

[190] Finn (2007).

[191] Reisch (2009).

[192] See a critical view in Hammer, P., (2005), "Medical Code Blue or blue light special: Where is the market for indigent care? *Journal of Law in Society* 82. The author argues that encouraging competition in health care services has led to unmet demand and lower quality care.

efficient than publicly provided services, since they both have advantages and disadvantages. There are both success stories and failures on both sides. Within United States law, the key is that government authorities are responsible for ensuring the effectiveness of welfare services, regardless if they are privately or publicly delivered.[193]

Broadly, the common belief is that the public sector tends to be better at policy management, regulation, ensuring equity, preventing discrimination or exploitation, ensuring continuity and stability of services, and guaranteeing social cohesion. In contrast, businesses or the market tends to be better at performing economic tasks, innovating, replicating successful experiments, adapting to rapid change, abandoning unsuccessful or obsolete activities, and performing complex or technical tasks. It is also a widely spread opinion that the non-profit sector (also known as the "third sector") tends to be best at performing tasks that (i) demand compassion and commitment to individuals; (ii) require extensive trust on the part of clients; and (iii) involve the enforcement of moral codes and individual responsibility.[194]

Along these lines, note that the private provision of welfare assistance (see sections 2.1 and 2.2 above) revolves around the drafting of the contracting schemes between government authorities and private providers, particularly if the latter qualify as profit-seeking companies. Obviously, the overall balance of the contracting scheme will trigger different incentives for the companies and other benefit-providing organizations (including nonprofits). There are some welfare contracts entered into with private providers including a set fee regardless of the specific benefits to be provided. In these cases, the more money the provider saves in the welfare benefit, the more profit it gets to keep. In other words: these contracting schemes raise incentives for profit-seeking organizations to implement cost-savings measures that can impact the quality of service. But, if the parties agree on a price depending on the services provided, the provision of welfare can also be distorted, there being incentives to help only those persons most easily helped through the welfare service. Thus, any contracting schemes between government authorities and companies or private providers must seek that the incentives triggered by the contract clauses not be in conflict with recipients' needs and, in case of a clash, that welfare recipients have enforceable rights against welfare providers.[195]

Generally, empirical case studies in the US are slightly pro-private provision of welfare, without overlooking the risks entailed thereby (corruption, hindered access for

[193]Smith Nightingale, Pindus (1997).

[194] Osborne, D., Gaebler, T. (1992). *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*. Reading, Mass.: Addison-Wesley Publishing Co., Inc.

[195] Estrin Gilman (2001: 592).

underprivileged citizens) and some highly common harmful effects, such as the loss of public employees or the opposition of public officials' associations. [196]

As for fully contracting out or privatizing welfare assistance, experience shows that it is really hard to come up with contracting schemes appropriately reflecting the complexity of the subject-matter.

Keep in mind that the rule-based and bureaucratic welfare model implemented in the mid-20th century, where assistance was provided subject to a rigid general framework, has been superseded by a completely different model. Under this new model, any decisions regarding the type of service and its scope are discretionary, progressive, flexible and made on a case-by-case basis. Decision-making in this regard rests on those who develop and actually provide the benefit.[197] As a result, welfare recipients can now enforce their rights through less rule-based and strict procedures.[198] Within this context, the role of public authorities focuses more on steering the system as a whole than on regulating: they have a holistic approach, focusing on training, on the appropriate use of economic incentives nudging private providers in the right direction, on shaping the benefits and on providing assessment and evaluation mechanisms. If the relevant benefit involves advising, informing or counseling the recipient, formal hearing processes are useless to address irregularities or due process issues such as unfair or unequal treatment. Indeed, some studies claim that African-American and Caucasian beneficiaries are treated differently.[199]

This is how the last major welfare reform occurs, a public-private partnership where planning the provision of benefits becomes more flexible and less strict and rule-based. This new, less structured approach has certain advantages, but it could also fragment the system, pulling it apart and giving rise to significant differences in service quality depending on the provider.

3.2. Oversight and accountability

Assuming some degree of private involvement in welfare provision, it is worth focusing on the need for government authorities to monitor and oversee private providers, the key factor being clear accountability for results and clearly laid down objectives.

Accordingly, public authorities that enter into welfare contracts, thus becoming a party thereto–this is the case with welfare assistance–must strictly oversee the contracting process,

[196] National Commission for Employment Policy. Annual Report (1989/1990). United States.
[197] Tani (2016:141).
[198] In this connection, and regarding the legal arrangement of welfare benefits as non-conditional final programs in Spanish law, see Rodríguez de Santiago, J.M., (2007) *La Administración del Estado social.*
[199] Tani (2016:195).

from the contract award until performance. Government authorities are also responsible for ensuring compliance with antitrust law.[200]

There are various remedies and mechanisms to enforce accountability of private welfare providers, including due process rights of welfare recipients. Considering that welfare benefits qualify as entitlements, welfare recipients may bring judicial proceedings relying, e.g., on the "state action doctrine." Under this classic legal doctrine in US law, claimants (plaintiffs) can sue over a law being violated, claiming that there has been a breach of constitutional provisions, demonstrating that the government (local, state, or federal), was responsible for the violation, rather than a private actor. In order for this doctrine to apply, the action of private welfare providers must have the status of "government action." Otherwise, the state action doctrine would not apply.

Some scholars criticize private involvement in welfare provision, arguing that agencies conducting independent oversight lack sufficient resources and capacity to perform their role.[201] They add that the transformation of the US welfare system gives rise to conflicts within organizations and between them, triggering ethical dilemmas related to (i) overlaps in reporting and loyalty; (ii) confidentiality; (iii) informed consent; or (iv) recipients' free choice.

There are also mechanisms to increase private welfare providers' accountability, including that representatives of stakeholders engage in decision-making processes and more comprehensive oversight aside from statistics−e.g., surveys with welfare officials and benefit recipients allowing to individually assess the benefits.

Another measure can entail introducing competition between the actors involved to increase efficiency, reduce costs, and improve quality and customer satisfaction. Within this context, competition means public-public competition, public-private competition, competition between public-private ventures and public-nonprofit competition. Allegedly, competition makes welfare provision more efficient, saves costs and improves quality and the satisfaction of end users.[202]

3.3. Nonprofits as welfare providers

The importance of nonprofits, including the so-called "charities," is intensifying in the United States across the board. The intense third sector's activity, also regarding welfare services, is largely due to the tax support it receives. Nonprofits, charities and other third sector

[200] Smith Nightingale, Pindus (1997).
[201] Finn (2007).
[202] Smith Nightingale, Pindus (1997).

organizations are encouraged through financial aid provided by the government in the form of tax benefits and deductions.

From a comparative perspective, in contrast with other legal systems,[203] the US regulatory approach to nonprofits revolves around taxation (or lack thereof) and tax incentives.[204] Tax policy is not only significant for nonprofits, but also constitutes the loose public oversight of these organizations. Note that section 501(c)(3) of the Tax Code exempts nonprofits from the federal income taxation. Section 170 of the Code also allows individuals who make contributions to those organizations (i.e., donors) to deduct some or all of their contribution on their federal income tax return. This option is only available for nonprofits established as "charities." These entities must have "charitable purposes," i.e., selfless or altruistic goals, such as improving the community's well-being. This draws a distinction between them and other nonprofits not qualifying as "charities" ("noncharitable" organizations), many of which are also exempt from income taxation and are entitled to additional tax benefits subject to federal and state law.

Theoretically speaking, the rationale for welfare provision by private (non-government) entities is market failure. Put differently, the need to supply public goods that would otherwise be underproduced by companies or profit-seeking organizations in the private market.[205] However, there is an issue here: these same market failures constitute the traditional basis of the economic rationale for government intervention (at least regarding benefit-providing and developing activities). US scholars draw a boundary between charity and government arguing that government meets only the needs of the majority, whereas charity can offer a wide array of services for all segments of society. Charities allow (i) services to be more pluralistic, tailored to society's needs and more specific; and (ii) to channel creativity and innovation in society.[206]

These advantages are often considered inherent to the provision of services by not-for-profit organizations, but they are not necessarily present in all cases. And, above all, one could argue that a federal Government precisely serves heterogeneous interests, where the majority does not always prevail. The federal Government is actually designed to be responsive to

[203] Dirusso, A.A. (2011), "American Nonprofit Law in Comparative Perspective," *Washington University Global Studies Law Review* No. 10, p. 82.

[204] Regarding the third sector, the US has regulation at both the state and federal levels. In spite of the myriad of state regulations, they broadly govern how charitable organizations may be created, the form they may take, the fiduciary duties of their leaders, and operational aspects. The oversight of these nonprofits is carried out by individuals, managers, trustees, donors and benefit recipients, but state judicial authorities have power over these nonprofits: Dirusso, A.A. (2011: 60 *et seq*.).

[205] Galle, B. (2012), "The Role of Charity in a Federal System," *William & Mary Law Review* No. 53, p. 785-786.

[206] Gergen, M. P. (1988), "The Case for a Charitable Contributions Deduction," *William & Mary Law Review* p. 1399.

society's demands, as well as to provide a wide array of different services. Theorists claim that multilevel or multi-tier government models offer flexibility, responsiveness and the ability to meet social needs. This is why some scholars challenge such strong encouragement of nonprofits in the US, considering that the various government and public authorities (particularly local bodies) could intensely produce public goods and services by themselves.[207] In line with these insights, we should wonder if, in fact, government authorities are better equipped than charities to deliver public goods and services,[208] particularly considering that governments usually enjoy economies of scale and scope compared to charity, being funded through progressive and redistributive taxation.

There is a long-standing debate in the US about whether public services should be (i) directly tax-funded or rather (ii) publicly funded (through indirect subsidies, tax exemptions, exempting donors from income taxation...) but privately provided by nonprofits. Both approaches have strengths and weaknesses, and each model is better suited for some services or the others.[209] Admittedly, mixing service provision by public authorities (local governments in particular) with charities tends to render the latter unnecessary (or reduces the need for charity to fill in), and it can also lead to overlaps and inefficiencies. These shortcomings are nonetheless a minor problem for society compared to the elimination of services (high quality services in certain sectors) delivered by charities.[210]

4. THE APPLICATION OF ANTITRUST LAW TO NONPROFITS FOR OVERSIGHT PURPOSES

4.1. The application of antitrust law to welfare services: an overview of the objectives

As is well known, antitrust law is primarily intended to protect companies and their business activities. It is also government authorities' gateway into welfare markets in the United States,[211] provided that antitrust law does not only protect entrepreneurs. Rather, it also safeguards the general interest.[212]

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[207] Galle, B. (2012: 782 *et seq.*).

[208] *Ibidem.*

[209] Galle, B. (2012:781-782)

[210] Galle, B. (2012:783)

[211] The United States is the birthplace of antitrust law. The 1890 Sherman Act was the foundational statute of antitrust law; it first banned cartels and monopolies. The 1914 Clayton Act condemns mergers that risk substantially lessening competition. These are the two major antitrust provisions in the United States, and they are both still in force.

[212] Does the fact that antitrust law safeguards the general interest (or public interests) turn it into public law? Find an answer in Velasco Caballero F. (2014) *Derecho público más Derecho privado*. Keep in mind that, in the US, antitrust law may very well be statutory, but it remains primarily common law, including civil and criminal law provisions.

Within free market economies, a competitive marketplace is based on two main premises. First, "competition secures individual freedom in any sectors where goods and services are delivered by providers and received by consumers." Second, "competition ensures the productive system's efficiency, thereby fulfilling many objectives to increase social well-being."[213] Self-evidently, antitrust law ultimately protects individuals demanding goods and services. Additionally, safeguarding free competition and preserving a competitive marketplace allows to also provide protection to society as a whole by making essential goods (such as social services and welfare assistance) accessible to the public and particularly to those in need.[214]

By protecting everyone's freedom, antitrust law enforcement can also be an indirect mechanism−not the only one−to protect the underprivileged. This is the case as long as antitrust law safeguards the efficiency of the productive system,[215] since this would entail that the supplied goods and services are accessible to the public. In other words: the main role of competition is to allow for meeting social needs at the lowest possible cost, assuming that such needs have been expressed by the individuals' willingness to pay for the relevant goods or services.[216] Therefore, the more competitive the marketplace, the cheaper the goods or services and, thus, the more accessible for low income consumers that need them the most.

Indeed, the legal interest protected by antitrust law is competition between suppliers of products meeting the same demands from a specific group of consumers within a given location. Consequently, from the perspective of antitrust law, the applicable legal provisions condemn the behavior of any suppliers providing goods that meet social needs when such behavior restricts, distorts or eliminates competition.

4.2. The scope of application of antitrust law within the US welfare system

The most harmful behaviors precluded by antitrust law are cartels, i.e., collusive arrangements entered into by a group of competitors agreeing not to compete against each other to increase profit. Although to a lesser extent, abusive monopolies (the acquisition or

[213] As aptly stated by Alfaro Águila-Real, J. (2017) "La libertad de competencia y el Derecho de la competencia." https://almacendederecho.org/la-libertad-competencia-derecho-la-competencia. He concludes that "[c]ompetition ultimately encourages suppliers to find out and meet consumers' demands at a lower cost than their competitors. Competition makes all individual suppliers powerless, who will be unable to pass on the costs to consumers because the latter can obtain the same good from a competitor. As Hayek explained, competition allows to coordinate consumers and suppliers by gathering all the available information scattered within society."

[214] Leslie, C.R. (2012) "Antitrust law as public interest law" in *UC Irvine Law Review*, 2 p. 885 *et seq.*

[215] Achieving efficiency is considered as the only actual goal pursued by antitrust law. See Posner, R.A., *Antirust Law*, 2nd Ed. (2001).

[216] Alfaro Águila-Real (2017).

maintenance of monopoly power relying on competitive practices) and unfair or anticompetitive mergers are also harmful. All of these behaviors entail distorting competition by reducing supply and generating shortages, thereby preventing access by consumers to certain goods and services (or raising the prices thereof dramatically), which clearly worsens consumers' situation.[217]

If we look for examples of anticompetitive behaviors and price-fixing contrary to antitrust law within the welfare sector, we will mostly find them in the US health care market.

4.2.1. Cartels

Within the context of essential social needs, courts have applied Section 1 of the Sherman Act largely to condemn price-fixing agreements among competitors. One of the largest and most harmful price-fixing cartels was the vitamins cartel, which operated both in the United States and Europe since 1989 until 1999. This cartel caused significant damage to vulnerable population segments such as children, pregnant women, lactating mothers and the elderly, i.e., the groups that purchased supplementary vitamins the most.[218] In another similar cartel, one of the earliest Supreme Court cartel cases, *Am. Med. Ass'n v. United States, 317 U.S. 519, 536 (1943)*, the Supreme Court found the American Medical Association guilty for recommending its members not to work with health maintenance organizations (HMOs), which provided health care at lower costs. Afterwards, there have been unlawful illegal price-fixing arrangements in the dental sector (1992),[219] and involving hospitals. Within the hospital care sector, one of the most harmful cartels (the court ruled on it in 2007) took the form of hospitals coordinating to limit the wages of nurses.[220] Lowering wages could lead to mid-term and long-term nursing shortages, which would clearly prejudice hospital care.

4.2.2. Bid rigging: secret agreements and conspiracies between competitors

Another common unlawful anticompetitive practice is bid-rigging, i.e., conspiracies between competitors agreeing on who will be awarded each contract. Let us recall the legal and administrative framework of social services: government authorities enter into agreements with private providers and nonprofits to deliver the services and provide the benefits as well as to administer them (including eligibility determinations and the award of benefits).

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[217] Leslie (2012).

[218] Connor, J.M. (2008), 2ª Ed., *Global Price Fixing*, p. 252-53.

[219] *United States v. Alston, 974 F.2d 1206 (9th Cir. 1992).*

[220] *United States v. Ariz. Hosp. & Healthcare Ass'n, 2007-2 Trade Cas. (CCH) P75,*869 (D. Ariz. 2007) (Consent Decree and Competitive Impact Statement).

A paramount example of bid-rigging is another United States case: the price of milk for schoolchildren procured through school milk programs had been artificially inflated for decades due to a web of bid-rigging arrangements.[221]

4.2.3. Abuse of dominance

Another example of anticompetitive arrangements are agreements under which various dominant companies (hospitals or health care centers) illegally agree not to treat patients whose payments are covered by certain types of insurance. Obviously, such shortage of supply triggers price increases.[222] Market division has also been found contrary to antitrust law. Under these arrangements, competitors allocate territory to each other or, in a more sophisticated fashion, drive competitors out of the market in exchange for legally required compensation. This was the case regarding certain pharmaceutical companies that alleged patent infringement based on the 1984 Hatch-Waxman Act to preserve their monopolies. They automatically paid compensation to the defendant (usually a generic drug manufacturer) which, as provided in the said legal provision, had to be paid prior to filing the suit. Thus, such payment amounted to compensation for the defendant who, in exchange, would suspend the launching of the new medical product.[223]

4.2.4. Anticompetitive mergers

Illegal monopolies seriously undermine health care markets, where there is growing concentration between health care providers and insurers.[224] As is also the case under EU law, not all forms of monopolization are illegal. Monopolies will only be illegal if the company holding the monopoly abuses its dominant position. For instance, imagine a hospital that only treats patients who enter into agreements including clauses providing for price raises in case the patient receives health care in other hospitals or health care centers. The issue with the health care sector is that market concentrations involving hospitals and insurance providers are tremendously common. This gives rise to significant price increases. Indeed, hospital consolidation during the 1990s increased overall prices by over 40%.[225] All

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[221] *Morton's Market, Inc. v. Gustafson's Dairy, Inc., 198 F.3d 823, 826 (11th Cir. 1999) Ohio ex rel. Montgomery v. Louis Trauth Dairy, Inc., 925 F. Sup. 1247, 1249 (S.D. Ohio 1996)*, cited by Leslie (2012: 895-896).

[222] See, for example: *FTC v. Ind. Fed'n of Dentists, 476 U.S. 447, 459 (1986)*. Also cited by Leslie (2012: 896).

[223] Leslie (2012: 898), Leslie, C. R., (2006), "The Anticompetitive Effects of Unenforced Invalid Patents," 91 *Minnesota Law Review*. 101, 148-49.

[224] Glied, S.A., Altman S. H. (2017) "Beyond Antitrust: Health care and Health Insurance market trends and the future of competition." *Health Affairs* 36, No. 9, p. 1572 *et seq.*

[225] Leslie (2012: 907).

of this drives many patients out of the market. If health insurance prices get too high, health insurance will be rejected as compensation for workers in employment contracts. This is why the Federal Trade Commission (FTC) prevents concentrations if it finds that such compensation has anticompetitive effects.

Judicial mistakes in application of antitrust law to mergers and concentrations can be devastating. Failure to stop certain mergers on time can lead prices of certain goods or services to skyrocket (pharmaceutical products, for instance). Let us take, for instance, the 2011 Lundbeck case.[226] After the merger between two major pharmaceutical companies−which had been challenged, although the district court held for the acquiring company in *FTC v. Lundbeck, Inc., 650 F.3d 1236, 1238 (8th Cir. 2011)*−the price of several pharmaceuticals skyrocketed, making them unaffordable. These were pharmaceutical products present in a medicine for newborns affected by heart conditions (roughly 30,000 newborns per year suffered this life-threatening heart condition) that prior to the merger was affordable. It is a heart-breaking case (pun intended) that aptly exemplifies the tremendous impact of misapplying antitrust law.

4.3. Welfare services provided by nonprofits do not, on an *a priori* basis, fall outside the scope of antitrust law: "the adoption of the non-profit form does not change human nature"

At first glance, it would seem repugnant to associate nonprofits with antitrust legislation.[227] However, it is a fact that the provision of welfare services by nonprofits has given rise to many antitrust cases. See the landmark case *Hospital Corporation of America versus Federal Trade Commission 1986*, which stemmed from a famous case ruled by the Supreme Court in 1984: *National Collegiate Athletic Association versus Board of Regents of University of Oklahoma*, 468 U.S. 85 (1984). In this case, the Supreme Court upheld the first instance court decisions regarding a national athletic association that breached antitrust law by restricting its members' broadcasting rights for soccer games.

[226] Leslie (2012: 907-908).

[227] Nawalanik, F. J., (1972) "Motives of Non-Profit Organizations and the Antitrust Laws," 21 *Cleveland State Law Review* 97. In this vein, see: Nonprofit Associations Are Subject to Antitrust Liability for the Acts of Their Agents with Apparent Authority: Am*erican Society of Mechanical Engineers v. Hydrolevel Corp*., 102 S. Ct. 1935 (1982), 60 Washington University Q. 1487 (1983).

In the United States, it is well-settled case law that nonprofits do not fall outside the scope of application of antitrust law.[228] US courts do not allow anticompetitive behaviors even if they (i) come from not-for-profit entities; or (ii) occur within the context of welfare provision.[229]

Antitrust law in the US qualifies as a generic and broad framework with little density. It is thus necessary to keep in mind that the aforesaid line of case law relies on a specific understanding of the facts, most certainly shared by antitrust law enforcers in the US, and particularly by the Federal Trade Commission (FTC), whose decisions are upheld by the courts of justice. This institutional connection is aptly illustrated by the 1990 lecture of the (back then) chairman of the FTC "*Federal Antitrust enforcement for non-for-profit organizations*" delivered on 28 June 1990 within the framework of the *Legal Seminar for nonprofit organizations* held in Milwaukee, Wisconsin.

The underlying rationale for this interpretation on the application of antitrust law to nonprofits is that, as any other entity, nonprofits also tend to maximize their income. There is no reason to believe that, within a competitive marketplace, nonprofits do not have the same "income-maximizing drive" as any other actor.[230] It is also worth considering that nonprofits have a growing presence in many goods and services sectors subject to market rules, and their behavior resembles more and more that of businesses and profit-maximizing entities. Along these lines, the FTC tends to consider that nonprofits can have the same willingness to carry out an anticompetitive behavior to maximize income, even if their purposes do not include making a profit for their shareholders or sponsors. Indeed, additional

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[228] There have been some rulings contrary to this line of case law that have been heavily criticized by scholars. See, for instance, Richman B.D. "Antitrust and Non-profit Hospital Mergers: a return to basics," *University of Pennsylvania Law Review* No. 156. One of the rulings arguing that there was no antitrust law violation was adopted in *The court's Trade Commission v. Butterworth Health Corp* in 1996, cited by Searing, E. A. M., (2014). "Charitable (Anti) Trust: The Role of Antitrust Regulation in the Nonprofit Sector*." Nonprofit Policy Forum,* No. 5 (2), p. 279. In this case, the court's rationale was that the presence of community leaders on the board would remove anticompetitive effects and restrain price increases. However, as Searing clarifies, nonprofits' charitable purposes and philanthropic aims can perfectly coexist and are not incompatible with profit maximization.

[229] In this regard, see Phelan, (2019). Blanchard, L. D. (2014) "Non profits use of noncompetition agreements: having the best of both worlds." *Golden Gate University Law Review* No. 44 (3), p. 277; Richman, B.D. (2006) "The Corrosive Combination of Nonprofit Monopolies and U.S. Style Health Insurance: Implications for Antitrust and Merger Policy," *Law and Contemporary Problems*; Elikenberry, A. M. Drapal, J. (2004) "The Marketization of the Nonprofit Sector: Civil Society at Risk" *Public Administration Review*, Vol. 64, No. 2; Greaney, T. L., (2004) "Chicago's Procrustean Bed: Applying Antitrust Law in Health Care," 71 *Antitrust Law Journal*. 857.

[230] Searing, E.A.M. (2014:261). In the United Kingdom, antitrust authorities have also fined private schools (registered as nonprofits or charitable organizations) for exchanging specific information regarding future pricing intentions on a regular and systematic basis from 1 March 2001 to 1 June 2003. See http://webarchive.nationalarchives.gov.uk/20140402142426/http:/www.oft.gov.uk/OFTwork/competition-act-and-cartels/ca98/decisions/schools.

income can help nonprofits to remain in operation, to continue performing their activities, to enhance their equipment or facilities, to extend or improve the scope of their charitable initiatives, to increase their institutional standing and reputation, as well as to raise their employee salaries or to improve their working conditions. There is no doubt that all of these factors can lead to anticompetitive behaviors by nonprofits, thereby restraining trade, distorting market operation and causing damage to their competitors or their users and clients. Within this context, it is worth examining former Seventh Circuit Judge Richard Posner's quote,[231] claiming that "the adoption of the non-profit form does not change human nature." Ultimately, the advocates of applying antitrust law to nonprofits assume that individuals tend to be non-competitive, particularly if the ground rules require fair play and that makes it harder to achieve one's own goals. Moreover, courts have even considered that this non-competitive attitude is even more prevalent in non-profit organizations, since they naturally favor cooperation at the expense of competition and rivalry.

Economically speaking, it is considered efficient from a social welfare perspective that antitrust law not differentiate between for-profit and non-profit firms.[232] This conclusion is based on the incontrovertible argument that both types of entities have incentives to distort competition and exploit their market power.

In fact, most anticompetitive behaviors by nonprofits take place within the health care market.[233] Some scholars have argued that the provision of health care services is not subject to classic market dynamics. However, the courts have upheld the application of antitrust law to health care providers.[234]

In practice, there are many antitrust cases within the health care sector because[235] of the geographic dimension of the health care market. In contrast with other sectors, health care services are provided in limited geographic markets where, in most cases, the service cannot be provided elsewhere. Accordingly, there is no single market for the provision of services, but rather many scattered geographic markets. This is inherent to health care services, which

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[231] Provided in the judgment delivered in *Hospital Corporation of America v. FTC, United States*, Court of Appeals for the Seventh Circuit, 12 September 1986.

[232] Philipson, T.J. Posner, R.A. (2006), "Antitrust in the not-for-profit sector*" Working Paper 12132, National Bureau of Economic Research 1050.*

[233] One of the most significant cases was *Federal Trade Commission v. Phoebe Putney Health System, Inc* in 2013. In this case, a non-profit acquisition of a for-profit hospital was blocked on anticompetitive grounds and the acquiring entity challenged the decision. On this matter, see: J.J. Miles, (1999) *Fundamentals of health law*. Chicago Marriott Downtown Chicago. También Hammer, P. J. Sage, R.W.M. (2002), "Antitrust Health Care quality and the courts." *The Columbia Law Review* 102.

[234] This is discussed in Searing (2014), who also refers to previous case law regarding professional associations already declaring that they could breach antitrust rules. For instance, in 1975, the Virginia State Bar was found guilty for anticompetitive practices for setting legal counseling fees (*Goldfarb versus Virginia State Bar*, 1975).

[235] See Hammer, Sage (2002: 571).

constitute customized or individualized care. The relationships between health care providers and patients often occur in specific, delimited locations, where proximity between providers and users is key, as well as the informal dissemination of information about these providers. Ultimately, all of this makes health care services a sector with lower demand but greater geographic concentration and with almost no substitute goods if compared to other services.

Admittedly, antitrust law should not be the only instrument to oversee nonprofits, but there is no doubt that its role is essential to ensure competition in welfare markets. On top of that, empirical analyses show that the various cases in this sector have triggered new lines of case law, allowing courts to include qualitative standards in their economic assessments when deciding on whether to find specific behaviors contrary to antitrust law.

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