SELECTED RECENT ANTITRUST DEVELOPMENTS IN HEALTH CARE

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This paper reviews selected developments in antitrust health care since the last conference in May 2014.1

I. PROVIDER MERGERS AND ACQUISITIONS

A. FTC Challenges Three Hospital Mergers

The Federal Trade Commission filed challenges to three separate hospital mergers near the end of 2015. These are all proceeding through Part III litigation.

1. You Can See Ohio From Here: FTC Seeks Sought to Block Merger of Two West Virginia Hospitals on the Banks of the Ohio River2

The Federal Trade Commission began its litigation onslaught in early November 2015, when it challenged the proposed merger of the only two hospitals in Huntington, West Virginia. The action was noteworthy, in part, because the state Attorney General earlier gave his approval to the acquisition, subject to certain conditions.

After the FTC filed its complaint, the state adopted a certificate of public advantage (COPA) law that may extend state action immunity to the deal. Following that, in late March, the Commission temporarily withdrew the matter from litigation, noting the withdrawal would “give us an opportunity to evaluate the impact, if any, of the state legislation without any adverse effects on competition or consumer interests.”3

Cabell Huntington Hospital is located three miles from St. Mary’s Medical Center in Huntington, a city of approximately 50,000 on the bank of the Ohio River. According to the FTC’s press release,4 Cabell Huntington’s acquisition of St. Mary’s “would create a dominant firm with a near monopoly over general acute care inpatient hospital services and outpatient surgical services” in a four-county area spanning West Virginia and neighboring Ohio. The agency asserts the transaction likely will lead to “higher prices and lower quality of care.” The FTC alleges each hospital is the other’s closest competitor and that together they have a market share greater than 75 percent.

1 The authors wish to thank Professor Thomas L. Greaney of the Saint Louis School of Law, who co-wrote the 2014 Year in Review presentation. Given the slow pace at which cases move through the federal courts, some of the material in that paper was reprised and updated here. We also thank Kaley Fendall and David Maas of Davis Wright Tremaine LLP, Aaron Ross of Cleary Gottlieb Steen and Hamilton LLP, and Lauren Battaglia and Caitlin Russo of Hogan Lovells US LLP for their assistance in preparing this paper. The paper was prepared with material current as of March 2016.


The transaction has not closed: it cannot be completed until the West Virginia Health Care Authority issues a certificate of need and the Catholic Church approves the sale of St. Mary’s. Nonetheless, the Commission voted 4-0 to authorize staff to seek injunctive relief, if necessary to prevent the hospitals from consummating their merger.

Earlier, in July 2015, West Virginia Attorney General Patrick Morrissey announced an agreement with Cabell Huntington “to ensure the acquisition complies with the West Virginia Antitrust Act, the federal Sherman Antitrust Act, and all other applicable state and federal laws.” The agreement with the Attorney General, which was to last for seven years following the acquisition, would maintain St. Mary’s as a free-standing, general acute care, faith-based hospital. Cabell Huntington also promised that, for the same period of seven years, neither hospital would raise rates beyond a benchmark established by the state’s Health Care Authority. If operating margins were to exceed four percent over a three-year period, rate reductions would be required in subsequent years to eliminate the excess. Other conditions include a commitment to maintain open medical staffs at each hospital, to release employees from non-competes, and not to oppose the award of a certificate of need that other health care providers might seek in order to provide services in the hospitals’ market.

On November 4, the day before the FTC issued the administrative complaint, Cabell Huntington and the Attorney General extended the term of the agreement to ten years and added additional conditions.

The FTC characterizes the agreement with the Attorney General, and another agreement Cabell Huntington reached with the state’s largest health plan, as “temporary” and “an attempt to avoid a merger challenge.” The agreements, the FTC asserts, “fall far short of replicating the benefits of competition.” When they expire, “employers and residents will be subject to the full harmful effects of a virtual monopoly for hospital services in their community.”

The FTC planned to begin a trial on its complaint before an administrative law judge April 5, 2016. However, in March 2016 the legislature approved, and the governor signed, a bill to immunize academic medical centers (such as Cabell Huntington) that enter into “cooperative agreements” from antitrust attack so long as those agreements are first approved by the state’s Health Care Authority. As a result, the matter has been stayed, and the trial date scotched, until 14 days after the Authority acts on Cabell Huntington’s anticipated request for immunity. The hospitals promise not to complete their merger while it is withdrawn from adjudication.

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The bill states that in reviewing a cooperative agreement, the Health Care Authority “shall give deference to the policy statements of the Federal Trade Commission.” The Authority also must “consult with the Attorney General of this state regarding his or her assessment of whether or not to approve the proposed cooperative agreement.”

Under the bill, the Authority must consider possible public benefits, which include enhancement and preservation of existing academic and clinical educational programs, hospital services, and population health, as well as the preservation of facilities, gains in cost-efficiency of services, improved utilization of resources, avoidance of duplication of hospital resources, participation in Medicaid, and constraints on increases in the total cost of care. These benefits must be weighed against “any disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.”

FTC staff had submitted a letter to the state legislature in February expressing “strong concerns” about the proposed legislation. According to the letter, the legislation “will very likely benefit only certain providers, and will do so by harming health care competition and health care consumers in West Virginia.” The letter asserts the bill is not needed because the antitrust laws already permit “efficient collaborations among health care providers.” The letter reports that “FTC staff are deeply concerned that the Bill would mainly serve to encourage mergers and conduct that likely would not pass muster under the antitrust laws because they would reduce competition, raise prices, diminish incentives to improve quality, and provide relatively small or no benefits to consumers.”

1. **No Kisses for Hershey: FTC Acts to Stop Combination of Penn State Hershey Medical Center and PinnacleHealth System**

In December 2015, the Federal Trade Commission and the Pennsylvania Attorney General sought to block the proposed merger of Penn State Hersey Medical Center and PinnacleHealth System, alleging that the combination would substantially reduce competition for general acute care inpatient hospital services in the area surrounding Harrisburg, Pennsylvania, and lead to reduced quality and higher health care costs. The FTC filed both an administrative complaint and a motion for a preliminary injunction to block the merger in federal court.

Hershey operates Hershey Medical Center, a general acute care hospital affiliated with the Penn State College of Medicine, as well as the Penn State Hershey Children’s Hospital. The former is a Level I Trauma Center employing more than 800 physicians; the latter is the only children’s hospital in the Harrisburg Area. In total, Hershey operates just over 550 beds. Pinnacle operates three general acute care hospitals with approximately 662 beds in and near Harrisburg, including Harrisburg Hospital and

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Community General Osteopathic Hospital, both in Dauphin County, and West Shore Hospital, in Cumberland County.

The FTC alleges that if combined, the hospitals would control 64% of the market for acute care services for Harrisburg residents.\(^\text{10}\) The parties have argued, in part, that academic medical centers are a market separate from that of other types of hospitals, which if true would greatly reduce the parties’ combined market share.

The FTC also alleges that the two systems are very close competitors, citing high diversion ratios as evidence. For example, the heavily redacted complaint notes that if Hershey were no longer available, 40% of its patients would divert to Pinnacle hospitals and if Pinnacle hospitals were unavailable, 30% of its patients would divert to Hershey.\(^\text{11}\) By contrast, Pinnacle and Hersey argue that rather than increase health care costs, the combined system would benefit health care consumers by creating the depth of services and scale required to manage certain populations and result in lower health care costs.\(^\text{12}\)

The preliminary injunction hearing in federal court took place the week of April 11, 2016, and the administrative trial is scheduled for May 17, 2016.

2. Returning to the Scene of Past Triumphs: FTC Seeks to Block Another Merger in the Northern Suburbs of Chicago\(^\text{13}\)

The third recent hospital challenge by the FTC also began in December 2015, when the FTC filed an administrative complaint and a motion for a preliminary injunction in federal court to block the proposed merger of Advocate Health Care Network and NorthShore University HealthSystem in the Chicago area.

Both Advocate and NorthShore have previous experience with antitrust investigations by the FTC. NorthShore, was previously known as Evanston Northwestern Healthcare Corporation, the subject of the Commission’s 2004 challenge to Evanston’s acquisition of Highland Park Hospital. In 2007, the FTC ruled that the acquisition was anticompetitive and required that Highland Park’s contracts with insurers be negotiated separately from those of NorthShore’s other hospitals.\(^\text{14}\) Meanwhile, Advocate had a run-in with the FTC in 2006, when its PHO entered into a consent agreement with the FTC that arose from allegations it unlawfully fixed prices by negotiating fees for its member physicians with health plans.\(^\text{15}\) The consent agreement allowed Advocate to continue to engage in its clinical integration program with independent physicians, including entering into payer contracts on behalf of these clinically integrated doctors.

\(^{10}\) Complaint, FTC et al., v. The Penn State Hershey Medical Center and PinnacleHealth System. No. 9368 at 2.

\(^{11}\) Id. at 10.


\(^{13}\) Complaint, FTC et al v. Advocate Health Care Network et al., No. 1:15-cv-11473.

\(^{14}\) In re Evanston Nw. Healthcare Corp., No. 9315, 2007 WL 2286195.

The current merger challenge stems from the September 2014 affiliation agreement between Advocate and NorthShore, valued at $2.2 billion. Advocate owns and operates 11 general acute care hospitals and a two-campus children’s hospital in Illinois. It has 85 outpatient facilities and over 5,000 employed or clinically-integrated affiliated physicians. NorthShore owns and operates four general acute care hospitals located just north of downtown Chicago. NorthShore employs approximately 900 physicians and participates with an additional 1,200 independent, clinically-integrated physicians.

The FTC alleges a typical relevant product market of general acute care in-patient services sold to commercial insurers, excluding psychiatric care, substance abuse and rehabilitation services. Because the merging parties both offer nearly all tertiary and quaternary services, these are included in the cluster of inpatient general acute care services. The FTC’s alleged geographic market is unique. The FTC alleges the relevant geographic market is the area in northern Cook County and southern Lake County, defined as the “North Shore Area.” This area is bounded by six hospitals. Advocate has two hospitals in the area—with 638 and 273 beds each—while NorthShore has four with 354, 173, 125 and 149 beds each. The merger allegedly would combine NorthShore’s 35% share and Advocate’s 20% share in this area, resulting in a combined share of 55%. The alleged market notably excludes the academic medical centers in downtown Chicago, including Northwestern Memorial, University of Chicago, and Rush, among others.

The parties believe the merger will result in substantial merger-specific efficiencies stemming from a high-performance narrow network insurance product, and result in cost savings for clinical services stemming from coordination among providers and scale-related cost savings.

The FTC on the other hand, alleges the merger would result in increased bargaining leverage against health plans for the combined entity, allowing it to raise prices. The FTC also questions whether the hospitals’ efficiencies claims are cognizable or merger specific, noting that the efficiency claims are “not nearly of the magnitude necessary to justify the Transaction in light of its potential to harm competition.”

A preliminary injunction hearing began on April 11 in the Northern District of Illinois and is expected to conclude on May 6.

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16 Complaint, FTC v. Advocate, at 15
17 Id.
18 Id.
B. FTC Challenges to Acquisitions of Physician Groups

1. Battle of the Saints Draws to a Close: St. Luke’s, Bested When Saint Alphonsus and Caesar Joined Forces, Loses at the Ninth Circuit and Struggles to Divest Medical Group

The Federal Trade Commission and Saint Alphonsus Medical Center last year won their challenge to the acquisition by the St. Luke’s Health System in Idaho of a large physician group. The Ninth Circuit Court of Appeals affirmed a district court’s earlier decision that the acquisition of the Saltzer Medical Group threatened competition and ordered the divestiture of the group. After the Supreme Court denied a petition for certiorari, the district court appointed a monitor to ensure the maintenance of Saltzer’s assets and appointed a divestiture trustee.

St. Luke’s operates hospitals and employs physicians in various locations in and around the greater Boise area. The litigation began in late 2012, when Saint Alphonsus, a rival health system that operates two hospitals and employs its own physicians, filed suit to challenge the proposed acquisition by St. Luke’s of the 41-physician Saltzer Medical Group. Soon after the case was filed, St. Luke’s completed the acquisition. The Federal Trade Commission joined the fray as a co-plaintiff in early 2013. A year later, following a bench trial, a district court held the acquisition violated Section 7 of the Clayton Act, finding it threatened to lessen competition in the market for adult primary care physician services in Nampa, a town 20 miles west of Boise.

The case represents the first time the FTC has litigated through trial a challenge to a physician acquisition. The decision by the Ninth Circuit, which largely—though not completely—affirmed the trial court’s findings, is a significant victory for the FTC. The highlights of the decision are:

- The court of appeals held the trial court’s decision to confine the relevant geographic market to Nampa was appropriate. St. Luke’s had argued the relevant geographic market should encompass the entire “Treasure Valley,” stretching from Boise west to Nampa and beyond. Although fully one-third of Nampa residents left Nampa for primary care, the appellate court agreed with the trial court that the market should be confined to Nampa because many of those who obtained health care elsewhere did so because they worked elsewhere. Insurers testified they could not successfully market a health plan without primary care physicians in Nampa. Based on this evidence, and evidence that “consumers choose physicians on factors other than price,” the court held patients choosing

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20 See Order to Maintain Assets and Appointing a Monitor and a Divestiture Trustee, entered in Saint Alphonsus Medical Center-Nampa and Federal Trade Commission, et al. v. St. Luke’s Health System and Saltzer Medical Group, Case 1:12-cv-00560-BLW (Dec. 10, 2015), available at www.ftc.gov/system/files/documents/cases/151210stlukeorder.pdf. As of the date this paper was prepared, the Saltzer group had not been divested.
primary care providers in Nampa would not change their behavior in the event of a small but significant increase in the price of that care.

- Once the market was confined to Nampa, market shares of the merging parties were high: Saltzer accounted for roughly half the market and St. Luke’s held about a quarter. The merged system would hold almost 80 percent of the Nampa primary care market. These large market shares produce substantial Herfindahl-Hirschman Index (HHI) numbers. Borrowing language from the Sixth Circuit’s decision two years ago rejecting a hospital merger in Toledo, Ohio, the St. Luke’s court said the merger “blew through” the government’s HHI guidelines “in spectacular fashion.”21 Interestingly, although market shares were high, the shares were based on small numbers: St. Luke’s employed 16 adult primary care physicians in Nampa, St. Luke’s employed eight, and rival Saint Alphonsus employed nine.

- The Ninth Circuit expressed skepticism that an anticompetitive merger could be justified by an argument that the merger will produce efficiencies. The court accepted the lower court’s finding that the Saltzer acquisition actually would improve health care in the area but said, given a very anticompetitive acquisition, the efficiencies alleged were insufficient. More specifically:
  
  o The court upheld the lower court finding that employment of physicians is not the only way to align the incentives of hospitals and physicians to provide better and more efficient patient care.
  
  o The court upheld the lower court’s finding that getting all physicians on a common electronic health record did not overcome the anticompetitive aspects of the acquisition.

- The court made short shrift of the argument that if a merger is anticompetitive, some remedy short of divestiture (such as requiring the merging parties to negotiate separately) suffices to protect competition. Divestiture is simple to administer, the court wrote, and is the preferred remedy. Conduct remedies are problematic because they require ongoing government supervision. The court noted the Sixth Circuit in ProMedica also rejected a conduct remedy and required divestiture.

On one matter the court of appeals sided with St. Luke’s. The trial court had found the combined entity would raise rates for hospital-based ancillary services. The documents on which the lower court relied, however, showed only that St. Luke’s expected to earn more revenue from these services post-transaction. Such increases in revenue, the appellate court held, could result from higher Medicare payments for facility-based

services (an artifact of Medicare’s administered pricing system) or from more referrals, but were not evidence of increased market power.\textsuperscript{22}

And speaking of revenue: in March 2016, the district court awarded fees to the successful plaintiffs. Saint Alphonsus was awarded $7,146,884, Treasure Valley Hospital was awarded $335,382, and the State of Idaho was awarded $943,988, for a total of more than $8.4 million.\textsuperscript{23}

2. **Horse-and-Buggy Medicine?: FTC Settles Claim Merger of Orthopedic Practices Combining 19 Doctors Is Anticompetitive (But 13 Is OK)\textsuperscript{24}**

Six groups of orthopedists, with 19 physicians among them, merged in 2011 into a single practice in Berks County, Pennsylvania. A total of 25 orthopedists practiced in the county. The merger, therefore, produced a group with a 76 percent market share. According to the FTC’s complaint, the merger deprived health plans of the ability to choose among competing orthopedists because, without the merged group, “health plans could not offer a commercially marketable and appealing provider network.” As a result, the FTC charged, the group “acquired substantial market power … which it used to raise prices to most health plans operating in Berks County.”

By the time the consent decree was entered in December 2015, however, six of the 19 orthopedists had left the group’s employ. The FTC’s consent order forbids the recombination of the departed doctors and the group they left, but otherwise ordered no further divestitures.

Judge Posner famously wrote in *Blue Cross & Blue Shield United of Wisc. v. Marshfield Clinic,*\textsuperscript{25} that “[w]e live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine.” Judging from the settlement agreement, the FTC appears to concur that combining 12 (or 13) physicians in one group is permissible, but 19—at least under the circumstances presented—is too many.

\textsuperscript{22} For a discussion of how the Ninth Circuit may have misunderstood the FTC’s argument on this point, see Thomas L. Greaney and Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation Under the Clayton Act,* 91 U. Wash. L. Rev. 199, 232 (March 2016).


\textsuperscript{25} 65 F.3d 1406, 1412 (7th Cir. 1995).
C. News Flash: FTC Loses a Health Care Merger Case! (But … It’s not a Hospital or Physician Merger…)\textsuperscript{26}

The Federal Trade Commission has an enviable track record in its health care merger litigation this century.\textsuperscript{27} In a recent merger case, however, the agency failed to obtain a preliminary injunction barring the consolidation of two companies that provide contract sterilization services on the theory that one provider was an “actual potential entrant” into the U.S. market.

Many health care products must be sterilized before use, and most sterilization is outsourced to contract sterilization providers. There are currently three primary sterilization technologies: gamma radiation, which sterilizes by exposing product to a radioactive isotope; ethylene oxide, which exposes product to a poisonous gas; and “e-beam,” which sterilizes by irradiating the product with an electron beam. Two companies, Sterigenics International and Steris Corp., provide the bulk of the contract sterilization services in the U.S. and are the only U.S. providers of gamma sterilization.

Synergy, a British company, offers all three sterilization modalities outside the U.S., but only offers e-beam sterilization in the U.S. E-beam is primarily effective for low-density products and accounts for perhaps 15% of all contract sterilization in the U.S.

After Steris agreed to acquire Synergy, the Federal Trade Commission sued seeking a preliminary injunction to block the transaction pending a hearing on the merits to be held before an FTC administrative law judge.

The FTC alleged that before the parties agreed to the merger, Synergy was poised to enter the U.S. market with an “emerging” x-ray sterilization technology that can be substituted easily for gamma sterilization (and, indeed, may be superior in certain aspects). Synergy’s entry, according to the FTC, would have created vigorous, three-way competition in the U.S. market. Steris’s acquisition of Synergy eliminated that potential competition.

More specifically, the FTC argued it should prevail on its argument the merger was unlawful under Section 7 of the Clayton Act if it could show (1) the U.S. sterilization market is highly concentrated, (2) Synergy “probably” would have entered the market without the merger, (3) Synergy’s entry would have been procompetitive, and (4) few other firms are able to enter effectively.

Steris and Synergy hotly contested the FTC’s “actual potential entrant” theory, asserting it is disfavored by many courts.\textsuperscript{28} Judge Polster, an alumnus of the U.S. Department of Justice’s Antitrust Division, noted the FTC would be proceeding with this theory in the

\textsuperscript{27} See Lisa Jose Fales and Paul Feinstein, “How to Turn a Losing Streak into Wins: The FTC and Hospital Merger Enforcement,” 29 ANTITRUST MAGAZINE No. 1, at 31; id. at 33 (chart showing government merger history).
\textsuperscript{28} The Supreme Court has expressly reserved the question whether the theory states a claim under Section 7 of the Clayton Act. United States v. Falstaff Brewing Corp., 410 U.S. 526, 537 (1973).
The court focused its attention on the second element of the actual potential entrant theory, that is, “whether, absent the acquisition, the evidence shows that Synergy probably would have entered the U.S. contract sterilization market by building one or more x-ray facilities within a reasonable period of time.”

Synergy had released an interim financial report and held an earnings call with investors in November 2014. At that time, the company reported optimistically on the status of its efforts to enter the U.S. with x-ray sterilization technology. Yet several months later—in the midst of the FTC’s investigation—one Synergy executive wrote that “the FTC inquiry was going down a rat hole” and the company decided to pull the plug on its x-ray efforts in the U.S.

The FTC charged that the November 2014 statements showed Synergy was committed to building x-ray facilities in the U.S. and the company’s later decision to kill the project was made to undercut the agency’s claim Synergy was poised to enter the market.

After an extended review of the evidence, the court disagreed with the FTC. “[T]he evidence unequivocally shows,” the court wrote, that serious problems, which the company was unable to overcome, “justified termination of the project.” The court’s decision rested on three principal factual findings:

- Synergy’s X-ray business plan was never fully developed and would not have obtained board approval. Among other failings, the plan did not show the internal rate of return Synergy typically targeted and the technology envisioned in the plan did not exist. The risky investment in x-ray would have consumed Synergy’s entire discretionary capital budget and would have been a “bet the farm” proposition.

- Synergy was unable to obtain customer commitments in the form of take-or-pay contracts, and the board never would have approved the project without such contracts. Despite its best efforts, Synergy was able to obtain only non-binding letters of interest from a few customers and none would commit to being Synergy’s first U.S. x-ray customer.

- The merger had no significant impact on Synergy’s strategy and efforts in x-ray. The court rejected the FTC’s theory that Synergy abandoned its U.S. x-ray effort so it could argue it was not poised to enter the U.S. market in competition with its acquirer, Steris. Synergy’s public statements regarding its planned U.S. entry were made after the merger was announced; it would not have made these statements if it intended to kill the project to facilitate its merger. Moreover, the executive in charge of the x-ray effort continued to work on it for months after the merger was announced. And this executive, not the CEO, ultimately made the decision to kill the project.
In sum, the Court looked past the “smoking gun” evidence the FTC presented—rosy public statements and internal emails discussing the FTC investigation—and found the economics of the new technology simply did not work. Therefore, it reasoned, Synergy was not an actual potential entrant.

In October 2015, after the court’s decision, the FTC dismissed the administrative proceeding.

D. Insurer Mergers

In 2015, four of the five largest for-profit health insurers in the U.S. announced two separate mergers: Anthem announced it would buy Cigna and Aetna stated it planned to buy Humana. UnitedHealth is the largest insurer in the U.S.

As of the date this paper was prepared, the Antitrust Division at DOJ was investigating both mergers. Various interested groups have submitted comments and testified before the Congress on the pending deals.29

II. STATE ACTION

A. Kicked in the Teeth: North Carolina Dental Board’s Effort to Corner Teeth Whitening Biz Not Immune as State Action30

The Supreme Court held in early 2015 that efforts by the North Carolina Board of Dental Examiners to prevent dental hygienists from engaging in the practice of teeth whitening are not immune from antitrust attack under the “state action” doctrine, first recognized by the Court in *Parker v. Brown*, eight decades ago.31 Because most of the Board’s

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31 317 U. S. 341 (1943).
members are dentists the Court characterized the Board as a “nonsovereign actor controlled by active market participants.” As such, the Court held, the Board’s conduct would be immune from antitrust challenge only if the State of North Carolina actively supervised its conduct. Because the state did not supervise the Board’s conduct, the effect of the Supreme Court’s decision is to uphold an earlier decision by the Federal Trade Commission that the Board violated the antitrust laws when it suppressed teeth whitening by nondentists.

The case represents the second win for the FTC before the Supreme Court in three years on a state action immunity issue.  

The Board of Dental Examiners is an eight-member state agency created by North Carolina statute. Six members are dentists elected by fellow dentists, one member is a hygienist elected by other hygienists, and the final member is a consumer appointed by the governor. State law makes it unlawful to practice dentistry without a license from the Board but does not explicitly identify teeth whitening as the practice of dentistry. After dental hygienists began offering teeth whitening services at significantly lower prices than dentists, the Board investigated the practice. The Board issued “cease and desist” letters to the non-dentists, claiming their actions could subject them to criminal prosecution. The Court reported that the letters had the intended effect: “Nondentists ceased offering teeth whitening services in North Carolina.”

The FTC filed an administrative complaint charging the Board with violating Section 5 of the FTC Act. By the time the case got to the Supreme Court, the Commission had found, and the Court of Appeals for the Fourth Circuit had affirmed, the conduct of the Board was not immune under the state action doctrine and was unlawfully anticompetitive.

The Supreme Court addressed the state action immunity issue only. While the action of a state in its sovereign capacity is shielded from antitrust challenge, private conduct also may be immune if it is undertaken pursuant to a state policy that clearly articulates and affirmatively expresses a policy to displace competition with regulation and if the state actively supervises the conduct. The FTC and Board assumed the requirement of clear articulation was satisfied by the Board, but disagreed on the second issue: the Board asserted it was a state agency and so not subject to the requirement of active state supervision. The FTC argued otherwise.

In prior decisions, the Supreme Court has held that conduct by municipalities is immune upon a showing that the entity acted pursuant to a clearly articulated and affirmatively expressed state policy to displace competition. Such entities need not show their conduct is actively supervised by the state because “[w]here the actor is a municipality, there is little or no danger that it is involved in a private price-fixing arrangement.”33 But where the actor is a private party, active supervision is necessary to ensure that the challenged conduct is the state’s own conduct.

32 The earlier case was FTC v. Phoebe Putney, 133 S. Ct. 1003 (2013).
The exception for municipalities and other substate entities is a “narrow” one, the Court held. The question of where to draw the line between substate entities not subject to the active supervision requirement and those that, like private parties, should be subjected to the requirement, “turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade.”

“State agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing” that the active supervision requirement was created to address. An “electorally accountable municipality with general regulatory powers and no private price-fixing agenda” need not be actively supervised. But an agency “controlled by market participants” is another matter: “When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest.”

Accordingly, the Court held, “a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy Midcal’s active supervision requirement in order to invoke state-action antitrust immunity.”

**B. State Action: The Sequel**

In the wake of the Supreme Court’s decision in *North Carolina Board of Dental Examiners*, reported above, the Federal Trade Commission\(^\text{34}\) and California\(^\text{35}\) both issued advice on how state regulatory boards might comply with the antitrust laws. Meanwhile, a variety of private plaintiffs have filed suits against state bar associations,\(^\text{36}\) boards of veterinary medicine,\(^\text{37}\) taxi commissions,\(^\text{38}\) and acupuncture licensing boards,\(^\text{39}\) among others.

1. **Go Tell It on the Phone: That Teladoc Is Here**\(^\text{40}\)

Teladoc offers “telehealth services.” Employers subscribe so their employees may contact a Teladoc physician through a web portal or over the telephone. A board certified physician reviews information supplied and then calls the patient and dispenses medical advice—which may include a recommendation they visit with a physician in person.

The Texas Medical Board adopted a rule that sought to limit telemedicine by restricting physicians from prescribing unless they conduct a “face-to-face visit or in-person

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evaluation” of a patient. Unhappy with this body blow to its business model, Teladoc sued The Medical Board in April 2015, asserting the Board’s rules violate the Sherman Act and the Commerce Clause.

The Texas Medical Board moved to dismiss the complaint on various grounds, including that its conduct was protected by the state action immunity doctrine.

After holding that the burden to establish immunity fell on the Medical Board, the court moved to the merits of the Board’s claim that it enjoyed immunity—and found it wanting. The Texas Board, like the North Carolina Board of Dental Examiners—was largely composed of market participants. The Board, therefore, did not disagree with Teladoc that, to gain immunity, it had to show its actions were actively supervised by a state actor. It disagreed whether such supervision was present, insisting that it was.

The Board argued active supervision was supplied by the courts, which can review certain Board decisions. The district court dismissed the idea that courts could provide the kind of supervision contemplated by the Supreme Court in North Carolina Board. Courts may consider whether a decision of the Board “exceeded the statutory authority granted to” it. But this does not permit them to question the policy decisions the Board made. Because the entire point of requiring active state supervision is to ensure the action of the regulatory body can, and should, be taken as the action of the State, judicial review did not suffice.

The court also made short shrift of the argument that the Texas Legislature supplied the necessary supervision because of a “sunset review” process written into state law and a provision requiring the legislature to be notified of proposed rule changes. Neither process permitted the Legislature to modify or veto the rule; therefore, neither provided the degree of active state supervision required by the Supreme Court.

2. Duke and UNC: We Compete in Basketball … That’s Enough!41

Dr. Danielle Seaman, a radiologist employed by the Duke University School of Medicine, decided the grass might be greener at the University of North Carolina Chapel Hill School of Medicine and inquired whether UNC had any job openings. After meeting with the UNC’s chief of cardiothoracic imaging, Dr. Seaman received an e-mail saying she “would fit in very nicely” at UNC and should apply when there was an open job. Later, when UNC posted a job opening, Dr. Seaman contacted the school to say she was interested in the position. She received an e-mail from UNC that stated, in part:

Dear Danielle,

Thank you for your continued interest in our department. I remember you well and certainly enjoyed your previous visit with us.

I agree that you would be a great fit for our cardiothoracic imaging division. Unfortunately, I just received confirmation today from the Dean’s office that lateral moves of faculty between Duke and UNC are not permitted. There is reasoning for this “guideline” which was agreed upon between the deans of UNC and Duke a few years back. I hope you understand.

(Emphasis added.)

Here’s what Dr. Seaman understood: she should visit with a lawyer. She filed a putative class action last year against Duke University and the Duke University Health System. The Dean of the UNC Chapel Hill School of Medicine was added later as a defendant. The complaint alleges that defendants and UNC—an unnamed co-conspirator—entered into an agreement not to compete for skilled medical labor. Dr. Seaman claims to represent a class consisting of all medical faculty members, physicians, nurses, and other skilled medical employees at Duke.

Significantly, the complaint does not name UNC, which (according to the complaint) is “incorporated under statute by the North Carolina General Assembly,” as a defendant.

The UNC Dean moved to dismiss on grounds that UNC and the Dean are sovereign state actors and so immune from antitrust liability. Duke moved to dismiss on grounds that if it entered into an agreement with UNC, a sovereign state actor, it should be immune from antitrust attack to the same extent as its alleged co-conspirator because, “[w]here a state is protected by state-action immunity, that immunity extends to private entities involved in the same course of dealing.”

In an order entered in February 2016, the district court denied defendants’ motions. The court noted the Supreme Court “has never extended ipso facto immunity beyond legislatures … and state supreme courts acting in their legislative capacity.” It acknowledged cases exist “holding that a state university system is entitled to ipso facto immunity, including one in this district holding that the very entity involved in this case, the University of North Carolina system, is entitled to immunity.” Accordingly, it certified the question of whether defendants are entitled to immunity for immediate appeal to the Fourth Circuit Court of Appeals.

43 Quoting VIBO Corp. v. Conway, 669 F.3d 675, 687 (6th Cir. 2012).
III. AGENCY GUIDANCE

A. A Rose by Any Other Name? Antitrust Agencies to States: Certificate of Need Laws Stink

Certificate of need laws were adopted decades ago largely as tools to keep health care costs down. But for many years now the federal antitrust enforcement agencies have opposed state certificate of need laws, arguing that because these laws “creat[e] barriers to entry in the health care market” they “prevent new health care entrants from competing” and so, rather than driving costs down, “may actually increase health care costs.” Not surprisingly, then, the agencies long have supported the “repeal of such laws” and have urged state legislatures that wish to keep CON laws to at least take “steps that reduce their scope.”

Until a year ago, however, the last time either agency had written a state legislature in opposition to CON regulation was in 2008, under the Bush administration. In 2015 and 2016, the agencies issued several documents that show they (with the possible exception, discussed below, of one now-former commissioner) remain opposed to CON regulation. These include:

1. FTC to North Carolina: Less Is More

FTC staff wrote to a North Carolina legislator to support a bill that proposed to narrow the scope of CON regulation in that state. The bill would “exempt diagnostic centers, ambulatory surgical facilities and psychiatric hospitals” from CON regulation. Under North Carolina’s CON law, regulatory approval is required for entry or expansion in a wide variety of health service facilities and health care activities.

In the letter, the FTC indicated that the state’s CON law, and other similar laws, may lessen competition for health care services by delaying and raising the cost of entry, limiting the availability of new or expanded health care services, and removing or delaying the competitive pressures that incentivize incumbent health care service providers to innovate and improve existing services.

Commissioner Wright wrote separately to support the staff’s position and to “expound upon the state of the empirical evidence on the effect of CON laws.” Specifically, according to Commissioner Wright,

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48 Letter from Commissioner Joshua Wright to North Carolina state representative Marilyn Avila (July 10,
Basic economic theory, supported by a large body of empirical work, is unequivocal in its teaching that regulatory barriers to entry are, in general, harmful to competition and consumers. Decades of empirical work are consistent with this view of state imposed regulatory barriers and show they are likely to lead to higher prices, reduced consumer choice, and provide few if any consumer benefits in terms of increased quality.

2. **Agencies to Virginia: CON Is Bad Policy**

In October 2015, the FTC and DOJ issued a joint statement to a legislative work group in Virginia considering the future of that state’s CON law (known in Virginia as a certificate of public need). The agencies criticized the state’s law and suggested the legislature and work group “consider whether repeal or retrenchment” of the law “would best serve its citizens.”

FTC Commissioner Julie Brill (who has since departed the agency) issued a concurring statement.50

3. **Court to Virginia CON Critics: Maybe so, but it’s CONstitutional**

Early this year the Fourth Circuit Court of Appeals rejected a long-running constitutional challenge to Virginia’ CON law. Virginia has a very broad CON law.

Plaintiffs, two out-of-state, advanced medical imaging service providers, sought to enter the Virginia market for MRI and CT scanning but encountered roadblocks while navigating the state’s CON process. Plaintiffs filed suit claiming that the CON law was unconstitutional because it placed an undue burden on interstate commerce in violation of the dormant Commerce Clause as well as the Fourteenth Amendment. Although plaintiffs’ conceded the CON law on its face applied equally to all health care providers, they argued that all existing providers were in the state and therefore the laws unfairly sheltered in-state providers from out-of-state competition. A unanimous three-judge panel rejected the argument, finding that the CON law did not give in-state providers a...


systemic advantage and that the law did not impose burdens on interstate commerce that outweigh the local benefits.

4. **Agencies to South Carolina: Most (But Not All) of Us Think CON Is a Bad Idea**

In early January 2016, the agencies issued a joint statement that reiterated their longstanding opposition to CON laws and supported a bill in the South Carolina legislature that would narrow and ultimately repeal the state’s CON law.

Commissioner Brill dissented. Accordiing to the Commissioner, the antitrust agencies do not “possess sufficient relevant information to opine on non-competition-related public policy goals of the CON laws.” She noted that “competition will not move resources from those that can afford health care to those that cannot,” in apparent reference to the argument, advanced by some supporters of CON laws, that by keeping competitors out, CON laws allow incumbents to earn a supra-competitive return in some services which can then be used to subsidize money-losing services or services to the poor.

The Commissioner also took issue with the state of economic research on the effects of CON law, maintaining that it is not as one-sided as the agencies state and that some studies support the claim that CON laws improve access to care.

5. **Commissioner Ohlhausen: Rags on CON Laws in Antitrust Mag**

Commissioner Maureen Ohlhausen wrote an article that appeared in Antitrust Magazine in 2015 criticizing CON laws and urging their repeal. She also disagreed with the notion that CON laws should be retained on the theory they promote care for the indigent.

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B. My Cup Runneth Over: COPAs Abound

In the 1990s, many states adopted laws permitting health care providers to merge or engage in other conduct that might violate the antitrust laws so long as they first obtain a certificate of public advantage from a state authority. Such laws fell out of fashion for a number of years but fashions change and COPAs are back.

1. FTC to Tennessee and Virginia: We’re Here to Help!

In late 2014, in southwest Virginia and northeast Tennessee two dominant health systems, Mountain States Health Alliance (MSHA) and Wellmont Health System announced an intent to merge pursuant to a COPA process in both states. The COPA process (known as a Cooperative Agreement in Virginia) provides a statutory framework whereby the state can approve certain health care transactions that might otherwise violate the antitrust laws, if the benefits of the transaction outweigh the disadvantages and harm to competition and the state exercises active oversight over the newly formed entity. Both the Virginia and Tennessee statutes were amended to apply to hospital mergers and comply with the most recent Supreme Court guidance on the state action doctrine just prior to the MSHA-Wellmont announced merger. Considering that Wellmont and MSHA are the only hospital providers in a number of counties in southwest Virginia and northeast Tennessee, absent a COPA agreement the merger likely would be closely scrutinized under the antitrust law.

While the FTC has not stated that it would challenge the merger absent a COPA, it has become involved in the COPA process in both Tennessee and Virginia. The Tennessee Department of Health sent a letter to the FTC to confirm whether a merger pursuant to the newly revised COPA statute would trigger an antitrust review.

In September 2015, the FTC’s Office of Policy Planning, Bureau of Competition and Bureau of Economics sent non-binding public comment letters to each state, offering FTC staff assistance to the Tennessee and Virginia health departments during their reviews of any COPAs. The letters emphasized the FTC’s longstanding position that legislation intended to grant state action immunity is unnecessary to encourage procompetitive collaborations and instead is likely to harm health care consumers. The FTC also noted its comments were intended to help ensure that any decision regarding the potential benefits and disadvantages of a proposed COPA are based on a rigorous competitive analysis. The statutory framework in both states, and in particular Tennessee,

contemplates consultation with and advice from the FTC during the state’s review of any COPA application.

MSHA and Wellmont submitted pre-submission reports in January 2016, as required by state regulations, to educate the public on the rationale for the merger and the proposed benefits. The formal applications were submitted in February 2016 and address how the two systems plan to integrate facilities, why the merger is necessary, and how operating as a combined entity will benefit health care consumers in Tennessee and Virginia, among other things.

Pursuant to state regulations both Tennessee and Virginia have the opportunity to request additional information from the parties and must issue a decision to grant or reject the COPA application within 120 or 150 days, respectively, from the time the application is deemed complete. To date, the FTC has not taken a public position on the parties’ applications.

2. **FTC to New York: No, It’s not COPAsetic**

FTC staff wrote to the New York State Department of Health in April 2015 to express concern that New York’s COPA regulations, which purport to provide antitrust immunity to certain health care collaborations, are unnecessary because the antitrust laws already permit health care collaborations that benefit consumers. The letter addressed the applications by three newly formed performing provider systems (“PPSs”) under the Delivery System Reform Incentive Program (“DSRIP”)—Adirondack Health Institute Performing Provider System, Advocate Community Partners Performing Provider System, and Staten Island Performing Provider System. For each of the three applicants, if a COPA is granted, certain collaborative activities among participating health care providers, including joint price negotiations, would be immune from the antitrust laws.

The FTC’s argument against granting a COPA for these three applicants—and against COPAs more generally—is that COPAs are unnecessary because procompetitive collaborations already are permitted under the antitrust laws. Granting a COPA, therefore, would have the primary effect of immunizing conduct that would not generate efficiencies and therefore would permit violations of the antitrust laws. According to the FTC, allowing certain health care collaboratives to obtain a COPA is likely to lead to increased health care costs and decreased access to health care services for New York consumers.

New York’s COPA regulations implement Article 29-F of New York’s Public Health Law, as amended in 2011. DSRIP PPS networks are eligible to apply for COPAs, and were formed under New York’s DSRIP program, which is intended to promote community level collaborations among New York health care providers in an effort to achieve system reform, quality improvements and cost reductions. The DSRIP program ties New York’s Medicaid funding to performance benchmarks and health care providers

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are required to participate to receive Medicaid funding. DSNIP PPSs are comprised of competing health care providers.

In its letter, the FTC expressed a strong concern that allowing DSNIP PPSs to obtain COPAs will encourage health care providers to share competitively sensitive information and engage in joint negotiations with payors in ways that will not yield efficiencies or benefit consumers. In addition, although the DSNIP PPSs only apply to Medicaid patients, the FTC believes there is a strong potential that anticompetitive information sharing among the participants may impact commercial and Medicare patients as well. The FTC’s letter is consistent with its position taken in other states against the use of COPAs to immunize certain collaborations from the antitrust laws under the state action doctrine.

IV. OTHER LITIGATION

A. Three Strikes, You’re Out: Court Holds—and Holds—and Holds—Plaintiffs Failed to State a Claim Against Hospital System for Contracting on “All or None” Basis

Three individual purchasers of commercial health care coverage have suffered the third and final dismissal of their purported class action complaint charging Sutter Health with an array of antitrust violations for its alleged practice of insisting that health plans include all Sutter hospitals in their networks if they want access to any of them.

Sutter operates hospitals throughout Northern California. According to plaintiffs, Sutter requires commercial health plans that want access to its hospitals in “must have” markets (where Sutter usually is the only hospital) to contract with Sutter hospitals in markets where many alternatives to Sutter exist. Plaintiffs also charged Sutter with dissuading health plans from steering their subscribers to lower cost hospitals by requiring the plans actively to encourage members to use Sutter and penalizing plans, by imposing higher rates, when they did not do so.

Plaintiffs defined two relevant product markets: the market for the sale of hospital inpatient services to commercial health plans, and the market for the sale of commercial health insurance by those plans to subscribers. Plaintiffs asserted the relevant geographic markets associated with the first product market were “health service areas” (or HSAs) as defined by the Dartmouth Atlas of Health Care. According to the Dartmouth Atlas, as quoted by the court, an HSA is “a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area.” Plaintiffs alleged the relevant geographic markets associated with the market for the sale of commercial health insurance to subscribers were metropolitan statistical areas (MSAs) in which particular plans operated.

According to plaintiffs, the tying and anti-steering provisions Sutter employed harmed competition in multiple ways. These practices caused Sutter’s competitors in the tied markets to lose patient volume they otherwise would enjoy. The practices allegedly led to increasing market power for Sutter in these same markets, as its market shares increased. Plaintiffs claimed too that Sutter’s conduct led to higher prices charged by hospitals to plans that were passed on to subscribers, as well as to lower quality of care.

The complaint before the court was the third amended complaint in the case. Plaintiffs amended their initial complaint, which was dismissed, then amended again. The second amended complaint was itself dismissed. Both of the earlier dismissals were without prejudice to plaintiffs filing another complaint.

The court dismissed the third amended complaint because its factual allegations failed to support the claimed relevant geographic markets. The complaint failed plausibly to define the relevant geographic markets for the sale of hospital services to health plans because HSAs “do not define the geographic markets in terms of the areas where a health plan (or its members) could seek substitutes for Sutter’s” hospital services. The complaint relied entirely on the Dartmouth Atlas to support the allegation that HSAs were relevant markets. But, the court wrote, just because HSAs “are useful tools for ‘assessing the economics of hospital markets’ in some capacity does not mean that they define relevant markets for antitrust purposes.” Even more critically, “the fact that most of the people in the HSAs seek treatment within those boundaries” sheds no light on whether these patients could “seek substitutes elsewhere” or whether a health plan could “contract with a substitute hospital from outside the HSA.” Because relevant markets are defined by where patients (and plans) could turn in the event of a small but significant price hike, it long has been declared insufficient to include in a relevant geographic market only those hospitals where patients actually go for care.61

Plaintiffs submitted the district court’s decision in the St. Luke’s case, discussed above, to support their claim that health plans make decisions as to which hospitals to include on the basis of where members in fact go, not on the basis of where they could go if prices were to increase. The court disagreed that this is what occurred in St. Luke’s: the evidence in St. Luke’s, wrote the Sidibe court, established there were no substitutes to where patients actually went for care. Therefore, in that case, where patients actually went properly defined the market.

Because all of plaintiffs’ claims were predicated on the faulty geographical markets, the court dismissed the complaint in its entirety. Finally, because the plaintiffs had already had two earlier complaints dismissed, the judge held no more attempts would be tolerated and dismissed the third amended complaint with prejudice.

Plaintiffs have appealed to the Ninth Circuit which should hold oral argument soon after this conference is concluded.

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61 See, e.g., FTC v. Freeman Hospital, 69 F.2d 260 (8th Cir. 1995).
B. Primed for Defeat: Ninth Circuit Affirms Dismissal of Lawsuit Claiming Kaiser Purposefully Shot Itself in the Foot

When we reported on this case two years ago, shortly after the second dismissal by the district court of plaintiff’s claims, we wrote “[i]t is unlikely … that two years hence the Year In Review program will describe a reversal by the appellate court, and Prime’s number will be up.”

Prime’s number is now up. The Ninth Circuit in March affirmed dismissal of Prime’s claim Kaiser conspired with its employee unions to raise Prime’s costs and so drive it, a competitor, from the market.

Prime Healthcare, a for-profit entity, operates 11 hospitals in southern California and employs a unique business model. Most of its patients enter its hospitals through its emergency departments or other emergency centers, rather than being admitted by their regular physicians. In its initial 60-page complaint, described by Kaiser as “deeply puzzling,” Prime alleged Kaiser conspired with the Service Employees International Union, which represents many Kaiser employees, to force Prime out of business by, among other things, raising Prime’s labor costs. Kaiser did this, Prime claimed, by paying its union employees too much. This forced Prime to do the same. Prime also challenged Kaiser’s practice of encouraging members to seek care only at Kaiser facilities and SEIU’s efforts to convince public authorities that Prime failed to comply with various Medicare, hospital safety, and licensing requirements. Prime alleged that this conduct was per se illegal and “threaten[ed] to eliminate the potentially lifesaving competitive choice Prime offers to Kaiser members.”

As evidence of an illegal conspiracy, Prime pointed to payments from Kaiser to SEIU, which it claimed could only be explained as “payment for participation in an illegal conspiracy.” Prime also offered Kaiser’s decision to increase nurse staffing ratios and its support of legislation endorsed by SEIU but opposed by others in the industry.

Kaiser and SEIU moved to dismiss. Judge Sammartino dismissed the complaint in August 2012, holding Prime failed to allege adequate facts suggesting that Kaiser conspired with SEIU in violation of Section 1 of the Sherman Act. Prime’s derivative monopolization claims against Kaiser failed for the same reason. The court also found Prime incorrectly invoked the per se rule. Because Prime admitted the “undisputed fact” that Kaiser does “not compete in the same market as union workers,” the court noted the relationship between the two was vertical, not horizontal, and the more lenient rule of reason should instead apply.

The court also made short shrift of the attack on SEIU’s lobbying efforts, holding they were immune from the Sherman Act under the Noerr-Pennington doctrine. The Noerr-Pennington doctrine protects petitioning activity from antitrust liability unless the activity is a mere “sham.” Because SEIU’s lobbying efforts were legitimately aimed at the outcome of legislative action, the court found SEIU’s conduct immune from antitrust attack.

Undeterred, Prime filed an amended complaint. Kaiser and SEIU again filed a motion to dismiss and again prevailed. As reported at this conference two years ago, Judge Curiel dismissed the complaint in July 2013.65 The court rejected the idea that labor contracts between Kaiser and SEIU were illegal antitrust conspiracies, or written in “code language” that “masked” their “ulterior motive of market ‘dominance.’” The court patiently waded through dozens of odd allegations which failed to support any alleged conspiracy. (Sample: “Kaiser Defendants encourages its members to call a ‘nurse line’ before seeking emergency care, in which Kaiser coerces their members to select Kaiser facilities for their emergency room needs instead of non-Kaiser hospitals.”) The allegations failed to meet Twombly’s plausibility standard (sample: accusing Kaiser and the union of establishing a “money laundering operation,” by which Kaiser paid SEIU vast sums).

The court granted plaintiff leave to file a third complaint and tutored plaintiff’s counsel on difference between per se and rule of reason claims, warning that the conduct alleged, if it might ever violate the antitrust laws, would have to be shown to be anticompetitive under the latter test. Plaintiffs failed to filed another amended complaint, however. Defendants moved for entry of judgment under Fed. R. Civ., P 41(b) for lack of prosecution. This spurred plaintiff to file an appeal to the Ninth Circuit.

On appeal Prime argued that the district court abused its discretion when it entered judgment under Rule 41(b). The Ninth Circuit assumed, without deciding, an abuse of discretion but affirmed anyway. The court affirmed the dismissal of the Section 1 claim because Prime did not sufficiently plead facts to show harm to competition.

Beyond conclusory statements, Prime never alleges that any competitors have exited the market or reduced their production because of the Defendants’ actions. Nor does it allege that the Defendants’ actions actually caused health care consumers to face higher prices or a reduction in quality of care, quantity of services, or overall choice of providers.

Quoting Brantley v. NBC Universal, Inc.,66 the court observed, “[c]onclusory allegations that an agreement has the effect of reducing consumers’ choices or increasing prices to consumers do[,] not sufficiently allege an injury to competition. Both effects are fully consistent with a free, competitive market.”

66 675 F.3d 1192, 1202 (9th Cir. 2012).
In the court’s view, the Section 2 claims also were woefully deficient. Prime had alleged Kaiser monopolized (and attempted and conspired to monopolize) the acute care emergency hospital services market. But the complaint contained no evidence of alleged monopoly power. In fact, based on the numbers of hospitals identified by the complaint, the court calculated Kaiser’s share as 12 percent and held this was “simply not sufficient to show market dominance” in light of the fact that “numerous cases hold that a market share of less than 50 percent is presumptively insufficient to establish market power.”

C. Kissing Camels: District Court Smacks Down Motion to Dismiss—Ungulates’ Claims Cross Summary Judgment Hump

After previously avoiding a motion to dismiss, four non-hospital ambulatory surgery centers now have survived summary judgment on their antitrust claims brought against two health systems (one of which has settled with plaintiffs), health insurers, a competing ambulatory surgery center (which also has settled), and a trade association. The district court found plaintiffs presented sufficient evidence of a conspiracy between defendant Centura Health and others to reduce competition for ambulatory surgery services by pressuring physicians and insurers not to do business with the plaintiff ASCs.

Plaintiffs perform outpatient surgical procedures and treatments in non-hospital environments in Denver and Colorado Springs, Colorado. Defendant Centura operates numerous hospitals, as well as ASCs (as joint ventures with private physicians), in both Denver and Colorado Springs, Colorado. Other remaining defendants include Colorado Ambulatory Surgery Center Association, Inc. (“CASCA”), a trade association purporting to represent the interests of the ASCs, and several health insurers.

Centura moved for summary judgment on all of the plaintiffs’ claims: (1) conspiracy in restraint of trade in violation of Section 1 of the Sherman Act; (2) conspiracy to monopolize in violation of Section 2; and (3) attempted monopolization in violation of Section 2.

Centura argued that plaintiffs’ Section 1 claim failed for lack of evidence that Centura conspired with health insurers or the other health system. In response, plaintiffs relied on the following evidence to support the alleged conspiracy: (1) a meeting between the CEOs of Centura and the other health system regarding concerns about the new ASCs in Colorado, and (2) handwritten notes taken during a meeting at a CASCA trade association gathering where a representative of defendant Audubon Ambulatory Surgery Center, LLC, one of Centura’s joint venture ASCs, and representatives of various health insurers were present. While the district court found that evidence of the meeting between Centura and the other health system’s CEO was insufficient to establish a conspiracy (particularly since there was no evidence that Centura agreed “to take action against Plaintiffs”), the court found that the notes from the meeting—which reflected possible actions with respect to “bad ASC’s”—supported an agreement “under which [i]nsurers would take action against Plaintiffs.” Centura argued it did not have any of its own representatives present at the meeting, and it could not be liable for any conspiracy.

entered into by the Audubon joint venture, but to no avail. Relying on a series of emails between executives of a Centura-owned hospital, which in plaintiffs’ view suggested that Centura used Audubon to take action against its competitors, the court concluded that a reasonable jury could find Audubon was acting on behalf of Centura. Accordingly, the court refused to enter summary judgment, asserting a jury could infer “a conscious commitment to a common scheme to achieve an unlawful objective.”

With respect to plaintiffs’ attempted monopolization claim, Centura argued there was no evidence that it had a dangerous probability of achieving monopoly power, citing its market share of only 4.3% for ambulatory surgery patient visits, and a market share of only 16.4% for use of operating rooms for such surgeries. Plaintiffs argued, however, and the court agreed, there was sufficient evidence from which a jury could conclude that Centura and Audubon were not “operating as competitors whose market shares must be considered separately, but instead were affiliates whose market share may be combined.” Because Centura and Audubon’s combined market share was 62%, the court found there was a disputed question of material fact as to the appropriate market share at issue.

Finally, Centura argued all plaintiffs’ claims should fail because plaintiffs presented evidence of injury only to themselves as competitors, not to competition as a whole. Although the court recognized the well-established principle that the antitrust laws are intended to protect competition, not individual competitors, it asserted “a plaintiff’s injury alone can constitute antitrust injury under certain circumstances.” Because plaintiffs’ expert concluded that elimination of any one of the plaintiffs from the market would have a “substantial negative impact on competition” in this case, the court found that this was evidence sufficient to defeat summary judgment.

D. Singing the Blues in Birmingham: Alabama Is Handy Spot to Consolidate Blue Cross and Blue Shield Litigation

Multidistrict class action litigation against the Blue Cross Blue Shield Association and various Blue entities in different states was centralized in the Northern District of Alabama in December 2012, under Judge R. David Proctor. The plaintiffs include subscribers of Blue plans nationwide and health care providers nationwide. Subscriber plaintiffs claim that BCBS customers are forced to pay inflated premiums because the Blue Cross Blue Shield Association (BCBSA) conspired with other regional health plans to illegally allocate certain geographic markets. Provider plaintiffs claim that the same market allocation has resulted in their receiving lower premiums and/or reduced services.

Plaintiffs challenge certain core aspects of the Blue System, including Exclusive Service Areas (ESAs) in the BCBSA license agreement, the national and local best efforts rules, Blue Card and National Accounts program rules that restrict provider contracting and mandate host pricing, non-acquisition rules that restrict the purchase or control of Blue entities, and Most Favored Nations clauses in provider contracts. Generally speaking,

68 In Re: Blue Cross Blue Shield Antitrust Litigation, MDL No. 2406, No. 2:13-cv-20000 (N.D. Ala.). The case includes two different class action track complaints, Conway v. Blue Cross Blue Shield of Alabama (Provider Track Complaint) and Galactic Funk Touring, Inc. v. Blue Cross Blue Shield of Alabama (Subscriber Track Complaint).
under the Blue System’s ESA policies, BCBSA owns the Blue Cross and Blue Shield trademarks, and licenses the right to use those trademarks in the individual exclusive service areas of the 36 Blue plans. With certain exceptions, the licenses prohibit the Blue plans from using the trademark outside of the service area to both sell insurance and contract with providers. Plaintiff’s core allegations claim that the license agreements are an unlawful market allocation agreement among Blue plans not to compete.

Although the market allocation claim is at the heart of the MDL, Provider Plaintiffs also challenge Blue Card and National Account program rules as unlawful price fixing because all Blue plans reimburse providers at the same rate negotiated by the host or control plan. Relatedly, Plaintiffs claim that these rules are an unlawful boycott of providers because Blue plans may not contract with providers outside of their ESA.

Defendants have argued that its regional plan system has been in place for half a century and enables the company to operate like a large nationally integrated health insurer, while still focusing on the needs of each individual region. As to the price-fixing allegations, defendants argue that Blue plans are not actually agreeing on reimbursement rates. Instead, Blue plans are simply purchasing provider services at rates negotiated by other Blue plans, like any group purchasing arrangement.

In mid-2014, Judge Proctor denied the defendants’ motion to dismiss, finding that if the plaintiffs’ claims that the Blue Cross business model simultaneously keeps prices high for subscribers and payments low for health care providers, the company would have violated the Sherman Act. In other words, Judge Proctor found that plaintiffs sufficiently alleged a viable market allocation theory. Judge Proctor, however, did not address all of the arguments put forth by defendants in its motion.

In October 2015, Judge Proctor accelerated two particular complaints in the MDL that were originally filed in Alabama.\textsuperscript{69} Those accelerated complaints generally include the same allegations, same putative nationwide classes seeking nationwide relief, and the same defendants, with a few exceptions. First, the expedited complaints limit the subscriber damages claims to an Alabama subscriber class. Second, the expedited complaints do not challenge MFNs. The remaining cases in the MDL (which include subscriber damages claims outside of Alabama and MFN claims) have not been stayed and are required to adhere to the September 2017 discovery cut-off date.

Currently, discovery negotiations are ongoing, and the current deadline for completing discovery of documents and data is in September 2017. However, the deadline for completing discovery for the accelerated actions is in January 2017. The next significant procedural steps will be class certification motions in March 2017 and early summary judgment motions.

\textsuperscript{69} Order Denying Motions to Dismiss Streamlining Case and economics day, \textit{In Re Blue Cross Blue Shield Antitrust Litigation}.
E. The Never Ending Ménage à Trois: Long-Running Antitrust Saga in Western Pennsylvania Fails to Close

Litigation involving the principal health insurer and largest delivery system in western Pennsylvania has raged across that bucolic landscape for 16 years. The litigation—while not yet over—now appears to be reaching an end.

But we reported as much in the Recent Developments session of this conference in 2012. And in 2010. So, stay tuned for 2018 …

Background

Aficionados of War and Peace, Remembrance of Things Past, and Jarndyce v. Jarndyce are familiar with the twists and turns of the tripartite litigation that that has raged over the last 15 years across the bucolic western Pennsylvania landscape involving UPMC, Highmark and the once-independent West Penn Allegheny Health System.

Antitrust litigation began when West Penn alleged that UPMC, abandoning a historic antagonism towards Highmark, colluded with the payer in an effort to drive West Penn out of business. West Penn charged UPMC worked with Highmark to reinforce the latter’s position as the dominant insurer in the market and, in return, Highmark propped up UPMC as the area’s dominant health care system—all to West Penn’s detriment.

During the course of that bitterly fought litigation, West Penn and Highmark suddenly announced they would merge. West Penn promptly dropped its claims against Highmark but continued the fight against UPMC. The Department of Justice opened, and then closed, an investigation into the proposed merger.

While some might have concluded that the DOJ statement might signal that the saga was winding towards its denouement—it wasn’t. UPMC sued Highmark and West Penn Allegheny, claiming West Penn’s raison d’être was not “to serve as a meaningful competitor in the provider market, but rather to serve as a complicit tool in Highmark’s scheme to dominate the regional health insurance market.” UPMC charged its former companion, Highmark, with conspiring with its new flame, West Penn, to steer Highmark patients from UPMC to West Penn.

70 Cole’s Wexford Hotel, Inc. v. UPMC and Highmark, Inc., Case No. 10-1609 (W.D. Pa., Sept. 1, 2015).
71 Jarndyce v. Jarndyce (est. 18?? – 18??): “Jarndyce v Jarndyce drones on. This scarecrow of a suit has, in course of time, become so complicated that no man alive knows what it means. The parties to it understand it least, but it has been observed that no two Chancery lawyers can talk about it for five minutes without coming to a total disagreement as to all the premises.” Charles Dickens, BLEAK HOUSE (1853). The UPMC/West Penn/Highmark litigation won the coveted Jarndyce award at the 2012 conference.
Eventually Highmark and UPMC settled their litigation. But the antagonism did not end: UPMC announced it would not renew its contract with Highmark after 2014. Highmark asked to the legislature to pass an “any willing provider” law that would to force UPMC to do business with it.  The legislative effort was unsuccessful. But Highmark sued in state court arguing it should be able to stay in-network for UPMC’s Medicare Advantage enrollees. In late November 2015, the Pennsylvania Supreme Court agreed, marking the end of the road for litigation between UPMC and Highmark.  

But meanwhile …

_The current litigation_

Perhaps concerned that some antitrust lawyer somewhere had not yet participated in, written about, or (to be fair) lectured on, this litigation, a new front was opened in 2010, when several purchasers of health care coverage claimed UPMC and Highmark engaged in anticompetitive conduct that raised the cost of the health care they offered their employees. Multiple motions to dismiss were filed and amended complaints were offered.

In September 2015, the district court partially granted (and so, also partially denied) a motion to dismiss the third amended complaint. In a lengthy decision, the district court held the sole remaining putative class representative, a small hotel represented by a large law firm, had alleged sufficient antitrust harm to continue the battle. Plaintiff claimed Highmark moved it and other small group customers into a for-profit subsidiary where it could set rates without the constraints imposed by the state’s insurance department. The subsidiary’s rates were high, according to plaintiff, because UPMC and Highmark conspired to reinforce each other’s position as the dominant health system and insurer. UPMC allegedly agreed not to make its entire provider network available to insurers other than Highmark, and to curtail its own insurance product. Highmark allegedly pulled its support for West Penn (this was before the switch in Highmark’s affections that led West Penn to merge with Highmark) leaving it an ineffective competitor to UPMC. The result of the conspiracy was higher rates for small group health care coverage.

Highmark also moved to strike the class action allegations on grounds the litigation necessarily would require individualized inquiry into each class member’s damages, thus precluding class treatment. The court disagreed, holding plaintiff did not have to show damages could be established on a class wide basis for its claims to proceed. The court noted that only in “rare” cases should class allegations be rejected at the pleadings stage. This was not one of those cases. The time and place for challenges to the appropriateness of the class allegations, the court wrote, is when plaintiff moves to certify the class.

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74 Bill Toland, Battle Continues between UPMC, Highmark Pittsburg Post-Gazette (Mar. 1, 2014).
In March 2016, plaintiff and UPMC moved for preliminary approval of an agreement that would settle the class claims against UPMC for $12.5 million. If approved, the settlement would leave Highmark as the sole defendant in the case. The proposed settlement agreement would require that any future settlement with Highmark meet or beat the $12.5 extracted from UPMC.

At a hearing in mid-March on the motion for preliminary approval of the settlement agreement, the court questioned whether the litigation “most-favored-nations” clause furthered the best interests of the absent class members. Supplemental briefing on the issue was submitted. As of the date this paper was prepared the settlement had not been approved.

F. A Tale of Five Cities: It Was a Season of Settlement In Nurses’ Wage-Fixing Litigation

In 2006, nurses, with the financial support of the Service Employees International Union (SEIU), filed cases against hospitals in five cities: Albany, Chicago, Memphis, San Antonio, and Detroit. These suits alleged that hospitals in each of these geographic markets (1) engaged in a per se violation of Section 1 of the Sherman Act by conspiring to suppress the wages of their nurse employees, and (2) engaged in a rule of reason violation of Section 1 through their exchange of nonpublic information regarding nurse wages. In the decade that followed, these cases have been resolved in large part via settlements.

Albany

Plaintiffs in the Albany case named five hospital systems as defendants: Albany Medical Center, Ellis Hospital, Northeast Health, Seton Health System, and St. Peter’s Health Care Service. In December 2007, plaintiffs filed a motion for certification of a class comprised of all registered nurses employed from June 2002 to June 2006 by the defendants. The court, in July 2008, certified a class of approximately 2300. This class certification was, however, only for the purpose of determining whether the defendants had violated Section 1 of the Sherman Act and whether plaintiffs had suffered an antitrust injury. The court declined to certify the class for the purpose of determining damages at that time. Following this mixed class certification ruling, three of the defendants agreed to settle, but admitted no wrongdoing. Northeast Health settled for $1.25 million, Seton Health System settled for $745,000, and St. Peter’s Health Care Service settled for $2.7 million.

In February 2010, defendants Albany Medical Center and Ellis Hospital filed separate Daubert motions seeking to exclude the testimony of plaintiffs’ economic experts and a joint motion for summary judgment. Ellis Hospital also filed a separate summary judgment motion based on the non-statutory labor exemption, which, in July 2010, Judge Thomas McAvoy denied, finding that, although the nurses’ wages were established through federally mandated collective bargaining, the non-statutory labor exemption did

76 Fleischman v. Albany Medical Center, Case No. 06-cv-0765 (N.D.N.Y.).
not apply because sharing nonpublic information fell outside protected bargaining practices. Judge McAvoy also denied Ellis’s and Albany Medical Center’s joint motion for summary judgment, which challenged the sufficiency of the evidence, finding that there was evidence that defendants shared wage information and the expert testimony supported Plaintiffs’ argument that wages were low when, because of a shortage, they should have been high. Ultimately, Albany Medical Center settled for $4.5 million, and Ellis Hospital agreed to pay $4.8 million. In February 2013, the court granted approval for the distribution of checks, averaging $1,730, to the nurses in the class.

Chicago

Plaintiffs in the Chicago nurses’ wages case sought to represent a class of registered nurses who held positions not requiring an advanced practice certification and were paid on an hourly basis at in-patient hospitals in Cook, DuPage and Lake Counties. The seven defendant hospitals and systems were Advocate Health Care, Children’s Memorial Hospital, Doctors Community Healthcare Corporation (and its hospital, Michael Reese Medical Center), North Shore University Health System (previously Evanston Northwestern), Resurrection Health Care, and University of Chicago Hospitals. The third amended complaint was filed in February 2007, and the plaintiffs moved for class certification in July 2008. On September 28, 2009, Judge John Grady denied class certification, finding that the predominance and superiority requirements under Federal Rule of Civil Procedure 23(b)(3) were not met because Plaintiffs were unable to provide reliable evidence to show “common impact or damages.” Judge Grady found flaws in the econometric model advanced by Plaintiffs’ expert, including that it would not reflect individual nurse’s damages and could not explain variation in the wages. Following this decision, the two named plaintiffs entered into nominal settlements. The case was dismissed on February 18, 2010.

Memphis

Although the Plaintiffs in the Memphis case alleged price-fixing agreements among multiple hospitals, the only named defendants were Baptist Memorial Healthcare and Methodist Healthcare. A turning point in the case was the September 4, 2009 order of Judge Samuel “Hardy” Mays, Sr.. Although Judge Mays found that the case met the numerosity and commonality requirements of Federal Rule of Civil Procedure 23(b)(3), he denied class certification because the named Plaintiffs, Suzanne C. Clarke (a former employee of Methodist) and Conise P. Dillard (a former Baptist employee), did not adequately represent nurses in the Memphis area. Of note, Judge Mays found that Clarke, who had worked for Nurse Alliance (an advocacy group affiliated with the SEIU), had an interest in unionizing the nurse workforce in order to reform the nurse-patient ratio to improve working conditions for nurses and treatment for patients. Plaintiff Dillard had filed for bankruptcy in August 2007. Although plaintiffs’ counsel had until August 28, 2007 to add parties, plaintiffs waited until January 4, 2008 to file a motion to amend the scheduling order to add Anna Bachelder (a registered nurse

77 Reed v. Advocate Health Care, Case No. 06-3337 (N.D. Ill.).
78 Clarke v. Baptist Memorial Healthcare, Case No. 2:06-cv-02377 (W.D. Tenn.).
employed by Methodist). A magistrate judge had denied the motion to amend as untimely, leaving plaintiffs’ counsel with Clarke and Dillard.

Following Mays’ September 2009 adverse ruling, plaintiffs appealed and plaintiffs’ counsel sought to introduce Bachelder as a proposed substitute plaintiff through a motion to intervene. Judge Mays denied the motion as untimely, noting that important litigation milestones passed, including denial of the motion to dismiss, discovery as to class certification closed and plaintiffs’ request for class certification had been denied. In addition, Judge Mays found that there would be prejudice to the defendants because plaintiffs’ counsel would “start from scratch” on class certification with “the benefit of hindsight” from defendants’ original opposition and other cases, as well. In particular, plaintiffs’ counsel sought to introduce an additional expert report, that of Princeton Professor Orley Ashenfelter, because the Albany court had rejected the analysis of plaintiffs’ original expert, Henry Farber. Bachelder appealed Judge May’s ruling, and the Sixth Circuit, in 2011, affirmed, finding that the district court did not abuse its discretion in denying the motion. The case was remanded to the district court, and Baptist and Methodist filed a motion seeking an order for Clarke and Dillard to participate in mediation, as required by the original scheduling order. Clarke voluntarily dismissed her individual claims, but Dillard opposed the motion and sought to litigate her individual claims, stating that she would appeal the class denial after obtaining a judgment. In June 2013, Dillard and the defendant hospitals reached a settlement agreement, and the court filed an order of dismissal and final judgment in August 2013.

Nineteen days later, Keith Ivy filed a motion to intervene as a plaintiff for the limited purpose of appealing the denial of class certification. Elizabeth Mason filed a similar motion one week after Ivy, and the two filed a joint notice of appeal on the issue of the denial of class certification. The district court denied the motions for lack of jurisdiction. Ivy and Mason then filed motions to intervene with the Sixth Circuit, which remanded the matter for consideration. The district court denied the motions for intervention as untimely, and Ivy and Mason appealed. On February 10, 2016, the Sixth Circuit held that the district court erred in not finding that United Airlines, Inc. v. McDonald\(^79\) was controlling precedent. The Sixth Circuit noted that Ivy and Mason, like the plaintiffs in McDonald, sought to intervene only after entry of the final judgment made the adverse class determination appealable and it was clear that the interests of the unnamed class members would no longer be protected by the named class representatives. The Sixth Circuit distinguished Ivy’s and Mason’s intervention motion from Bachelder’s attempt to intervene by noting that Bachelder sought to participate as a class representative in her own right, while Mason and Ivy sought intervention for the limited purpose of appealing the denial of class certification on the issue of Clarke’s and Dillard’s adequacy as class representatives. Because the district court erred in its application of McDonald and its opinion rested on the issue of timeliness, Sixth Circuit remanded the case to the district court to consider the other elements of Rule 24.

Detroit

The nurses’ case in Detroit\(^{80}\) came to a close this Spring. On January 27, 2016, Judge Gerald E. Rosen approved the $42 million settlement by Detroit Medical Center (“DMC”) and nurses in the class of more than 20,000 had until April 16, 2016 to file a claim form.

_Cason-Merenda_, which began six months after the other nurse wage cases, named eight defendant hospitals and health systems in the Detroit-Warren-Livonia Metropolitan Statistical Area: Bon Secours Cottage Health Services, Detroit Medical Center, Henry Ford Health System, Mount Clemens General Hospital, St. John Health, Oakwood Healthcare, Trinity Health Corporation, and William Beaumont Hospitals.

Trinity Health filed a Federal Rule 12(b)(6) motion, which the court denied. In March 2009, Judge Gerald Rosen denied Mt. Clemens’ motion for summary judgment based on the non-statutory labor exemption, finding that the alleged wage-fixing agreement could have had a demonstrable effect upon Mt. Clemens’ negotiations with the unionized nurses and declining to rule as to whether plaintiffs could show antitrust injury.

On April 24, 2009, plaintiffs filed a motion for class certification, four defendants (Henry Ford, William Beaumont, Trinity Health, and Mt. Clemens) filed a joint motion for summary judgment, and both sides filed _Daubert_ motions to exclude the opposition’s expert testimony. Mt. Clemens and Detroit Medical Center also filed separate motions for summary judgment.

Prior to decisions on the 2009 motions, Bon Secours, Oakwood and St. John entered into settlement agreements. Bon Secours settlement was $325,000, on account of its financial situation and its exit from the Detroit MSA. Oakwood’s settlement of $7,183,000 was for two percent of the wages paid to its employed registered nurses and advanced practice nurses during the four-year class period. St. John agreed to pay $13,583,475 on the express condition that the class certified by the court not be materially modified from that defined in the settlement agreement and, if that condition were not met, then the settlement would only be $3.4 million. Both Oakwood and St. John included most favored nation clauses in their settlements, allowing for refunds if the plaintiffs settled with the other defendants for less than 2% of the wage amounts. Judge Rosen approved these three settlements on March 5, 2010 and entered final orders and judgements on September 8, 2010.

In March 2012, Judge Rosen denied defendants’ motions for summary judgment and, in May 2012, denied a motion for reconsideration. Defendants argued that plaintiffs failed to produce direct or circumstantial evidence of a wage-fixing agreement and failed to establish any anticompetitive effects. Plaintiffs acknowledged that they failed to produce direct evidence of an explicit wage-fixing agreement. Based on an analysis of the evidence, the court found that defendants were entitled to summary judgment on plaintiffs’ claim of a _per se_ Section 1 violation, but held that plaintiffs produced

\(^{80}\) _Cason-Merenda v. Detroit Medical Center_, Case No. 06-15601 (E.D. Mich.).
sufficient evidence to withstand summary judgment as to their rule of reason claim under Section 1.

Prior to issuance of this opinion, Mt. Clemens and William Beaumont reached tentative settlements with the plaintiffs. Mt. Clemens followed the example of Oakwood and agreed to two percent of total registered nurse wages paid during the class period, equaling $2,036,791. Plaintiffs moved for approval of this settlement in June 2012. William Beaumont agreed to a similarly styled settlement of approximately $11.3 million.

In early 2013, Henry Ford and Trinity Health both reached agreements with the plaintiffs. Henry Ford agreed to a settlement of $8.4 million, which was presented to the court in March 2013. Trinity Health, in a settlement presented to the court in early April 2013, agreed to pay $5.1 million. Judge Rosen approved the Mt. Clemens, William Beaumont, Henry and Trinity settlements in a final order and judgement in October 2013. Claims for these and the prior settlement funds—a combined total of $48 million prior to the deduction of attorneys’ fees, class representative fees and costs and expenses—were submitted by 11,581 nurses from the original class of more than 20,000.

Defendants’ motion to exclude plaintiffs’ expert Orley Ashenfelter was denied April 22, 2013. Plaintiffs’ major victory in the case was the September 13, 2013 order certifying the class. The remaining defendant, Detroit Medical Center, sought leave to appeal. The Sixth Circuit denied the petition, but, in light of Comcast Corp. v. Behrend, vacated the district court’s ruling and remanded the case for reconsideration. On March 7, 2014, Judge Rosen reinstated the September 13 order in full. Detroit Medical Center once again sought leave to appeal, and the Sixth Circuit denied that motion on February 3, 2015. With jury selection set for October 5, 2015, Detroit Medical Center and the plaintiffs reached agreement on a settlement amount of $42 million in September 2015.

G. Failure to Copperweld: Joint Operating Agreement Among Four Hospitals Subject to Section 1 Attack

The Sixth Circuit has thrown into doubt the legality under Section 1 of joint operating agreements and other structures frequently used by hospitals that seek to affiliate without completely relinquishing their separate identities. Such structures often are used in affiliations between religious and secular systems.

Four competing hospitals in Dayton, Ohio, were parties to a joint operating agreement that governed their delivery of health care services. The initial JOA was established in 1995 by two hospitals, one of which was a hospital in a Catholic system. As a Catholic hospital, that institution could not be party to a merger with a secular organization and still retain its Catholic identity. The original founders established Premier Health

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81 133 S. Ct. 1426 (2013)
Partners to manage the affairs of the JOA. The JOA later expanded from two members to four, and Premier continued as manager. All JOA members held interests in Premier.

The Medical Center at Elizabeth Place, a 26-bed, acute care hospital that was not a member of the JOA, sued, claiming Premier and its hospitals had denied it access to payer contracts, physicians, and physician referrals needed to compete. Plaintiff asserted a single claim, arguing the defendants’ conduct in operating the JOA was a per se violation of Section 1 of the Sherman Act. A district court in Ohio entered summary judgment for defendants, finding the members in the JOA operated under the control of Premier and so were functionally a single entity, incapable of conspiracy under Copperweld Corp. v. Independence Tube Corp. But in March 2016, the Sixth Circuit, in a 2-1 decision, reversed and permitted plaintiff to proceed with its claim.

Copperweld held that a corporation and its wholly owned subsidiaries are a single entity and so incapable of conspiring for purposes of Section 1. Copperweld did not address situations where the parent organization has less than complete control over the operations of its subsidiaries or affiliates. More recently, in American Needle v. National Football League, the Supreme Court indicated that whether parties have engaged in concerted action under Section 1 “does not turn simply on whether the parties involved are legally distinct entities.” Instead what is required is “a functional consideration of how the parties involved in the alleged anticompetitive conduct actually operate.”

The district court found the Dayton JOA was similar to the alliance among otherwise competing providers at issue in Health America Pennsylvania, Inc. v. Susquehanna Health System. In that case, the constituent hospitals retained their separate identities and boards, and continued to own their separate assets, but contractually agreed that the alliance would govern their delivery of health care. The district court in Pennsylvania found the hospitals Copperwelded: for purposes of Section 1 of the Sherman Act, they were a single entity.

The majority of the three-judge panel considering the case on appeal disagreed with the district court that the Dayton JOA was a single antitrust entity. Writing for the majority, Judge Merritt asserted that “[t]he question cannot be answered in the abstract as to whether a joint venture like the one here constitutes a single entity incapable of conspiring with itself in an anticompetitive manner, or whether, instead, it becomes a vehicle to facilitate separate entities to conspire illegally to restrain trade.” To answer the question, the majority wrote, it is important to examine the intent of the parties when they created the JOA:

Based on defendants’ stated intent to keep plaintiff out of the Dayton market, the evidence of coercive conduct threatening both physicians and insurance companies with financial loss if they did business with plaintiff, evidence of

84 560 U.S. 183 (2010).
continued actual and self-proclaimed competition among the defendant hospitals, and evidence that the defendant hospitals’ business operations are not entirely unitary, we conclude that there is a genuine issue of material fact as to whether the defendant hospitals’ network constitutes a single entity or concerted action among competitors for purposes of Section 1 of the Sherman Act.

The court supported this conclusion by referring to “Justice Brandeis’s multi-factored test in Board of Trade of Chicago v. United States”\(^\text{87}\) in which the Supreme Court articulated the scope of the rule of reason analysis. The majority examined purportedly anticompetitive conduct, such as demands made by the members of the JOA that insurers not do business with plaintiff and threats to withdraw medical staff privileges from doctors who did participated in the plaintiff hospital, in deciding not to treat the JOA as a single entity.

Writing in dissent, Judge Griffin engaged in a more traditional antitrust analysis. He argued that intent is irrelevant to the issue whether the hospitals had sufficiently integrated so they could be considered a single entity. He explained that Chicago Board of Trade is relevant only if Section 1 already has been found to apply because concerted activity is involved; the case does not help resolve the antecedent question whether concerted action is involved in the first place.

The dissent argued the JOA hospitals had a unity of interest because they shared in the net income (or loss) of the JOA. “Most importantly,” according to the dissent, “the allocation of network net income is not linked to any individual hospital’s revenue or profitability” because each hospital’s share was fixed in a predetermined proportion. And, the hospitals’ integration was “not limited to profits and losses on a balance sheet.”

The JOA granted Premier, the management company, “significant operational authority over each defendant hospital.” The JOA designated Premier as the “operator” for all activities gave that company “general authority to operate and manage the operations of the health system activities of all defendants.” Specifically, the dissent wrote:

- Defendant hospitals CEOs report to Premier’s COO.

- Each defendant’s management reports to Premier’s executives, and Premier’s system vice presidents and senior vice presidents serve at the top of each department throughout the system.

- Premier has integrated a number of system management functions among defendant hospitals, such as managed care and legal functions, into single departments for the entire system.

\(^{87}\) 246 U.S. 231, 238 (1918).
• The JOA grants Premier authority and control over defendants' strategic plans, budgets, and business plans.

• The JOA requires Premier to develop and oversee the implementation of a strategic plan for all system activities, and each defendant must comply with and implement the strategic plan.

• It also requires Premier to develop annual capital expenditure and operating budgets for the system, and each defendant must adopt and implement the budget approved for it by Premier.

• Premier’s CEO has the power to remove each defendant hospital’s CEO.

• Premier controls defendant hospitals’ material debt incurrence and negotiates and manages their relationships with insurance companies.

In April, a petition for rehearing by the panel or en banc was filed.88

V. REVERSE PAYMENTS

The primary focus of reverse payment litigation in the wake of Actavis has whether non-cash forms of payment from a branded manufacturer to a generic ANDA filer are also subject to scrutiny under the Actavis framework set forth by the Supreme Court.

Two Circuit Courts have now weighed in and found that Actavis does apply to non-cash forms of payment, including so-called “no-AG” agreements whereby a branded manufacturer agrees not to market an authorized generic during the generic challenger’s 180-day exclusivity period.89

In King Drug, Teva agreed to end its challenge to a GSK patent related to its anti-epileptic and bipolar disorder drug, Lamictal, in return for early entry (approximately 37 months prior to expiration of the patent) and GSK’s commitment not to produce an AG version of Lamictal. The Third Circuit found that the Actavis framework applied to this agreement “because it may represent an unusual, unexplained reverse transfer of considerable value from the patentee to the alleged infringer and may therefore give rise to the inference that it is a payment to eliminate the risk of competition.” The court explained that “no-AG agreements are likely to present the same types of problems as reverse payments of cash” because they “may be of great monetary value to Teva as the

88 Petition for Panel Rehearing or for Rehearing En Banc (filed April 5, 2016).
first-filing generic.” Additionally, as with a cash payment, a no-AG commitment allows the brand to avoid the risk of patent invalidation or finding of non-infringement, the generic “presumably agrees to an early entry date that is later than it would have otherwise accepted,” the brand’s monopoly remains in force prior to this entry, and even once the generic enters, it faces no competition with other generics. The court rejected the defendants’ arguments that no-AG agreements are essentially nothing more than exclusive licenses, concluding that what defendants’ were seeking to do was in fact to “use valuable licensing in such a way as to induce a patent challenger’s delay.”

The First Circuit reached the same conclusion regarding settlements between Warner Chilcott, Watson, and Lupin related to Warner Chilcott’s oral contraceptive, Loestrin 24. In overturning the district court’s ruling, the court explained that while Actavis “emphasizes that the value of a reverse payment is a key component in determining whether it is unlawful,” it was not limited on its terms to cash forms of payment and that it would be possible to adequately estimate the value of non-cash payments. The court held that it was not necessary for plaintiffs to allege the precise value of a non-cash payment at early stages of litigation: plaintiffs need only “allege facts sufficient to support the legal conclusion that the settlement at issue involves a large and unjustified reverse payment under Actavis.”

The FTC also has remained active in challenging alleged reverse payment patent settlements, most recently filing a complaint alleging that Endo Pharmaceuticals paid first-filer generic manufacturers to delay their entry with generic versions of Endo’s Opana ER and Lidoderm.90 The FTC alleges that Endo’s settlement with Impax involved multiple forms of payment from Endo to Impax to delay its entry with a generic version of Opana ER—namely a no-AG agreement worth approximately $37 million to more than $100 million, and a side-deal pursuant to which Endo paid Impax at least $10 million in return for development and co-promotion efforts. The suit also alleges that a settlement between Endo, Watson, and Teikoku involved reverse payments in the form of a no-AG agreement, as well as a supply arrangement under which Watson received $96 million worth of free Lidoderm. Among other things, the FTC is seeking disgorgement remedies in the suit. Teikoku settled with the FTC prior to issuance of the complaint against the other parties.

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90 Federal Trade Commission v. Endo Pharmaceuticals Inc., et al., Case No. 2:16-cv-01440 (E.D.Pa. March 30, 2016). Opana ER is an extended-release opioid used to relieve moderate to severe pain and Lidoderm is a topical patch used to relieve pain associated with post-herpetic neuralgia, a complication of shingles.