Editor’s Report

In this issue of the Chronicle, we are pleased to offer five new articles covering a variety of topics relating to antitrust in the health care and pharmaceuticals industries.

In our lead article, Katie Ambrogi of the FTC’s Mergers IV Division breaks down the key issues relating to clinical quality analysis in hospital mergers and provides lessons learned from the FTC’s recent challenge to OSF Healthcare’s proposed acquisition of Rockford Health System.

Tom Lang and Dave Brenneman of Morgan Lewis next follow up with an update to their hospital mergers article appearing in the last issue of the Chronicle, which reports on recent developments in the OSF/Rockford and Phoebe Putney/Palmyra cases.

In our third article, Valentina Rucker and Dan Kane of Wilson Sonsini analyze a recent challenge by Russian competition authorities over contracting policies by Novo Nordisk and the dominance standard applied under Russian law.

In our fourth article, Rani Habash of Dechert and John Scaf of NERA analyze the FTC’s recent closure of its investigation into the Express Scripts-Medco transaction.

In our fifth article, Caitlin Russo of Hogan Lovells summarizes the lively debate from a recent committee program covering the state action doctrine and the Phoebe Putney merger challenge.

We are always interested in hearing from our committee members. If there is a topic that you would like to see covered in an article or a committee program, please contact Seth Silber (ssilber@wsgr.com) or Christi Braun (cjbraun@mintz.com). If you are interested in writing an article for the Chronicle, please contact Jeff White (jeff.white@weil.com), Gus Chiarello (gchiarello@ftc.gov), or Leigh Oliver (leigh.oliver@hoganlovells.com).

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In April 2012, the U.S. Federal Trade Commission (FTC) successfully obtained a preliminary injunction blocking the proposed merger of two of the three hospitals in Rockford, Illinois. One of the defendants’ central arguments was that the merger would create a higher quality health system and enable the combined entity to better participate in federal health care reform initiatives. But the FTC’s investigation found that these alleged benefits were unlikely and, in any event, the hospitals could practically achieve the purported quality benefits either independently, or through a joint venture or other more competitively neutral transaction. The U.S. District Court for the Northern District of Illinois agreed, holding that it could not find that “these goals would be realized with, and only with, the proposed merger, or that these claimed benefits are sufficient to overcome the FTC’s compelling prima facie case.”

As the most recent litigated hospital merger challenge, FTC v. OSF Healthcare builds on several other successful hospital challenges by the FTC in recent years, including ProMedica Health System and Evanston Northwestern Healthcare Corporation. In granting the preliminary injunction, the OSF Healthcare court found that the quality-related claims were insufficient to overcome the evidence of likely competitive harm resulting from the merger. The decision highlights the courts’ and the enforcement agencies’ willingness to evaluate merging health care providers’ clinical quality claims with analytical rigor. The court’s treatment of the claimed quality benefits of the proposed merger—including analysis of whether such claims are non-speculative, likely to actually improve clinical quality, and merger-specific—is consistent with the FTC’s approach in hospital merger investigations.

1 Katherine Ambrogi is a staff attorney in the Bureau of Competition at the Federal Trade Commission. The views expressed are solely the author’s own, and do not represent the views of the Federal Trade Commission, any Commissioner, or any other Commission staff members. The author thanks Jeff Perry and David Balan for their insightful comments and feedback.


5 OSF Healthcare and Rockford Health System abandoned their proposed merger on April 12, 2012, five days before the FTC administrative hearing was slated to begin. Accordingly, unlike Evanston Northwestern or ProMedica, OSF Healthcare was never adjudicated to a permanent injunction or divestiture.
Importance of Quality in Health Care Mergers

According to a recent press report, 2011 was a 10-year high-water mark for hospital deals, with 86 mergers announced at a total value of $7.95 billion. Press releases announcing mergers invariably promise that patients will benefit from higher quality of care post-merger through various clinical, access, and technological improvements. But such claims regarding potential quality improvements are largely outside the province of antitrust law because the vast majority of hospital mergers proceed without attracting any antitrust scrutiny.

For the handful of hospital mergers that raise competition concerns each year, however, evaluating those transactions’ likely effects on quality of care is an important aspect of the antitrust analysis. A hospital’s ability to improve its patient outcomes, including reducing mortality, readmission rates, and complications, is a critically important goal. As such, merging hospitals’ claims of potential quality improvements and other patient benefits warrant careful consideration by courts and enforcement agencies.

And, in practice, quality claims are also thoroughly tested during the merger investigation and by courts. The empirical research on hospital mergers’ effects on clinical quality shows mixed results. Certain studies found that mergers can actually reduce quality. As a result, the academic research provides no basis to presume that hospital deals will improve quality. Also, as the Evanston administrative court warned, there is a “difficulty of proof inherent in the analysis of quality of care arguments” and, as a result, courts frequently “treat the issue with skepticism.” More pointedly, the U.S. antitrust authorities cautioned, in a joint report evaluating competition in the health care industry, that “enhancing quality has long been the invariant excuse of providers who engage in anticompetitive conduct.” Against this backdrop, quality claims will be carefully vetted, and high-level statements concerning quality improvements, without supporting facts and empirical research or evidence that such proposals are merger-specific, will not justify an otherwise anticompetitive merger.

Quality in the Context of Merger Enforcement

One threshold issue is how quality claims should be evaluated in the context of merger case law and agency investigations. The Evanston administrative court recognized this dilemma, explaining: “If quality of care is relevant to a hospital merger action under


7 For example, in fiscal year 2010, 32 transactions where hospitals were listed as the acquired entity required H-S-R filings. Only four of those deals resulted in a Second Request investigation. See U.S. Dep’t of Justice and Fed. Trade Comm’n, Hart-Scott-Rodino Annual Report, Fiscal Year 2010, Table XI, available at http://www.ftc.gov/os/2011/02/1101hsrreport.pdf.


9 Initial Decision, supra note 4, at 177; see also Jeff Miles, Observations and Lessons From the FTC’s Evanston Northwestern Healthcare Hospital-Merger Decision, 20 HEALTH LAWYER 24 (2007) (“A ‘quality-improvements defense’ must meet the stringent proof standard for efficiencies under the Merger Guidelines.”).

Section 7, it is not clear whether it should be considered a procompetitive justification, an affirmative defense, or an efficiency. Antitrust, to date, has not recognized a single approach to a quality of care defense.\textsuperscript{11} In other words, a merger’s effect on quality does not necessarily fit neatly into a specific area of the antitrust analysis.\textsuperscript{12}

Of course, the Horizontal Merger Guidelines recognize that efficiencies can “enhance the merged firm’s ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products.”\textsuperscript{13} In \textit{OSF Healthcare}, the defendants principally argued that their quality objectives would be achieved from the merged entity’s increased scale, that is, from pooling patients, procedural volumes, and institutional know-how.\textsuperscript{14} To a lesser extent, the defendants separately argued that the merger would generate cost savings that could then be diverted to various quality improvements.\textsuperscript{15}

The \textit{OSF Healthcare} court noted that it was “more appropriate” to evaluate the bulk of the defendants’ quality claims as part of the rebuttal case on the FTC’s likelihood of success on the merits though defendants included them as part of the argument for why the equities weighed in favor of the merger.\textsuperscript{16} Ultimately, the court found that the FTC “presented sufficient evidence to raise serious and substantial questions as to whether these potential benefits outweigh the potential harm to consumers from the presumptively anticompetitive merger.”\textsuperscript{17} The potential quality improvements sat on the scale alongside the traditional cost-saving efficiencies and were collectively weighed against the likelihood of anticompetitive effects. The court considered each proposed improvement carefully and, ultimately, determined that the claims were, in varying degrees, too speculative, too uncertain of producing any actual quality improvement, and not sufficiently merger-specific to outweigh the likely anticompetitive effects in a preliminary injunction proceeding.

\textbf{Court Treatment of Quality Claims in FTC v. OSF Healthcare}

\textbf{Background}

In \textit{OSF Healthcare}, the defendants claimed that the merger would produce several specific quality improvements, including that consolidating services would improve patient outcomes and that the merger would facilitate recruiting specialists and increase graduate medical education.\textsuperscript{18} For these claims, the FTC considered three principal issues: 1) the likelihood that the proposed changes would occur post-merger; 2) whether such changes would actually improve clinical quality; and 3) whether the alleged changes could practically be

\textsuperscript{11} Initial Decision, \textit{supra} note 4, at 177.

\textsuperscript{12} Id. (noting that the Eighth Circuit, in \textit{FTC v. Tenet Health Care Corp.}, 186 F.3d 1045 (8th Cir. 1999), suggested that quality of care may have relevance for the competitive effects analysis).


\textsuperscript{14} Respondents’ Pre-Trial Brief at 41-45, FTC v. OSF Healthcare Sys., FTC File No. 111-0102 (Apr. 12, 2012) [hereinafter “Respondents’ Pre-Trial Brief”], available at \url{http://www.ftc.gov/os/adipro/d9349/120412resppttrialbrief.pdf}.

\textsuperscript{15} Id.


\textsuperscript{17} Id. at 1093.

\textsuperscript{18} See Respondents’ Pre-Trial Brief, \textit{supra} note 14, at 41.
achieved through a less anticompetitive alternative (i.e., either independently, through a joint venture, or through a different merger with a non-proximate hospital). In its decision, the court used a similar framework for evaluating the proposed benefits. The defendants also alleged that the merger would help the combined entity participate in clinical integration prompted by health care reform.

As a starting point, it was largely undisputed that the Rockford hospitals provided similar levels of high quality care without the merger. This fact was supported by significant evidence obtained both during the FTC’s investigation and during discovery in the preliminary injunction proceeding, including investigational hearings and depositions, party and third-party documents, and interviews and affidavits from local health plans and employers. In addition, the FTC and its quality expert evaluated various measures of clinical performance, including data collected by health care organizations, such as the Centers of Medicare and Medicaid Services (CMS) (as displayed on its Hospital Compare website), Leapfrog, and the Agency for Healthcare Research and Quality.

The Rockford community, as well as commercial insurance companies doing business in the area, did not perceive any meaningful disparity between the quality of care that both hospitals provided pre-merger. Hospital executives testified that quality was critical to their institutions and that they had been able to successfully implement quality improvements programs over their years as independent organizations. Their processes and management structures were consistent with high quality hospitals, and both had received several national awards and certifications from well-known, accredited health care authorities.

Mergers and acquisitions certainly may improve clinical performance at some high quality hospitals. But when two merging hospitals are operating at similar, consistent quality levels, as they were in OSF Healthcare, more case-specific evidence is needed to show that quality is likely to improve at a magnitude large enough to offset potential competitive harm.

**Clinical Consolidations and Relationship to Patient Outcomes**

One of the defendants’ most important claims was that the proposed merger would improve patient outcomes by allowing the hospitals to consolidate certain service lines post-merger and thereby increase the number of procedures performed at a single location. These consolidations, if they occurred, would increase the number of procedures performed at one hospital. In light of research that hospitals and physicians performing higher volumes of certain highly specialized procedures may see better patient outcomes, as well as the merger specificity of service line consolidations, this argument is theoretically compelling. But the court agreed with the FTC and concluded that the defendants were unlikely to fully consolidate service lines and the proposed consolidations might not improve quality even if they occurred.

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19 The FTC retained Patrick Romano, M.D., M.P.H., to consult on the likelihood that the proposed merger would improve quality of care. Dr. Romano’s typical approach in assessing quality of care issues is described in detail in P. Romano and D. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 INT’L J. ECON. OF BUS. 45-65 (2011).

20 See Respondents’ Pre-Trial Brief, *supra* note 14, at 41-45.

21 *Id.*

To support this finding, the court reviewed expert testimony that hospital mergers would lead to higher volumes of procedures only if the merged hospitals actually consolidate services—that is, shut down services at one hospital and transfer them to the other—and that the consolidated services must be ones that exhibit a relationship between volume and patient outcome. Citing testimony from defendants’ executives confirming that no decisions had been made on the location of clinical services, the court found that the defendants’ plans for clinical consolidations were “speculative at this point” and “no specific plans have been made on how or when any of these service lines would be consolidated….” The court also relied on empirical literature on the topic of clinical consolidations describing the risks and challenges to such consolidations, including resistance from community members, the difficulty of integrating different physician cultures, and the need to continue certain services at both hospitals to support other service lines that are not consolidated.

The court further noted expert testimony that increasing the volume of procedures performed at a particular hospital—without increasing the number of procedures actually performed by individual physicians—may not produce the claimed patient outcome improvement.

**Health Care Reform and Accountable Care Organizations**

Another potentially important claim by the defendants was that the proposed merger would allow the combined entity to participate in Accountable Care Organizations (ACOs) and other shared savings programs, as well as produce the type of integration that such programs encourage. According to the merging parties, the FTC’s suit to obtain a preliminary injunction against OSF and Rockford Health System was at “cross purposes” with the federal government’s “own goals for healthcare reform.”

Unlike the defendants’ other claimed quality benefits, the court did not consider this claim as a traditional efficiency but rather weighed it when finding that the equities favored a preliminary injunction. According to the court, the defendants’ argument concerning health care reform was “inherently difficult to evaluate.” Because ACOs can provide important quality improvements and cost savings, the FTC seriously considered this claim. ACOs, however, are designed to encourage coordination between complementary, not competing, health care providers in order to offer more effective care. Both the FTC’s quality and economic experts presented evidence that the defendants—before the merger—were already principally competitive, not complementary, organizations. Each defendant is a sizeable, vertically-integrated system with hospitals, home health care, ambulatory facilities, and employed physician groups. As such, the FTC’s experts opined that the defendants were already well positioned to participate in ACOs without the merger. Indeed, at the time of the preliminary injunction hearing, OSF was already enrolled in the “Pioneer ACO” program launched by CMS.

Also, in its final rule implementing ACOs, CMS made clear that the fundamental goals of competition and high quality, coordinated care

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23 Id. at 1091.
24 Id.
25 Id. at 1093.
27 Id. at 20.
are positively correlated: “[C]ompetition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care for Medicare beneficiaries and protects beneficiary access to care….” Both FTC experts concluded that, contrary to the defendants’ claims, the ACO program is entirely consistent with the position that competition among health care organizations produces, not reduces, clinical quality.

The court ultimately granted the preliminary injunction without crediting the defendants’ argument that the merger would help the combined organization participate in ACOs. The decision directly addressed only the defendants’ claim that health care reform would place an undue financial burden on the hospitals, finding that this was “contradicted” by defendants’ financial predictions of success. Specifically, one chief executive officer testified in the preliminary injunction hearing that the hospital’s most recent management plan projected dramatic increases in profits through 2015, after health care reform took effect.

**Recruiting Specialists and Subspecialists**

The defendants also claimed that the merger would improve their ability to recruit and retain specialists and subspecialists, which would increase the scope of services offered locally. The court, however, found that there was no reason to believe merging with a close competitor would increase the likelihood of achieving this goal.

First, the court found it persuasive that one of the defendants, Rockford Health System, had successfully recruited about 20 subspecialists in the last year and had “excellent representation in essentially all of the medical specialties and subspecialties,” without the merger. Second, the court cited the FTC quality expert’s testimony that the empirical research does not support the proposition that mergers facilitate specialist recruitment. While specialists and subspecialists usually require a greater total patient population to keep busy, the FTC’s quality expert testified that the merger would not change the demographics or the population trends in the Rockford area. Independent physicians (i.e., physicians not employed by hospital systems) typically fill this role because they can divide time between competing hospitals and access the area’s entire patient population.

**Graduate Medical Education**

Another alleged procompetitive benefit of the merger was that it would allow the defendants to implement graduate medical education programs at the merged organization. As with the other claimed improvements, the court found that these arguments were not “sufficient to counteract the presumption of illegality.” The court cited the FTC’s quality expert’s report, explaining that case-specific facts made this claim speculative, unlikely to produce a quality improvement, and not merger specific. In particular, the court pointed to evidence that there was “no funding” allocated for the purpose in the affiliation agreement, as well as “no plans” for how these programs would be developed or implemented. Moreover,
limited types of graduate medical education that the defendants claimed the merger would produce (e.g., internal medicine and pediatrics) are not among the types that medical literature shows improve quality, a fact noted by the court. The court also found that the merger was not necessary to initiate graduate medical education programs, and cited expert testimony that it is common for hospitals to join together to implement joint residency programs.33

**Potential Concerns Relating to Quality of Care**

When evaluating the potential of a given merger to improve clinical quality, the FTC also provided an analysis of how the merger could negatively affect quality of care to the court. First, a merger between close competitors such as OSF and Rockford Health System—where testimony and documents demonstrated vigorous competition between the two organizations on quality and services—would be likely to eliminate this important non-price competition.34 As a result, the merger would deprive all area patients (including patients who do not pay for commercial health insurance) of the valuable quality benefits that competition produced.

Next, the court found that the merger would give the combined organization “significant bargaining leverage” to “extract higher prices” from commercial health plans.35 These higher rates are ultimately borne by employers and employees in the form of higher premiums, co-payments, and potentially a loss of health insurance coverage altogether. As the FTC’s quality expert emphasized, courts should consider the well-documented negative impact on patients’ health when lost health insurance results in less and inferior care.

Third, during the preliminary injunction proceeding, the defendants’ expert recommended that the merged organization reduce staffing in the quality and compliance departments in order to lower operating costs. But since hospital staffing levels are typically a function of the number of beds in the hospital, which would not change substantially post-merger, this proposal arguably could have threatened the hospitals’ high levels of quality of care pre-merger by reducing the number of qualified staff on a per-bed basis.

**Conclusion**

*FTC v. OSF Healthcare* is the third consecutive hospital merger—following administrative and Commission decisions in *ProMedica* and *Evanston*—where the merging parties introduced evidence purporting to demonstrate substantial improvements in quality of care post-merger and a court found them to be insufficient to rebut the strong presumption of anticompetitive harm.36 Notably, each of these three cases were marked by high post-merger market shares and HHIs, as well as ample documents, testimony, and econometric evidence that the transactions raised serious competitive concerns under Section 7 of the Clayton Act. The hospitals at issue in these enforcement actions were also, by all accounts,

33 Id.

34 See Horizontal Merger Guidelines, *supra* note 13, at §1 (“Enhanced market power can also be manifested in non-price terms and conditions that adversely affect customers, including reduced product quality, reduced product variety, reduced service, or diminished innovation.”).


36 In another recent hospital merger case, *FTC v. Phoebe Putney Health System*, the primary issue before the court was the applicability of the state action doctrine. *FTC v. Phoebe Putney Health Sys.*, 793 F. Supp. 2d 1356, 1360 (M.D. Ga. 2011).
not suffering from poor pre-merger clinical quality.

*OSF Healthcare* underscores that the FTC and federal courts will seriously consider quality claims made by merging hospitals. Hospitals will undoubtedly continue to make such claims in support of their mergers before the enforcement agencies and courts. What the court decisions and the agency enforcement actions show, however, is that the proposed quality benefits must be real, meaningful, and verifiable. This is especially true when the merger raises significant competitive concerns. Moreover, health care providers’ claims that mergers are needed to participate in ACOs are likely to require concrete evidence demonstrating exactly what the hospitals are lacking that the merger will help them achieve. That scrutiny will be particularly close when the proposed transaction involves two sizeable horizontal competitors already employing physicians and offering other ancillary services, and thus may be unlikely to realize the benefits of clinical integration that providers of complementary care services might otherwise achieve.
Since the Chronicle’s March issue, the Federal Trade Commission (FTC) has continued its efforts to block hospital mergers initially challenged in 2011:

- **Phoebe Putney’s acquisition of Palmyra in Georgia (Phoebe):** The FTC has continued its challenge to Phoebe Putney Health System, Inc.’s (Phoebe) merger with Palmyra Park Hospital, Inc. (Palmyra). There, the threshold issue was whether state action immunity extended to the merging hospitals who, according to the FTC, allegedly solicited a state entity to become a party to a transaction for the purpose of shielding the transaction from the antitrust laws. The Eleventh Circuit affirmed the district court’s denial of the FTC’s request for a preliminary injunction on the grounds that the transaction was immune from antitrust scrutiny under the state action doctrine. In March 2012, the FTC petitioned the U.S. Supreme Court for a writ of certiorari, which was granted on June 25.2

Argument before the Supreme Court will be heard November 26, 2012.3

- **Rockford Health System’s acquisition of OSF Healthcare System (Rockford):** In March 2012, the U.S. District Court for the Northern District of Illinois granted the FTC’s request for a preliminary injunction in its challenge to the proposed merger between OSF Healthcare System (OSF) and Rockford Health System (Rockford). On April 12, 2012, the parties abandoned the proposed transaction, and the FTC dismissed its complaint the next day.4

Both cases reflect the FTC’s continued resolve to pursue challenges against hospital mergers it perceives as anticompetitive. Phoebe demonstrates the FTC’s determination to limit the applicability of the state action doctrine where state political subdivisions are granted “general corporate powers.” Meanwhile, Rockford tests whether the current economic and regulatory climate justifies the merger of hospitals in highly concentrated markets; it also

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1 Tom Lang is a Partner and Dave Brenneman is an Associate in the Antitrust Practice at Morgan, Lewis & Bockius LLP in Washington, DC.


explores the bargaining dynamics between hospitals and managed care organizations (MCOs).

**Phoebe: Foreseeability vs. Affirmatively Expressed State Policy**

One of the FTC’s enduring “priorities” through several recent administrations, according to Chairman Leibowitz, has been to limit the “anticompetitive potential of the state action doctrine.”\(^5\) Now that the Supreme Court has granted certiorari to review the FTC’s challenge to Phoebe’s merger with Palmyra, the FTC might finally achieve its goal.

Phoebe, a general acute care hospital in Albany County, GA, sought to acquire its rival Palmyra, the only other provider of general acute care services in the county, by having the Hospital Authority of Albany-Dougherty County (the Authority)—using Phoebe’s funds—acquire and then lease-back the Palmyra assets to Phoebe for $1 per year.\(^6\) The FTC alleged that the parties sought to include the Authority as a party to the transaction to circumvent the antitrust laws.\(^7\) After the U.S. District Court for the Middle District of Georgia denied the FTC’s request for an injunction, the Eleventh Circuit concurred, reasoning that anticompetitive harm was a foreseeable result of the “broad” corporate powers granted to the Authority, which included the power to “acquire . . . projects.”\(^8\) The Eleventh Circuit noted that the legislature must have been aware that the acquisition of two or more hospitals by the Authority in Georgia, a largely rural state, could have anticompetitive consequences.\(^9\)

In its brief to the Supreme Court, the FTC argued that Georgia’s legislation granting the Authority its corporate powers did not clearly articulate and affirmatively express a state policy to displace competition as required by Supreme Court precedent.\(^10\) The FTC explained that the “clear articulation” requirement is satisfied only when the state’s affirmatively expressed public policy or regulatory framework “inherently,” “by design,” or “necessarily” displaces the free market.\(^11\) By contrast, the FTC argued that when laws can function effectively without displacing free-market competition, and particularly when the law grants mere “general corporate powers,” the Supreme Court standard is not met.\(^12\) In its petition for certiorari, the FTC noted that other circuits have declined to apply the state action doctrine to similar general corporate powers and that each of the cases in which the court found the state action doctrine applicable involved “a regulatory structure or affirmatively expressed state policy calculated to order a particular market by means other than free-market competition.”\(^13\)

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\(^7\) FTC v. Phoebe Putney Health Sys., 663 F.3d 1369 (11th Cir. 2011).

\(^8\) Id. at 1377.

\(^9\) Id.


\(^12\) Brief for the Petitioner, supra note 10, at *27, *33.

\(^13\) Id. at *23-26 (citing Surgical Care Ctr. of Hammond, L.C. v. Hosp. Serv. Dist. No. 1, 171 F.3d 231, 232-33 (5th Cir. 1999)).
The Eleventh Circuit’s flaw in holding that the legislation did clearly articulate the state’s intent to displace competition, the FTC argued, was its misapplication of the “foreseeability standard.” Specifically, the FTC argued that “foreseeability” is an “appropriate tool” for determining the state’s intent to displace competition and that anticompetitive conduct is foreseeable “only if state law speaks with relative specificity to the particular conduct involved, and the conduct is inherently anticompetitive, thereby supporting the inference that the State anticipated and endorsed such behavior...” For instance, the FTC noted that in City of Columbia v. Omni Outdoor Advertising, Inc., the Supreme Court considered the applicability of the state action immunity doctrine to an allegedly anticompetitive zoning ordinance and described the relevant inquiry as whether “suppression of competition is the ‘foreseeable result’ of what the state statute authorizes.” There, the Court concluded that the “very purpose” of the zoning regulation was to interfere with normal competition, and therefore, anticompetitive conduct was foreseeable.

By contrast, the FTC contended that the Eleventh Circuit applied the “foreseeability” standard too broadly. The Eleventh Circuit’s approach, the FTC argued, reflected a “literally plausible understanding” of the term that captures foreseeable anticompetitive results that may not have been intended. The FTC noted that, when analyzed without any underlying context, “because anticompetitive behavior often furthers the economic and other interests of those who engage in it,” anticompetitive behavior is almost always a foreseeable result from the granting of general corporate powers. Yet, the FTC argued, just because anticompetitive behavior can be foreseen from a state’s grant of powers, in a literal sense, the court should not infer that the state intended to displace competition. The FTC argued that, in Phoebe, the enabling legislation at issue was silent as to the displacement of competition, and the general corporate powers granted could be used “both in ways that are anticompetitive and in ways that raise no antitrust concerns.” In these instances, the Georgia’s constitution reflects a policy favoring free-market competition. In these instances, the

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14 Brief for the Petitioner, supra note 10, at *37-44.
15 Id. at *41, *44.
17 Brief for the Petitioner, supra note 10, at *43-44.
18 Id.; see also Petition for a Writ of Certiorari at *21, FTC v. Phoebe Putney Health Sys., No. 11-1160, 2012 WL 978177 (U.S. Mar. 23, 2012) (arguing that applying the Eleventh Circuit’s more liberal view of foreseeability would greatly expand the state action doctrine’s applicability to “virtually all cases involving public corporate powers.”).
19 Brief for the Petitioner, supra note 10, at *38.
20 Id.
21 Id. at *32.
22 Id. at *28 (citing GA. CONST. Art. II, Sec. VI, Para. V(c)(1)).
FTC argued, the most foreseeable result is that the recipient (e.g., the Authority) would act in accordance with background rules that bind similarly situated private actors.23 Thus, the FTC believed that the court should infer that a state foresees anticompetitive conduct only when “state law speaks with relative specificity to the particular conduct involved, and the conduct is inherently anticompetitive, thereby supporting the inference that the State anticipated and endorsed such behavior as part of a policy to displace competition.”24

In its brief to the Supreme Court, Phoebe did not contest the FTC’s argument that a statutory grant of general corporate powers does not grant parties antitrust immunity; instead, Phoebe argued that the Authority’s power was more limited.25 For instance, Phoebe noted that under Georgia law, the Authority may operate only in a narrowly defined geographic area, the Authority’s projects may not be operated for profit, and their prices must not exceed the amount necessary to cover costs and create reasonable reserves.26 Moreover, Phoebe argued, from the grant of these “limited” powers, including acquiring and leasing property to further its purpose of providing for the “operation and maintenance of needed health care facilities,” anticompetitive results were foreseeable.27 The statutory power to acquire and operate another hospital, Phoebe reasoned, would pose “obvious risks to any model of price control based on ‘free competition.’”28

In addition, the FTC alternatively argued that the state cannot authorize an anticompetitive acquisition by private parties without adequate supervision and that Georgia’s regulatory framework did not provide such supervision.29 Phoebe responded that the Authority would have sufficient statutory supervisory power over the merged entity, and that state law provides ample accountability to the Authority.30

Rockford: Real World Justifications and Bargaining Leverage Explored

Soon after the Northern District of Illinois granted the FTC’s request for a preliminary injunction, on April 12, 2012, OSF and Rockford abandoned their plans to merge.31 The FTC had challenged their merger in November 2011, alleging the transaction would reduce the number of hospitals in the Rockford area from three to two and substantially lessen

23 Id. at *40-41.
24 Id. at *43-44.
25 Brief in Opposition for Respondents, supra note 13, at *8.
26 Id. at *8-9.
27 Id. at *7-9 (citing O.C.G.A. § 31-7-76).
28 See Brief in Opposition for Respondents, supra note 13, at *24. In its response, the FTC reiterated its argument that granting the Authority the power to acquire and to operate projects “is not inherently incompatible with free competition.” See Reply Brief for the Petitioner at *3, FTC v. Phoebe Putney Health Sys., No. 11-1160, 2012 WL 1997854 (U.S. June 4, 2012).
29 Brief for the Petitioner, supra note 10, at *44-52 (noting that the state cannot “confer antitrust immunity on private persons by fiat”) (quoting FTC v. Ticor Title Ins., 504 U.S. 621, 633 (1992) (“The mere potential for state supervision is not an adequate substitute for a decision by the State.”)). The FTC alleged that (1) the terms of the agreement were negotiated entirely by private actors, and not by the state, and (2) there is no state entity overseeing the operation subsequent transfer of assets. Id.
30 See Brief in Opposition for Respondents, supra note 13, at *30-31.
competition in the markets for general acute-care inpatient services and primary care physician services. To Rockford, the FTC’s challenge was déjà vu: in 1989, the U.S. Department of Justice Antitrust Division successfully challenged a proposed merger between Rockford and the third competitor, Swedish American Health System (SAHS). SAHS is the third hospital in Rockford, Illinois.

Reviewing The Merger in the Context of Healthcare Reform and Changing Conditions

In its pre-trial brief, the merging parties described in detail the current environment in which the hospitals operated, underscoring the proposition that, “[i]n the healthcare world of 2012, Rockford citizens will benefit greatly from the enhanced ability of the consolidated entity to more effectively deliver healthcare services.” Specifically, the defendants cited to provisions in the Patient Protection and Affordable Care Act of 2010 that emphasize “efficient delivery of healthcare services,” which, the defendants contend, the proposed merger would deliver. The parties argued that the current and future regulatory climate favors efficiency over redundancy, and that the hospitals could compete more effectively in this environment by merging.

The parties also pointedly described Rockford, Illinois as having a “slow population growth” and a “depressed economy,” which has led the city to become oversaturated with three underperforming hospitals. Moreover, the three hospitals had overlapping and expensive practices, such as open-heart surgery programs, which the parties argued were a product of government subsidization from a previous era. Now, the defendants contend, those policies have changed, and “efficient and effective delivery of healthcare is paramount.” In furtherance of the current regulatory climate, and in response to the poor economic climate, the parties argued that consolidating the hospitals’ practice areas would create “centers of excellence” and would make it easier to recruit top specialists, creating better hospitals for the Rockford community.

Bargaining Dynamics

Despite the economic and regulatory environment described by the merging parties, the district court nevertheless granted a preliminary injunction on the grounds that the anticompetitive effects that would result from the parties’ increased bargaining power outweighed any efficiencies and community benefits.

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34 Respondents’ Pre-Trial Brief at 4-5, FTC v. OSF Healthcare Sys., FTC File No. 111-0102 (Apr. 12, 2012) [hereinafter “Respondents’ Pre-Trial Brief”], available at http://www.ftc.gov/os/adjpro/d9349/120412resppretialbrief.pdf. OSF argued that courts should not review mergers in a vacuum; instead, courts should examine “both the history and probable future of the market to assess whether anticompetitive effects are likely” even in cases where the proposed transaction results in high concentration. Id. at 28-29.
35 Id. at 5.
36 Id. at 29. The parties noted that the FTC “failed to take account of the degree to which regulation of healthcare has influenced market structures and performance in the past” and how healthcare reform will influence the future. Id.
37 Id. at 4-5.
38 Id. at 55.
39 Id.
40 Id. at 41.
In its complaint, the FTC alleged that Rockford residents strongly prefer having a choice between two hospitals, and a merger leaving only two hospitals remaining would cause both hospitals to become “must haves” for health plans.\textsuperscript{41} In response, the merging parties argued that, because a second hospital system, SAHS, existed in the market, managed care organizations (MCOs) could credibly threaten to exclude the merged entity from network participation in negotiations as leverage to keep rates down.\textsuperscript{42} Defendants further noted that many MCOs are marketing narrow provider networks to consumers, describing the practice as a “nationwide trend.”\textsuperscript{43} The parties also argued that large and sophisticated MCOs inherently possess enough bargaining leverage to withstand a merger between Rockford and OSF.\textsuperscript{44}

The district court was not persuaded, concluding that the merger would result in the hospitals having an anticompetitive bargaining chip in becoming “must haves” for MCOs. The court noted that after the proposed merger, only two health-plans could be offered to consumers with a reasonable chance of success: (1) one with all three hospitals and (2) one with the combined OSF-Rockford hospitals.\textsuperscript{45} Moreover, the court was not persuaded that narrow-networks that included one hospital would have any chance of success.\textsuperscript{46}

\textbf{Proposed Stipulation}

To preemptively remedy the FTC’s concerns that parties could exclude SAHS from a network, the merging parties filed a proposed stipulation that would not require an MCO company to: (1) “exclude [SHS] from its provider network as a condition for a contract with [the merging parties]” or (2) “contract with [the merging parties] on a system-wide basis or any other individual OSF hospital outside of the [Rockford region] as a condition for obtaining a contract with the [parties’ Rockford hospitals].”\textsuperscript{47}

The district court determined that, although this stipulation would alleviate some competitive concerns, it still left several issues unaddressed.\textsuperscript{48} First, the stipulation would merely leave open the possibility of a three-hospital network; this configuration, the court concluded, would still result in the MCO having reduced bargaining power because it could no longer steer patients.\textsuperscript{49} Second, and more importantly, the district court noted that because the result of not contracting with the merged parties would be a single-hospital network, the parties would still be able to demand higher prices.\textsuperscript{50}

\textbf{What to Expect}

The Rockford case demonstrates the challenges facing hospitals. Despite tough economic

\begin{footnotesize}
\begin{enumerate}
\item Rockford Admin. Complaint, supra note 32, at ¶36.
\item Id.
\item Id. The defendants further noted that MCOs possess significant bargaining power sufficient to shield themselves against rate increases. For instance, defendants claimed that MCOs have an informational advantage over the hospitals, including access to competing hospitals’ rates and utilization. Id.
\item Respondents’ Pre-Trial Brief, supra note 34, at 30-34 (noting that in addition to being large and sophisticated entities, MCOs have an informational advantage when bargaining with hospitals as well).
\item FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1083 (N.D. Ill. 2012).
\item Id.
\item Id. at 1085.
\item Id.
\item Id.
\item Id.
\end{enumerate}
\end{footnotesize}
conditions and a regulatory climate that arguably favors strategic alliances—if not consolidations—the FTC and courts do not appear receptive to permitting hospital mergers in concentrated markets. These merger challenges could have the effect of leading underperforming hospitals in highly concentrated markets to decline proposals to merge with competitors.51

And now that the Supreme Court has granted certiorari in Phoebe, the Court’s decision could have wide-ranging effects on hospital mergers around the country; in its petition for certiorari, the FTC noted that as of 2008, nearly 20% of hospitals were owned by states and local governments.52 Private, non-profit hospitals located near state-owned hospitals might be less inclined to pursue strategic alliances as result of a Supreme Court victory for the FTC.


52 Petition for a Writ of Certiorari, supra note 18, at *12.
Imagine, for a moment, that you head an American pharmaceutical company that primarily manufactures medications for diabetes. For years you have worked hard to build and grow your brand. You have conducted clinical testing to show the value of your drugs; you have streamlined the manufacturing process to cut production costs; you have worked with distributors to position your drug correctly and to market it efficiently. As with any other business, there have been setbacks, but you have established a firm presence in the market.

One day, however, you discover that a cabal of disgruntled former distributors have been complaining about your behaviour to the government. Specifically, they claim that you are a monopolist—as indeed you may be since your drugs are patented—and that you have been illegally exercising your power to deprive them of the right to distribute your pharmaceuticals. They argue that your refusal to deal is crippling their business and that, without government intervention, their businesses will disappear. A nightmare scenario of government investigations and years of costly litigation spins through your mind. Frantic, you call up your antitrust counsel (on speed dial, of course) and ask what you should do. He tells you to relax: the distributors’ claims are baseless, and no domestic authority will act on them. Your fears allayed, you hang up the phone and tend to matters far more important.

Of course, the key qualification in this advice is that it relates only to “domestic” authorities. In the United States, it has long been established that firms generally have the right to choose their business partners. Absent extreme circumstances, the government will rarely require one firm to work with another. In foreign nations, however, this principle is not as widely accepted. One such nation—Russia—recently investigated, litigated, and settled with a private pharmaceutical company whose actions essentially mirrored those described above. This case provides insight into Russia’s review and unexpected application of seemingly fundamental antitrust principles.

An Overview of Russian Competition Law
Russia is a relative newcomer to antitrust enforcement. In the waning days of the USSR, the representatives to the Supreme Soviet ratified legislation that became the nation’s first
antitrust law. Following the breakup of the Soviet Union, this legislation remained national policy, though it was not codified in statute until 2006 with the adoption of The Federal Law “On Protection of Competition” (the Competition Law).\(^3\) In the last six years, this law has been substantially amended twice, first in 2009 (The Second Antimonopoly Package)\(^4\) and again in January of this year (The Third Antimonopoly Package).\(^5\) The most recent revision, while extensive, had minimal impact on the provisions relating to the abuse of dominance, which continues to be governed by the Second Antimonopoly Package.

Generally, under Russian antitrust law, any company with market share above 35% may be considered dominant. Even firms that fall below this threshold may be deemed dominant if they possess a larger market share than any other competitor and are able to exercise a dominant influence on the functioning of the relevant goods market. The precise determination of what qualifies as “exercising a dominant influence” is not entirely clear, though based on certain cases brought by the Russian competition authority—the Federal Antimonopoly Service of Russia (FAS)—it seems that the elements that comprise this determination are somewhat fluid. In fact, in certain instances, companies with as little as 8% of the market may be found dominant.\(^6\) Once dominance is found, the affected firm is subject to a much higher degree of scrutiny. Most notably, dominant firms are required to work with all partners who wish to engage them and operate similarly to already-established partners. As such, a monopolist may not “unjustifiably” refuse to deal with a potential partner: to do so is an abuse of dominance and a violation of the Competition Law.

Some Russian practitioners believe that these market share thresholds were written specifically to target the pharmaceuticals market.\(^7\) While some may dismiss this as a

\(^2\) See USSR Law on Limiting Monopoly Conduct in USSR, IZVESTIIA, July 25, 1991, at 4. Though this was a national law, the statute provided that it would be applied by antimonopoly committees in each of the USSR’s different regions, as well as at the state level. See, e.g., Rose Anne Devlin & Stylianos Perrakis, Legislating competition in the Russian Federation: a new challenge for antitrust policy, 40 ANTITRUST BULL. 901 (1995).


\(^6\) Federal Law of the Russian Federation on Protection of Competition, ROSSIISKAIA GAZETA [ROS. GAZ.], July 27, 2006, available at http://base.garant.ru/12148517.htm. (“The position of each of several economic entities (except financial organizations) is recognized dominant if all of the conditions below apply to the entity: . . . this provision is not applied if the share of at least one of the aforementioned economic entities is less than eight per cent.”).

\(^7\) Yevgeny Voevodin, CMS NEWSLETTER: SECOND ANTIMONOPOLY PACKAGE (2009), available at http://www.aebrus.ru/application/views/aebrus/files/legalcommitte_files/CMS_newsletter_-_Second_Antimonopoly_Package_file_update_2009_10_06_13_52_03.pdf (“This is an attempt by FAS to address issues surrounding retailers and pharmaceutical
conspiracy theory, FAS’s record of enforcement indicates, at the very least, that it has particular concerns about the competitive conditions in this industry. Indeed, as one Danish company discovered over the course of 2009-2011, FAS’s interest in this area, coupled with its expansive authority to draw relevant markets and make determinations regarding monopoly power, potentially makes Russia a risky jurisdiction in which to do business.

Novo Nordisk: An Overview

OOO “Novo Nordisk” (Novo Nordisk) is the Russian subsidiary of a large Danish pharmaceutical company with a specific focus on diabetes medication.8 In line with the practices of many large pharmaceutical companies, Novo Nordisk manufactures its drugs and relies upon third parties to distribute them to end consumers. In 2005, the company’s first year operating in Russia, Novo Nordisk partnered with twelve local distributors. The following year this network swelled to forty. In 2007, Novo Nordisk made a conscious decision to decrease the number of distributors to a more manageable number. That year, it partnered with twenty distributors; the following year, it partnered with only five. While the firm had a number of distributors approach it seeking to do business in this year and those following, the company decided to keep its direct distribution channel narrow. The company did not, however, impose any limitations on sub-distribution. Rejected applicants could still contract with the initial distributors and sell Novo Nordisk’s products in that manner.

Following an investigation into these distribution practices, FAS notified Novo Nordisk in September 2010 that it believed the company had violated the Competition Law (Clauses 5 and 8, Part 1, Article 10).9 Specifically, FAS alleged that Novo Nordisk possessed monopoly power and that it had abused its dominant position in the insulin wholesale market by restricting its distribution network to only five partners. To remedy this harm, FAS fined Novo Nordisk 85.9 million rubles (approximately US$3 million) and enjoined the company from engaging in similar anticompetitive limitations of its distribution network in the future.

Once FAS confirmed the initial finding, Novo Nordisk appealed the agency’s decision to the Moscow Arbitrazh Court. Six months after the company filed its appeal—and on the day the hearing was scheduled to commence—the parties reached a settlement.10 Pursuant to the agreement, Novo Nordisk remained subject to a fine, but the court reduced it to the minimum amount allowed, 53.5 million rubles (approximately US$1.9 million).11

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9 The Decision and Order on the Case Against Novo Nordisk, No. AK/33869, approved by the Federal Antimonopoly Service of the Russian Federation, Oct. 6, 2011 (Russ.), available at http://www.fas.gov.ru/solutions/solutions_31980.html (with the operative part of the decision announced on September, 23, 2010 and the full decision announced on October 6, 2010).


11 Id. It is notable that originally FAS threatened to impose a fine that was much higher, up to 15% of the company’s Russian revenues. See, e.g., Reuters, Novo Nordisk A/S To Challenge Russian Anti-Trust Charges In Court-DJ (Sept. 27, 2010), available at http://www.reuters.com/finance/stocks/NOVOb.CO/key-developments/article/1986015.
importantly, Novo Nordisk agreed to drastically alter its distribution policy as part of the settlement. Whereas before the company could exercise discretion in selecting its distributors, now Novo Nordisk is required to accept any applicant that satisfies the precise criteria delineated in the company’s distribution policy. Distributors that fail to meet the criteria are not automatically rejected; rather, they must be told where their application was deficient and given an opportunity to remedy their shortcomings.

Novo Nordisk should be regarded as a signal for future antitrust review and enforcement in Russia. As a spokesman for FAS commented following the decision, “This is the first turnover-based fine by FAS as applied to a pharmaceutical company that has a dominant position in the Russian pharmaceutical market. We are sure that this case will serve as a cautionary tale for all other pharmaceutical companies operating in Russia.” Indeed, FAS has remained heavily involved in the pharmaceutical industry since this decision. This past April, in fact, FAS participated in discussions regarding the development of a legal regime covering competitive bidding in pharmaceutical markets and general substitutability of medical products.

The Impact of Novo Nordisk

To avoid drawing the sort of scrutiny that Novo Nordisk did, it is imperative that multinationals planning to operate in Russia understand the nuances of FAS’s decision in that case, particularly the agency’s determination that Novo Nordisk possessed monopoly power and was abusing its market position. For businesses that operate primarily in jurisdictions where the behavior deemed illegal by the Russian authorities would not have been problematic, it is particularly necessary to understand the manner in which FAS defined the market, the conduct it considered to be anticompetitive, and the likely application of the laws of other jurisdictions (including the U.S.) to similar facts.

Market Definition

The threshold to satisfy the “dominance” test in Russia is fairly low. In the Novo Nordisk matter, FAS managed to avoid tricky math calculations by drawing an incredibly restrictive market. Rather than examine the inter-brand competition in the broad market for insulin, FAS concluded that Novo Nordisk’s own branded drugs constituted the entire relevant market. Subsequently, the agency determined that as the only manufacturer—again, the product is patented—Novo Nordisk possessed unrestricted monopoly power with 100% of the relevant market. Subsequently, the agency determined that as the only manufacturer—again, the product is patented—Novo Nordisk possessed unrestricted monopoly power with 100% of the relevant market. Unfortunately, FAS did not elaborate on the basis for its finding. The agency simply stated that Novo Nordisk possessed 100% share in the

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13 Id.


wholesale market for drugs with eptacog alfa (activated) and a 100% share in the wholesale market for Novo Nordisk-branded insulin, including NovoRapid PenFill, NovoRapid FlexPen, NovoMix 30 PenFill, NovoMix 30 FlexPen, and Levemir, among others. FAS failed to specify whether it considered other Russian insulin suppliers as potential competitors, or whether manufacturers of branded drugs will always presumptively possess 100% market share in their own branded drugs. This complete lack of guidance from FAS should be of great concern for any business operating in Russia, as it brings into question the legality of any limitations imposed on distribution networks.

**Anticompetitive Conduct**

FAS’s investigation into Novo Nordisk was centered on the company’s distribution process. As part of its efforts to ensure a quality distribution network, Novo Nordisk required, beginning in 2008, that all of its distributors submit to a two-prong review. New applicants were reviewed at the time of their submission of interest, and existing partners were subject to reevaluation every two years. This review included: (1) financial and other documentary due diligence; and (2) audits of storage facilities and transportation systems.

After investigating this policy, FAS concluded that Novo Nordisk did not subject existing partners to the same level of scrutiny as it subjected new applicants. FAS relied heavily upon the fact that multiple companies had applied to distribute Novo Nordisk insulin since 2008, but that the company chose to work only with the five already-confirmed distributors. The agency gave little weight to the realities of the industry or potential reasons for Novo Nordisk’s decision, including that the product was highly specialized, that Novo Nordisk could better review and monitor its distribution network with fewer participants, and that consumers would benefit from consistently safe storage and delivery practices. Rather, FAS reasoned that all of the denied applicants were licensed pharmaceutical distributors in Russia and that they, therefore, had sufficient storage and transportation experience to safely handle Novo Nordisk’s products. Additionally, FAS held that by asking these already-licensed pharmaceutical distributors to go through a facilities audit, Novo Nordisk had supplanted the role of the Russian certification authorities, which have the sole authority to license qualified distributors.

Though there are numerous business justifications that justify different levels of scrutiny for existing and new distribution partners—e.g., goodwill, unbroken trust, positive customer reviews—FAS refused to accept them. Instead, the agency concluded that Novo Nordisk’s application review was a sham and that the policy existed only as a pretext to permit the company to unfairly limit its distribution network.

**Comparison to the United States Standard**

The FAS decision in *Novo Nordisk* stands in stark contrast to established law in the United States. Generally, in the United States, a pharmaceutical manufacturer has great discretion when selecting the members of its distribution channel. Given the presence of other diabetes medications on the market, as well as the opportunity for rejected distributors

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to work as sub-distributors, it seems unlikely that the Department of Justice or Federal Trade Commission (together, the “U.S. agencies”) would have deemed Novo Nordisk’s business conduct sufficiently anticompetitive to investigate, much less litigate.

**Market Definition**

The antitrust laws in the United States emphasize that consumer welfare is derived primarily from inter-brand competition, *i.e.*, competition between manufacturers. So long as multiple manufacturers compete on price, quality, and other variables to earn the business of the consumer, the U.S. agencies are less concerned with ensuring that there is adequate intra-brand competition, *i.e.*, competition among distributors.

In the U.S., the determination of whether Novo Nordisk possessed monopoly power likely would have been made by reviewing inter-brand competition in the market for diabetes medications in general. Specifically, the U.S. agencies likely would have assessed Novo Nordisk’s market position relative to the firms that manufacture a competitive product—firms like Eli Lilly and Sanofi-Aventis. Then, the agencies would determine whether Novo Nordisk possessed sufficient market power to raise prices and deter innovation without losing market share to competitors. Regardless of how the market analysis was conducted, it is extremely doubtful that a U.S. agency would have proposed that the relevant market was limited to Novo Nordisk-branded insulin. If, somehow, the U.S. agency had determined that this definition were proper, it most assuredly would have provided a detailed explanation of its reasoning.

**Refusals to Deal Under U.S. Law**

Even if the U.S. agencies’ market analysis showed that Novo Nordisk possessed monopoly power, it remains unlikely that the firm would be required to work with any distributor meeting predetermined standards. That another firm wants to deal with a monopolist does not obligate the monopolist to deal with that firm; indeed, a bedrock principle of American antitrust policy is that businesses are free to contract with the firms of their choosing. Granted, there are limitations to this principle. As explained in *Aspen Skiing*, “[t]he high value we have placed on the right to refuse to deal with other firms does not mean that the right is unqualified.”

Any hope that distributors might have held about gleaning support from *Aspen Skiing*, however, was all but dashed by the Court’s recent opinion in *Verizon Comm'ns v. Law Offices of Curtis V. Trinko, LLP* (commonly referred to as *Trinko*), which placed *Aspen Skiing* “at or near the boundary of Section 2 liability.” While acknowledging that a monopolist’s choice to not cooperate with rivals may, on occasion, violate the antitrust laws, the Court clearly explained that these occasions are rare: “We have been very cautious in recognizing such exceptions, because of uncertain virtue of forced sharing and the difficulty of identifying and remedying anticompetitive conduct by a single firm.”

Even ignoring *Trinko*, the U.S. agencies would still be unable to bring a case against Novo Nordisk because of the extensive list of valid business justifications that support the decision to use a smaller distribution network. Courts have previously considered, and upheld, refusals to deal based on: (1) a manufacturer’s determination that it already has adequate

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19 Id. at 408.
distribution,\(^{20}\) (2) a manufacturer’s decision to not work with a potential new distributor,\(^{21}\) (3) a manufacturer’s attempt to impose appearance and image requirements upon distributors,\(^{22}\) and (4) a distributor’s failure to meet quality standards.\(^{23}\)

**Conclusion**

Unfortunately for Novo Nordisk, this matter was raised in Russia and not the United States. And unfortunately for other multinational corporations operating in Russia, this case is unlikely to be an outlier: representatives from FAS have noted recently that the agency is particularly concerned with dominant firms that are the exclusive provider of certain products.\(^{24}\)

To combat this, FAS has stated that it will impute dominance to any firm that positions its products as exclusive.\(^{25}\) That this presumption ignores the benefits of exclusive arrangements and barring them could in fact lead to higher prices and less innovation does not appear to be important to FAS. What is important, apparently, is that no dominant firm be allowed the freedom to run its business as it wishes, even those firms dominant only in the products they alone manufacture.

\(^{20}\) See *e.g.*, Winn v. Edna Hibel Corp., 858 F.2d 1517, 1520 n.5 (11th Cir. 1988) (manufacturer has right to terminate dealer when area could not support two).

\(^{21}\) See *e.g.*, Tidmore Oil Co. v. BP Oil Co., 932 F.2d 1384, 1389 (11th Cir. 1991).

\(^{22}\) See *e.g.*, *Winn*, 858 F.2d at 1520 (terminating distributor to maintain image and integrity of product).

\(^{23}\) See *e.g.*, Three Movies of Tarzana v. Pac. Theatres, 828 F.2d 1395, 1399-41 (9th Cir. 1987).


\(^{25}\) *Id.*
An Inside Look at Monopsony Issues in the FTC’s Express Scripts-Medco Merger Investigation

By Rani Habash and John Scalf

Introduction

After an intense eight-month investigation by the Federal Trade Commission (FTC), both chambers of Congress, and 32 state attorneys general, Express Scripts, Inc. closed its $29 billion acquisition of fellow pharmacy benefit manager (PBM) Medco Health Solutions, Inc. without any conditions on April 2, 2012. The transaction created the largest PBM in the nation despite unprecedented levels of public opposition.

The most highly-publicized and politically-charged issue during the investigation was whether the merger would give the combined firm monopsony power over retail pharmacies. Various pharmacy groups, fearful that the combined firm would reduce the reimbursement rates they received for filling prescriptions, did everything they could to try to stop the merger: they launched an extensive public relations campaign; they advocated to the FTC in several meetings; they lobbied members of Congress to hold congressional hearings and to pressure the FTC in its investigation; and they even filed a last-minute lawsuit seeking to enjoin the merger.

As the majority of the Commission ultimately determined, however, the facts did not support the pharmacy groups’ monopsony theory. Quite the opposite, the FTC found that any reduction in reimbursement rates was likely to result in cost savings to be passed through to PBM customers, benefiting consumers through lower healthcare costs. This article summarizes and analyzes the monopsony issues raised during the Express Scripts-Medco merger investigation.

Background on PBMs and Pharmacy Reimbursement Rates

PBMs help employers, unions, government agencies, health plans, and other plan sponsors design and manage prescription drug plans for their insured members. As part of this service, PBMs establish pharmacy networks at which their clients’ members can fill their prescriptions at negotiated rates. These pharmacy networks are established through individual negotiations between PBMs and pharmacies throughout the

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1 Rani Habash is an Associate in Dechert LLP’s Washington, D.C. office who provided antitrust counseling to Medco Health Solutions, Inc. in its merger with Express Scripts, Inc. John Scalf is a Senior Consultant at NERA Economic Consulting’s San Francisco, California office who performed economic analyses relating to the transaction on behalf of Medco.

United States over the reimbursement rate that the PBM will pay to the pharmacy for filling the PBM members’ prescriptions. Reimbursement rates generally have two main components: (1) the ingredient cost, i.e., the cost of the dispensed drug; and (2) dispensing fees, i.e., the fee paid to the pharmacy for processing the prescription.

PBM clients balance cost and convenience to their members in choosing the breadth of their pharmacy network. Some clients opt for broader pharmacy networks that provide greater access and convenience for their members, but at a higher cost to the client because the network includes pharmacies that negotiate higher reimbursement rates. Other clients opt for narrower pharmacy networks that consist of fewer pharmacies, but at a lower cost to the client because the network consists mostly of pharmacies that are willing and able to accept lower reimbursement rates than their pharmacy competitors in exchange for access to the PBM’s narrower network. In this way, PBMs offer clients a cheaper network option to reduce the cost of their pharmacy benefits. Some pharmacies that are not included in the narrower networks, however, allege that these networks are anti-competitive in that they reduce patient access to patient’s preferred pharmacies. This allegation often forms the basis of pharmacy groups’ monopsony claims.

Agencies’ Precedent on Monopsony

The agencies have provided helpful guidance on analyzing whether increased purchasing power harms consumers. As a general matter, transactions that reduce input costs are likely to create an incentive for firms to lower prices, thereby benefiting consumers.3 In special circumstances, however, increased power to negotiate input prices can adversely impact consumers by reducing output or services.4

According to the agencies’ Merger Guidelines, in evaluating a transaction’s effects on the buying side of the market, the agencies “employ essentially the framework” used to evaluate market power on the selling side.5 For example, relevant markets are defined by “focus[ing] on the alternatives available to sellers in the face of a decrease in the price paid by a hypothetical monopsonist.”6 The FTC has explained that “[a] buyer has monopsony power—or a group of buyers has oligopsony power—when it can profitably reduce prices in a market below competitive levels by curtailing purchases of the relevant product or service.”7 In such cases, competitive harm can result if purchases are shifted to a less efficient source and/or if the buyer(s) “supply too little output to the downstream market.”8 Importantly, however, the agencies stress that mergers resulting in decreased prices paid by the merged firm are not necessarily anticompetitive, but often create pro-competitive efficiencies that lower prices for consumers.9 The FTC’s closing statement in

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3 Id. at 8.
5 Merger Guidelines § 12. 
6 Id. 
8 Id. at 2. 
9 Merger Guidelines § 12.
Caremark’s 2006 acquisition of its PBM rival AdvancePCS illustrates this point. Although the FTC believed that the transaction might increase the bargaining power of the merged PBM vis-à-vis retail pharmacies, the FTC stated that the PBM’s increased bargaining power was likely to benefit consumers even if it meant that pharmacies made less money. The FTC found that “vigorous” post-merger competition among PBMs was “likely to cause PBMs to pass on at least some of their cost savings” from the increased bargaining power to customers.

Analysis of Potential Monopsony Power Arising from the Merger

Express Scripts and Medco raised a number of arguments countering the pharmacists’ claims of monopsony power arising from the merger. Ultimately, the FTC agreed with the parties that the merger would not establish monopsony power.

Monopsony Power vs. Buyer Power

Pharmacy groups argued that Express Scripts would obtain monopsony power through the merger and therefore would be able to unilaterally reduce the reimbursement rates that pharmacies received. They argued that this reduction in reimbursement rates would particularly push small independent pharmacies out of the market. However, these pharmacy groups failed to recognize that the antitrust laws are designed to protect against harm to competition and consumers due to monopsony power, not harm to producers and competitors due to buyer power.

By itself, a reduction in the reimbursement rates to pharmacies would not fall under the definition of monopsony. In cases of a buyer having market power sufficient to compel an upstream producer to price their product below competitive prices, monopsony power can only exist if there is a concomitant decrease in the output or services in the buyer’s downstream selling market. If there is no reduction in output or services to consumers, the exercise of buyer power simply represents a transfer of wealth, not harm to competition. In this case, Express Scripts’ power falls under the definition of buyer power, not monopsony power, because in Express Scripts’ competitive downstream selling market, other PBMs could fill the residual demand created by a hypothetical reduction in output.

To further highlight this point, as the Merger Guidelines explain, "Market power on the buying side of the market is not a significant concern if suppliers have numerous attractive outlets for their goods or services." Here, the evidence showed that the merged firm’s purchasing share of retail prescription dispensing would be less than 25 percent, falling well below levels necessary to create a presumption of monopsony power. Given this low share, along with the facts that the FTC has rarely found that a merger would result in monopsony power and has consistently recognized the consumer benefits of PBMs in reducing prescription drug prices to end users, there was little support for a monopsony theory in this merger.

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10 Caremark/AdvancePCS Closing Statement, supra note 7, at 3.
11 Id. at 3 n.6.
12 Philip E. Areeda and Herbert Hovenkamp, ANTITRUST LAW, ¶ 575 (3d ed. 2009).
13 As the FTC concluded, there are “at least ten significant competitors” capable of providing full PBM services. Express Scripts/Medco Closing Statement, supra note 2, at 8.
14 See Merger Guidelines, supra note 4, at § 12.
15 See, e.g., Caremark/AdvancePCS Closing Statement, supra note 7, at 2 (stating that “bargaining power is
Countervailing Buyer Power

Pharmacy groups also argued that Express Scripts would stand to gain monopsony power particularly over independent pharmacies, as independent pharmacies did not hold the negotiating power enjoyed by the large, multi-location chain pharmacies. However, independent pharmacies also have significant countervailing buyer power as a result of their ability to act collectively through Pharmacy Services Administration Organizations (PSAOs) and because independent pharmacies often enjoy disproportionate buying power due to the lack of pharmacy competitors in their immediate geographic area.

The evidence demonstrated that it would be difficult to exercise monopsony power because of the countervailing buyer power that smaller pharmacies have over PBMs. Over 80 percent of independent pharmacy owners participate in PSAOs. The typical PSAO represents thousands of pharmacies and provides benefits typically associated with the scale of larger, multi-location chain pharmacies. Among these benefits is the ability to collectively bargain on behalf of all pharmacies in the PSAO so that the negotiating power of the independent pharmacies with PBMs is more akin to that of the large chain pharmacies. Indeed, PSAOs often tout their ability to increase reimbursement rates from PBMs for independent pharmacies.16

Furthermore, independent pharmacies frequently possess significant buyer power even abstracting from their ability to pool their collective buyer power in a PSAO. This power exists because PBMs are more attractive to clients if they are able to offer a better and broader network of pharmacies that provide convenient access for a client’s members. If a PBM is not able to attract a sufficient number of pharmacies to participate in its network, an attempt by a monopsonist in the PBM industry to limit consumer access to independent pharmacies could quickly degrade the quality of its PBM services, which would encourage clients to seek out other PBMs.

In addition, many large clients (e.g., TRICARE) contractually specify the level of member access to pharmacies, thereby requiring PBMs to include many independent pharmacies in less densely populated areas within their networks. The potential to lose these large clients would far outweigh any savings Express Scripts might enjoy from reducing reimbursement rates. In addition, various state and federal laws and regulations, including Medicare, also require PBMs to meet certain access standards in their pharmacy networks, making independent pharmacies a necessity.

The Importance of Independent Pharmacies

Pharmacy groups also argued that a reduction in the reimbursement rates they would be able to negotiate—particularly the reimbursement rates paid to small independent pharmacies—would push these pharmacies out of the market. This outcome would likely represent a loss to consumers since independent pharmacies typically serve rural areas and other areas that lack the presence of large chain pharmacies. However, this argument ignores the importance of independent pharmacies to PBMs in decreasing the countervailing buyer power of large chain pharmacies such as CVS and Walgreens.

The evidence showed that it would be against a PBM’s economic interests to reduce

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16 Statement of Adam J. Fein to the U.S. Senate Judiciary Comm. Subcomm. on Antitrust, Competition Policy, and Consumer Rights, at 6 (Dec. 6, 2011).
reimbursement rates to independent pharmacies to the point that these pharmacies exit the market. The exit of a significant number of independent pharmacies would only enhance the market power of the remaining large pharmacy chains and therefore weaken a PBM’s negotiating power with these pharmacies. For these very reasons, many independent pharmacies have been able to negotiate higher reimbursement rates than large chain pharmacies. Indeed, Express Scripts’ recent dispute with Walgreens over reimbursement rates likely made independent pharmacies even more important to the company so that it could meet the access standards of many large clients and state and federal regulations. Moreover, if a PBM were to limit consumer access to retail pharmacies in favor of, say, mail order services, the result would be a reduction in the quality of PBM services that would not be justified by the cost savings that would be obtained by eliminating the higher-cost, but geographically convenient, pharmacies from their network. Offering a comprehensive retail network is an important selling point for a PBM. Indeed, more than 80 percent of all prescriptions are dispensed at retail locations today. In addition, the majority of prescription drugs are used to treat acute conditions, including antibiotics, pain medication, and cold and flu medication, and are not typically dispensed by mail, making retail pharmacies an even greater necessity for PBM networks.

**Historical Relationship between Consolidation in the PBM Industry and Pharmacies’ Profits**

Underlying the arguments of pharmacy groups was the presumption that consolidation within the industry would lead to increased industry concentration and a subsequent increase in monopsony power by PBMs. This result would lead to the concomitant power to reduce reimbursement rates to pharmacists. However, the historical evidence does not suggest that there is a positive relationship between consolidation within the PBM industry and the gross profits of pharmacies in general or independent pharmacies in particular.

Over the past ten years, the PBM industry has experienced a spate of consolidation. More than 20 PBMs have been acquired since 2002. These have included some of the largest PBMs in the industry, including AdvancePCS, Caremark, WellPoint’s NextRx, and Walgreens Health Initiatives. As other PBMs have gained share, however, it is not necessarily the case that consolidation within the industry has in fact led to increased market concentration over time.

If PBMs were to gain monopsony power and subsequently reduce reimbursement rates through mergers, this spate of consolidation would most likely be reflected in the gross profits of pharmacies and the viability of independent pharmacies. Yet as consolidation has occurred within the industry, there has been no evidence of a detrimental impact to pharmacies in general. From 2004 to 2009, annual gross profits of pharmacies have actually increased by 37.4 percent from $43.5 billion to $59.8 billion.\(^{17}\) Moreover, data from the U.S. Census Bureau shows that the gross profit margin of the pharmacy industry has remained relatively constant between 1993 and 2010.\(^{18}\)

In particular, consolidation within the industry has also not had a detrimental impact on independent pharmacies. The number of independent pharmacy locations has remained nearly constant in recent years—20,896 in 2000 versus 20,835 in 2010.\(^{19}\) The National

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\(^{17}\) 2011-12 Chain Pharmacy Industry Profile, National Association of Chain Drug Stores, August 2011, at 12.

\(^{18}\) U.S. Census Bureau, 2010 Annual Retail Trade Report.

\(^{19}\) 2011-12 Chain Pharmacy Industry Profile, National Association of Chain Drug Stores, August 2011, at 12.
Community Pharmacists Association also has reported that gross profit margins remained relatively constant—ranging between 22 and 24 percent—from 2000 to 2010. In addition, gross margins on prescription sales increased from 21.5 percent in 2006 to 23.3 percent in 2010. Based on the continued stability of independent pharmacies in the face of PBM consolidation, there was a lack of evidence showing that the Express-Scripts-Medco merger would harm independent pharmacies. This was particularly true given the empirical evidence that PBM size had little correlation with pharmacy reimbursement rates.

The FTC’s Assessment of the Express Scripts-Medco Transaction

In a 3-1 decision the FTC concluded that the Express Scripts-Medco merger was “unlikely to lead to the exercise of monopsony power for the retail dispensing of prescription drugs” for three key reasons.

First, the FTC stated that the combined firm’s approximate 29% share was lower “than is ordinarily considered necessary for the exercise of monopsony power.” To corroborate this presumption, FTC economists carefully analyzed the merging firms’ and third parties’ data to determine whether there was a relationship between “PBM size and the reimbursement rates paid to retail pharmacies.” The FTC concluded that little correlation existed, implying that even if the combined firm’s share grew even higher, it would not necessarily result in the market power necessary to lower reimbursement rates to pharmacies.

Second, the FTC did not believe that the merger would reduce pharmacy output or services even assuming that the merged firm would in fact be able to reduce reimbursement rates to pharmacies. The FTC had previously observed that the market for the “retail dispensing of brand name and generic prescription drugs” was not susceptible to monopsony power given that “dispensing fees are negotiated individually between each PBM and each pharmacy.” Although these individual negotiations make it possible that the merged firm would be able to negotiate a lower purchasing price, “[b]oth the

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20 2011 NCPA Digest, National Community Pharmacy Association, October 2010, 6.
22 Express Scripts/Medco Closing Statement, supra note 2, at 8.
23 Id. at 7-8. In the lone dissent, Commissioner Julie Brill did not address monopsony issues. Dissenting Statement of Commissioner Julie Brill Concerning the Proposed Acquisition of Medco Health Solutions Inc. by Express Scripts, Inc. at 1-8, FTC File No. 11-0210 (Apr. 2, 2012), available at http://www.ftc.gov/speeches/brill/120402medcobrillstatement.pdf.
24 Express Scripts/Medco Closing Statement, supra note 2, at 7-8.
25 Id. at 8.
26 Id.
27 Id. at 8 n.15; Caremark/AdvancePCS Closing Statement, supra note 7, at 3 n.4 (explaining that “[i]n conventional monopsony and oligopsony models, all sales take at a single price. A reduction in price is associated with a movement downward along the supply curve to a lower quantity. By contrast, each contract between a PBM and a pharmacy company is subject to individual negotiation. Both the PBM and the pharmacy have the incentive to contract for the efficient quantity, while bargaining on the price in order to determine how the gains from the transaction are divided between them. In this situation, an increase in the bargaining power of the buyer may lead to a lower price, but there is no reason to expect a lower price to lead to a lower quantity.”).
PBM and the pharmacy have the incentive to contract for the efficient quantity,” making it unlikely that the reduced price would actually reduce output.\(^{28}\) Without a likely reduction in output, monopsony power was not likely to be created by the merger.

Finally, the FTC found that “for contractual and competitive reasons,” it was likely that “a large portion” of any pharmacy cost savings obtained by the merged firm were likely to be passed through to PBM customers.\(^{29}\) The FTC recognized that although retail pharmacies would be “concerned about this outcome,” any reduction in reimbursement rates was likely to be passed on to clients and lower healthcare costs.\(^{30}\) This finding was supported by the fact that Express Scripts and Medco faced competition from “at least ten significant competitors” and that this competition had made pass-through pricing arrangements “commonplace in the industry.”\(^{31}\)

**Conclusion**

After a thorough investigation that left no stone unturned, the FTC correctly determined that Express Scripts’ acquisition of Medco would not provide the merged firm with monopsony power to the detriment of consumers. As the *Merger Guidelines* explain, monopsony enforcement should only arise under a limited set of special circumstances. Otherwise, beneficial strategic transactions such as Express Scripts-Medco that create purchasing efficiencies and lower costs to benefit consumers would be inefficiently deterred.

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\(^{28}\) Caremark/AdvancePCS, *supra* note 7, at 3 n.4.

\(^{29}\) Express Scripts/Medco Closing Statement, *supra* note 2, at 8.

\(^{30}\) *Id.*

\(^{31}\) *Id.* at 2, 8 n.16.
A Heated Debate Over the State Action Doctrine and
Phoebe Putney: An ABA Program Summary

By Caitlin M. Russo
Hogan Lovells US LLP

This term, the Supreme Court will review its first antitrust case concerning the state action immunity doctrine since 1992. In the Federal Trade Commission vs. Phoebe Putney Health System Inc., U.S. No. 11-1160, cert. granted, June 25, 2012 (Phoebe Putney), the Supreme Court will decide whether the Eleventh Circuit correctly found that a hospital merger consummated by a county hospital authority is shielded from antitrust review by the state action doctrine. That decision has sparked heated debate in the antitrust community and spurred a lively discussion during the June 14 ABA Antitrust Law Section Health Care and Pharmaceuticals Committee’s brown bag lunch and telephone conference.

In Phoebe Putney, the Federal Trade Commission challenged the merger between Phoebe Putney Health System Inc. and Palmyra Park Hospital as violating Section 7 of the Clayton Act. A Georgia federal district court and the Eleventh Circuit disagreed, determining that the consolidation was immune from antitrust scrutiny under the state action doctrine. That decision has sparked heated debate in the antitrust community and spurred a lively discussion during the June 14 ABA Antitrust Law Section Health Care and Pharmaceuticals Committee’s brown bag lunch and telephone conference.

In Phoebe Putney, the Federal Trade Commission challenged the merger between Phoebe Putney Health System Inc. and Palmyra Park Hospital as violating Section 7 of the Clayton Act. A Georgia federal district court and the Eleventh Circuit disagreed, determining that the consolidation was immune from antitrust scrutiny under the state action doctrine because the acquisition and the subsequent operation of the hospital were authorized pursuant to a state policy to displace competition. Many in the antitrust community disagree about nearly every aspect of the case, from the exact holding of the Eleventh Circuit, to the appropriate scope of the state action doctrine. At the ABA brownbag panel those divergent opinions were voiced, previewing for participants some of the arguments to be raised before the Supreme Court next term.

The panelists represented opposite sides of the debate. McDermott, Will & Emery Partner, David Marx, strongly defended the transaction and the decision of both the Georgia district court and the Eleventh Circuit that the merger was immunized from the reach of the federal antitrust laws by the state action doctrine. Federal Trade Commission, Deputy Chief Trial Counsel, Michael Kades, and Assistant Attorney General of Tennessee, Vic Domen, fought back, contending that the decisions were egregiously wrong and set a slippery slope precedent for future parties to structure transactions to avoid federal antitrust scrutiny and for courts to find that the state action doctrine applied merely upon a grant of general corporate powers to an entity of the state.

The discussion began with a brief overview by Chris Sagers, the moderator and the James A. Thomas Distinguished Professor of Law at Cleveland State University. Prof. Sagers introduced the case, citing to the origins of the state action doctrine, namely, the 1943 Supreme Court decision, Parker v. Brown, which held that activities of the state are exempt from antitrust liability when “the state itself exercises its legislative authority in making the regulation and in prescribing the condition of its
application. Prof. Sagers went on to explain that this rule has been extended to municipalities, including hospital authorities, if they can “demonstrate [they are] engaging in the challenged activity pursuant to a clearly expressed state policy.” This demonstration requires either explicit proof by the state legislature that it intended to displace competition with regulation or a monopoly public service, or the reasonable foreseeability of the legislature that such effects would occur based on the statutory power granted to the political subdivision.

In Phoebe Putney, the statute at issue is a 1941 Georgia statewide policy allowing local governments to establish “Hospital Authorities.” One such authority, the Albany-Dougherty County Hospital Authority is a quasi-public nonprofit entity that can own and operate health care facilities, among other things. Phoebe Putney Memorial Hospital, a private non-profit facility, is one such facility. In the case, the parties argued that the transaction was immune under the state action doctrine because Albany-Dougherty County Hospital Authority was a party to the transaction.

Because the state action doctrine requires either a clearly articulated policy by the state to displace competition or evidence of the reasonable foreseeability of such a result, the precise intent and scope of the Georgia statute is a core issue in Phoebe Putney. Mr. Marx argued that the powers granted to Albany-Dougherty hospital authority were specific and much more than a mere grant of general corporate powers. For example, Mr. Marx pointed to the power to operate projects, which specifically includes hospitals, the power to acquire, purchase and lease hospitals, and the power to establish rates. Given these specific grants of power, Mr. Marx stated, the state created a policy to allow local authorities to acquire competitors with the foreseeable consequence of increasing local market concentration.

Mr. Kades staunchly disagreed. Mr. Kades argued that those grants of power were merely general corporate grants of power, which is not enough to invoke the state action doctrine. He characterized the Eleventh Circuit’s holding as exactly that; and therefore, the Eleventh Circuit is in direct conflict with the law of the Fifth, Sixth, Ninth, and Tenth Circuits. Instead, Mr. Kades argued that a state must convey a larger expression of state policy to satisfy the reasonable foreseeability test. Mr. Kades contrasted Phoebe Putney with Town of Hallie, a case that, in his view, demonstrates a larger state policy at play, which justifies a finding of reasonable foreseeability.

Mr. Marx then moved beyond the mere corporate grants of powers contained in the statute and cited the statute’s geographic limitation as evidence of reasonable foreseeability. The Georgia statute confined the hospital authorities’ powers to a limited geographic region. For Mr. Marx, and the Eleventh Circuit, this limiting factor demonstrated that the legislature must have anticipated that hospital mergers could result in monopolies in such a defined geographic market. In the Eleventh Circuit’s words, “it defies imagination to suppose the legislature could have believed that every geographic market in Georgia was so replete with hospitals that authorizing acquisitions by the authorities

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could have no serious anticompetitive consequences."3

The discussion then shifted to potential policy motivations behind the reasonable foreseeability test in general. Mr. Domen postulated that the policy might be to help disadvantaged, non-profit hospitals in rural areas compete against big national providers. Mr. Marx offered a similar thought, focusing, however, more on the desire to aid in public-private hospital collaboration in general. He suggested that the court’s decision in *Phoebe Putney* might spur increased public-private hospital collaboration in the future. Lastly, Mr. Kades worried that a lenient interpretation of the reasonable foreseeability test, as applied in *Phoebe Putney*, could sanction non-competitive market conditions when the state did not actually intend to do so.

Mr. Kades’ concern about *Phoebe Putney*’s ability to create a precedent that sanctions non-competitive market conditions arose at another point in the debate when he articulated an argument the FTC has raised in every stage of the litigation; namely that the hospital authority merely “rubber-stamped” the transaction in order to avoid antitrust scrutiny and, therefore, state immunity should not apply. In fact, it was not until after direct negotiations between *Phoebe Putney* and Palmyra fell through that the companies subsequently arranged to have the Albany-Dougherty Hospital Authority agree to purchase Palmyra and lease it back to *Phoebe* for 40 years at $1 per year.

Mr. Marx agreed that the hospital authority’s minimal involvement in the transaction made the case a more compelling target for the FTC, but he, like the Eleventh Circuit did not question the motivations of the parties and argued that the state action doctrine does not require such an inquiry. In fact, the Eleventh Circuit wholly refused to address the FTC’s “active supervision” argument that there was no “genuine state action” because the transaction was essentially a combination of two private hospitals with minimal involvement by the hospital authority. The court also stated that it was inconsequential if the hospital authority merely “rubber-stamped” the transaction because it would not “‘look behind’ governmental actions for ‘perceived conspiracies to restrain trade’” nor would it “‘deconstruct . . . the governmental process’ or ‘probe . . . the official intent’ to determine whether the government’s decision-making process has been usurped by private parties.”4 Rather, all that mattered to the Eleventh Circuit was that the state law authorized the transaction and that it was reasonably foreseeable to the state legislature that anticompetitive consequences could arise.

The ABA program concluded with the panelists predicting whether the Supreme Court would grant certiorari. Although a moot point now, the panelists expressed similar opinions that the case presents a unique opportunity for the Court to review an important health care antitrust case and to clarify the appropriate balance between the state action doctrine and federal antitrust laws. The Supreme Court has agreed to hear the case next term.

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3 FTC v. Phoebe Putney Health Sys., 663 F.3d 1369, 1377 (11th Cir. 2011).

4 Id. at 1376 n.12 (quoting City of Columbia v. Omni Outdoor Adver., 499 U.S. 365, 377 (1991)).
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