Antitrust Chronicle
SPRING 2015, VOLUME 1, NUMBER 2

Healthcare and Antitrust Looks at Recent Caselaw

CPI COMPETITION POLICY INTERNATIONAL

COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle

April 2015 (2)

Rediscovering Capture: Antitrust Federalism and the *North Carolina Dental Case*

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Rediscovering Capture: Antitrust Federalism and the *North Carolina Dental Case*

Herbert Hovenkamp[1]

I. INTRODUCTION

The federal antitrust laws are concerned almost entirely with private restraints. The Sherman Act's legislative history provides little evidence that Congress intended for antitrust to ride herd on anticompetitive or badly designed state regulation. The question itself is anachronistic, however. In 1890 and even in 1914 when the Clayton Act was passed the prevailing interpretation of the Commerce Clause would have precluded the reach of federal antitrust into internal state economic policy, to say nothing of the policy of local governments. For their part, the states in the late nineteenth century were precluded from regulating conduct that crossed a state line.[2]

Conflicts between federal antitrust law and state regulation did not frequently arise prior to the Supreme Court's 1942 decision in *Wickard v. Filburn*,[3] which expanded federal power to reach conduct or transactions that "affected" interstate commerce. Following *Wickard*, the Court held a few years later in *Women's Sportswear Manufacturing* that the Sherman Act reached a completely intrastate cartel of garment stitchers when their product was later shipped across state lines.[4]

During the era of "dual federalism" that prevailed in the 1930s and earlier, federal power did not reach activity unless it encompassed more than a single state, and the states had power to regulate only within their borders. One important exception permitting state extraterritorial control was corporation law. Early in the twentieth century some states began to authorize their corporations to do business outside the state and also to acquire equity interest in other corporations, or corporate mergers.[5] Already in 1904, however, the Supreme Court held that the legality of an interstate corporate merger under state corporation law did not immunize the transaction from the Sherman Act.[6] While the merger in question was accomplished through a New Jersey incorporation act that permitted holding companies, the railroads involved operated between the Great Lakes and the West Coast, entirely outside of that state and quite far from it. In condemning the merger under Section 1 of the Sherman Act, the Supreme Court did not question New Jersey's power to authorize an extraterritorial transaction in this fashion—

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[2] E.g., *Wabash, St. Louis & Pac. Rwy. Co. v. Illinois*, 116 U.S. 557 (1886) (negative Commerce Clause precluded state from price regulating even the intrastate portion of an interstate route).

[3] 317 U.S. 111 (1942).

[4] *United States v. Women's Sportswear Mfg. Ass'n*, 336 U.S. 460, 464 (1949).

[5] *See* HERBERT HOVENKAMP, ENTERPRISE AND AMERICAN LAW, 1836-1937 at 56-66 (1991).

[6] *Northern Securities Co. v. United States,* 193 U.S. 197, 345-346 (1904).

however, in doing so it could not interfere with national competition policy over interstate commerce: "It cannot be said that any state may give a corporation…authority to restrain interstate…commerce against the will of…Congress."[7]

Serious conflicts between state power to regulate internal markets and federal antitrust emerged after the full implications of *Wickard v. Filburn* became obvious for areas that were traditionally subject to state regulation. In the *South-Eastern Underwriters* case (1944) the Supreme Court extended federal antitrust law to the business of insurance, a market that had traditionally been regulated entirely by state law.[8] That decision soon prompted federal legislation, the McCarran-Ferguson Act, which restored insurance regulation to the states and granted a partial antitrust immunity.[9] The Supreme Court first acknowledged the modern "state action" antitrust exemption for state-sanctioned conduct in *Parker v. Brown*.[10] The principal difference between the *Women's Sportswear* case and *Parker* was that the cartel in the former case was purely private, while the raisin cartel in *Parker* was initiated and managed by the state.

The *South-Eastern Underwriters* decision and subsequent passage of the McCarran-Ferguson Act serves as a good object lesson: If the Supreme Court does interpret statutory federal antitrust policy in a way that diminishes state power, Congress can always intervene. It did so again with the Local Government Antitrust Act,[11] which responded to the Supreme Court's liability-expanding *Boulder* decision by largely taking damages off the table.[12]

The expansion of federal commerce power naturally invited reconsideration of one of the most central concerns of federalism: namely, the power of state governments to regulate their own economies in the face of conflicting federal policies favoring competition.[13] The resulting antitrust principles were judge-made, although they at least purported to be inferred from congressional intent:

First, it seems clear that Congress never intended to displace sovereign state regulation of their own internal economies in any significant way, and most of the legislative history of federal antitrust speaks of federal-state cooperation rather than preemption.[14]

Second, however, nothing prevents the federal antitrust laws from being applied to private economic conduct within their reach, even under an affecting commerce test. Indeed, Congress itself has spoken on this issue. While the language of the Sherman Act is very broad, the original language of the substantive Clayton Act and FTC Act provisions was not, reaching only restraints

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[7] *Id*. at 346.

[8] *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944). On the traditional view, *see Paul v. Virginia*, 75 U.S. 168, 183–84 (1868).

[9] 15 U.S.C. §§ 1101–1102; *see* 1A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶219 (4th ed. 2013).

[10] *Parker v. Brown*, 317 U.S. 341 (1943).

[11] 1A AREEDA & HOVENKAMP, *supra* note 9, ¶223d.

[12] *Cmty. Commc'ns Co., Inc. v. City of Boulder,* 455 U.S. 40, 65 n.2 (1982); Local Government Antitrust Act, Pub. L. 98-544, 98 Stat. 2750 (1984), 15 U.S.C. §§34-36. *See* 1A AREEDA & HOVENKAMP, *supra* note 9, ¶223c.

[13] On concerns of federalism that arose in the wake of *Wickard*, *see* HERBERT HOVENKAMP, THE OPENING OF AMERICAN LAW: NEOCLASSICAL LEGAL THOUGHT, 1870-1970 at 294-298 (2015).

[14] *See* Herbert Hovenkamp, *State Antitrust in the Federal Scheme,* 58 IND.L.J. 375 (1983).

in the actual course of interstate commerce. That limitation reflected the dual federalism of the period in which the Clayton Act was passed.[15] However, after the *Wickard* principle was well established Congress amended Section 5 of the Federal Trade Commission Act in 1975[16] and Section 7 of the Clayton Act in 1980[17] so as to reach restraints "in or affecting" commerce. It chose not to amend Sections 2 and 3 of the Clayton Act, dealing with price discrimination and tying.[18]

The "commerce" delimiter on federal authority is also very important for identifying the proper scope of antitrust federalism. The federal antitrust laws are passed under the commerce power, and they explicitly apply only to restraints that affect commerce.[19] They were never intended to be a device for ensuring good government. State and local governments might pass a wide variety of very bad laws that do not implicate federal antitrust policy for the simple reason that they have nothing to do with commerce. Further, the Tenth Amendment is designed to prohibit federal encroachment on state regulatory prerogatives, and also acts as an important break on federal legislation passed under the commerce power.[20]

The distinction between "private" conduct and the conduct of a sovereign state is critical in the post-*Wickard* world. If a state is regulating within its territory *and* it is actually the state that is doing the regulating, then the highly general language of the antitrust laws generally requires federal antitrust tribunals to stand aside. Federal antitrust has no power to police bad state regulation as such. It cannot require that state regulations pass a cost-benefit test that might weed out some instances of badly designed regulation.[21] But it can properly insist on a showing that the conduct in question be that of the state, and not of a private entrepreneur.

The antitrust "state action" doctrine addresses this problem by trying to identify the line between sovereign state conduct, which is largely immune from federal antitrust oversight, and private conduct, which is not. After nearly forty years of litigation the Supreme Court adopted the modern two-prong "*Midcal*" test,[22] which after subsequent elaboration, states:

1. "Sovereign" conduct performed by the "state" itself is immune; and
2. "Private" conduct must be both (a) authorized by the state, and (b) any anticompetitive consequences must be "actively supervised" by a government official.

These prongs have been further refined:

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[15] E.g., *United States v. E.C. Knight Co.*, 156 U.S. 1 (1895); *Hammer v. Dagenhart*, 247 U.S. 251 (1918) (applying *E.C. Knight* to strike down federal child labor provision). *See* HOVENKAMP, OPENING, *supra* note 13 at 278-299.

[16] 15 U.S.C. §45(a)(2).

[17] 94 Stat. 1159, 15 U.S.C. §18.

[18] *See* 1A AREEDA & HOVENKAMP, *supra* note 9, ¶¶265, 267.

[19] *See id.*, ¶ ¶260-262.

[20] On the Tenth Amendment as a constraint on federal antitrust law, *see id.*, ¶¶215-217.

[21] Cf. Exec. Order No. 12291 (President Ronald Reagan), 46 FR 13193 (Feb. 17, 1981). *See* Michael A. Livermore & Richard L. Revesz, *Regulatory Review, Capture, and Agency Inaction*, 101 GEO. L.J. 1337 (2013); Richard L. Revesz, *Quantifying Regulatory Benefits*, 102 CAL. L. REV. 1423 (2014).

[22] From *Cal. Retail Liquor Dealers Ass'n, v. Midcal Aluminum*, 445 U.S. 97 (1980), hereinafter "*Midcal*." *See* 1A AREEDA & HOVENKAMP, *supra* note 9, ¶221f.

3. In between the extremes defined by numbers (1) and (2) is conduct by state-created government subdivisions that are not “sovereign” under the United States Constitution (although they may be under state law); for these, the challenged activity must be “authorized” but it need not be “supervised;” and
4. The issue whether conduct is "private" or that of a state-created subdivision presents a federal question; that is, a state legislature's designation of a private group as an "agency" of the state does not necessarily make it so.[23]

The question in *North Carolina Dental*, which was decided by the Supreme Court in February, 2015, was whether the conduct in question fell more closely to number (2), the Court’s majority conclusion, or number (3), which was the conclusion of the dissent. Question (4) also divided the majority from the dissenters.

This multi-stage, judge-made set of inquiries is intended to enable the federal courts to walk the very thin and indistinct line that defines the relationship between the federal government and the states in the making of competition and regulatory policy. In some cases placing the line is easy. For example, the governor, legislators and judges are state employees who exercise sovereign power. This is true even though the state legislature is composed of part-time members who also have their own businesses and whose decisions as legislators may be affected and even biased.

An important brake here is that legislative action must generally be signed by the Governor before it becomes law. Another is that the state's highest executive, legislative, and judicial branches are multi-sectoral, facing competing pressures from diverse constituencies. A third is that most of these officials are answerable to the electorate. To one degree or another all of these three considerations also apply to the highest officials in municipal government. They do not necessarily apply, however, to specialized state agencies that may represent producers in a single market, be composed largely of interested decision-makers in that market, and often are not directly accountable to either the electorate or higher reviewers.

As formulated, the state action doctrine is not concerned with geographic spillovers. Insofar as antitrust state action is concerned, the courts generally do not care whether the state itself experiences most of the harmful effects of anticompetitive decisions rather than exporting them to other states. As a result, the doctrine authorizes federal antitrust policy to dig into local and intrastate issues, even to the point of rescuing the state from its own improvident decisions. The doctrine is less concerned with one state's power to impose anticompetitive harm on other states, and more concerned with ensuring that each state's own processes are transparent and actually reflect articulated state policy. The dissenters in *North Carolina Dental* did not pick up on this point.

II. THE *NORTH CAROLINA DENTAL EXAMINERS* CASE

A. The Decision

The *North Carolina Dental Examiners* case[24] is the second time in two years that the Supreme Court rejected a "state action" defense to an anticompetitive arrangement that had been

[23] *See id.*, ¶¶224-227, which develops each of these factors.

approved under state law and that very likely visited any competitive harm almost entirely on its own residents. In *Phoebe Putney* the Court unanimously held that a state statute that permitted two hospitals to merge did not authorize an anticompetitive merger to monopoly. As a result, it did not immunize the transaction from an antitrust challenge.[25]

In both cases the problems that the Supreme Court identified are fixable by state legislation, although the legislation would require greater transparency about the interests that the state was protecting. The facts of both cases suggested—but the Court did not consider—whether it should be relevant that the anticompetitive conduct in question was harmful mainly to the state's own residents. If state-sanctioned anticompetitive conduct harms mainly that state's own citizens should federal authorities be less concerned?

The dispute in the *Dental Examiners* case reduced to one question: To what extent can a state simply designate a private group as a state "agency" for purposes of asserting state sovereignty, permitting all decision-making to be made by the unsupervised power of the market participants themselves, and without review by a superior and independent state official? The result may amount to a naked cartel, harming its customers wherever they are located.

This question arose in the very first state action decision, *Parker v. Brown*, where the raisin cartel in question had market power within the state but exported 90 percent of its product to other states.[26] In addition to the antitrust claim the Court also considered and rejected the challenger's argument that the raisin cartel program unconstitutionally burdened interstate commerce.[27] A somewhat similar case, *Goldfarb*,[28] involved the inadequately supervised fee setting of a state bar, presumably providing legal services to clients both inside and outside the state.[29]

In *N.C. Dental*, by contrast, it seems clear that most of the consumers injured by the dental board's restrictions on teeth whitening were within the state.[30] Indeed, to the extent the dental board's rule limiting the provision of teeth-whitening services to licensed dentists caused competitive harm, it would have encouraged North Carolina consumers to obtain their teeth whitening outside of the state or look for means (such as self-treatment) that were either outside the reach of the rule or else difficult to detect. The same thing was likely true in the *Phoebe Putney* case, involving a rural hospital in central Georgia that very likely served mainly Georgia residents.[31]

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[24] *N. C. State Board of Dental Examiners v. FTC*, 135 S.Ct. 1101 (2015), hereinafter "*N.C. Dental*."

[25] *FTC v. Phoebe Putney Health Sys*., 133 S.Ct. 1003 (2013).

[26] *Parker v. Brown*, 317 U.S. 341 (1943).

[27] *Id.* at 359-361.

[28] *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975).

[29] The district court observed that a significant number of purchasers of title insurance in Fairfax County, Virginia, worked outside the state. *See* 355 F. Supp. 491, 494 (E.D. Va. 1973).

[30] The Federal Trade Commission spoke of harm to "consumers in North Carolina," but did not quantify the percentage in its opinion. *See In re North Carolina Board of Dental Examiners*, 152 F.T.C. 75 (2011), fact finding #158.

[31] *See* the FTC's decision, 2013 WL 4627512 (Aug. 22, 2013) (limiting geographic market to a six county area). While the Commission did not reference the Elzinga-Hogarty test for a geographic market, if applied 90 percent of

A divided (6-3) Supreme Court[32] agreed with the Fourth Circuit and the Federal Trade Commission that the state dental board's restriction violated the antitrust laws because it was not adequately supervised by a sufficiently independent state decision-maker. The regulatory board in question was controlled by a majority actively engaged in the practice of dentistry.[33] A state statute provided that this Board was "the agency of the State for the regulation of the practice of dentistry,"[34] and it had authority over licensing as well as power to discipline the unlawful practice of dentistry.[35] Nothing in the statute, however, identified teeth whitening as part of the practice of dentistry.[36] Under the Act, six of the Board's eight members must be actively practicing dentists, and these members were elected by other licensed dentists practicing in North Carolina. A seventh member was required to be a dental hygienist, and an eighth "consumer" member was appointed by the Governor.[37]

Dentists in North Carolina began whitening teeth in the 1990s, earning substantial fees. In the early 2000s, however, non-dentists entered into competition with them and charged lower fees, some of them operating from facilities such as cosmetic salons or kiosks in shopping malls.[38] The Board received numerous complaints from dentist members. Most of these complaints were about the lower fees, although some also complained of possible harm to consumers.[39] The Board began an investigation conducted by several dentist members of the Board, but excluding the hygienist and consumer members. Beginning in 2005 the Board sent out numerous cease-and-desist letters to non-dentists performing teeth-whitening services.[40] At that point the FTC filed its complaint, challenging the rule limiting teeth whitening to licensed dentists and the use of the cease-and-desist letters. It concluded that the Board's conduct was a trade restraint prohibited by Section 5 of the FTC Act and was not immunized by the "state action" doctrine.[41] The Fourth Circuit agreed.[42]

The Supreme Court rejected the Board's argument that because its members "were invested by North Carolina with the power of the State," its actions required neither authorization nor supervision in order to be free of antitrust scrutiny. "Here, the Board did not receive active supervision by the State when it interpreted the Act as addressing teeth whitening and when it enforced that policy by issuing cease-and-desist letters to non-dentist teeth

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patients would have had to come from this area; *See* 2A PHILLIP E. AREEDA, HERBERT HOVENKAMP, ROGER D. BLAIR, & CHRISTINE PIETTE DURRANCE, ANTITRUST LAW ¶550a3.

[32] Justice Kennedy's majority opinion was joined by C.J. Roberts and Justices, Ginsburg, Breyer, Sotomayor, and Kagan. Justice Alito dissented, joined by Justices Scalia and Thomas.

[33] *Id*. at 1107.

[34] *Id*., quoting N. C. Gen. Stat. Ann. §90–22(b) (2013).

[35] *N. C. Dental*, 135 S.Ct. at 1107, citing *Id*., §90–40.1.

[36] *Id*. at 1108.

[37] *Id*.

[38] *See* the Fourth Circuit's opinion, *N.C. State Bd. of Dental Examiners v. F.T.C,* 717 F.3d 359, 364 (4th Cir. 2013).

[39] *N.C. Dental*, 135 S.Ct. at 1108.

[40] *Id*.

[41] 152 F.T.C. 75 (2011).

[42] *N.C. State Bd. of Dental Examiners v. F.T.C.*, 717 F.3d 359 (4th Cir. 2013).

whiteners."[43] A grant of "state action" immunity applies only to "exercise[s] of the State's sovereign power."[44] That status "requires more than a mere facade of state involvement.... "[45] The Court then observed:

> Limits on state-action immunity are most essential when the State seeks to delegate its regulatory power to active market participants, for established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor. In consequence, active market participants cannot be allowed to regulate their own markets free from antitrust accountability.....So it follows that, under *Parker* and the Supremacy Clause, the States' greater power to attain an end does not include the lesser power to negate the congressional judgment embodied in the Sherman Act through unsupervised delegations to active market participants.
>
> ... *Parker* immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State's own.[46]

Speaking then of the immunity requirements of clear articulation (authorization) and active supervision,[47] the Court observed:

> The first requirement—clear articulation—*rarely* will achieve that goal by itself, for a policy may satisfy this test yet still be defined at so high a level of generality as to leave open critical questions about how and to what extent the market should be regulated.... Entities purporting to act under state authority might diverge from the State's considered definition of the public good. The resulting asymmetry between a state policy and its implementation can invite private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity."[48]

Turning to the active supervision requirement,[49] the Court noted that municipalities were exempted from it because "there is little or no danger" that they might be involved "in a private price fixing arrangement."[50] Rather, the principal danger from municipal regulation was that the municipality might "seek to further purely parochial public interests at the expense of more overriding state goals."[51] In addition, municipalities are "electorally accountable" entities, and they exercise regulatory power "across different economic spheres, substantially reducing the risk

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[43] 135 S.Ct. at 1110.

[44] *Id.*, citing *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 374 (1991).

[45] 135 S.Ct. at 1111, citing *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992); and referring *Parker v. Brown*, 317 U.S. 341 (1943).

[46] *Id.* at 1111, citing 1A ANTITRUST LAW ¶226; Einer Elhauge, *The Scope of Antitrust Process*, 104 HARV. L. REV. 667, 672 (1991); and Merrick B. Garland, *Antitrust and State Action: Economic Efficiency and the Political Process*, 96 YALE L. J. 486, 500 (1986).

[47] From *Midcal*, *supra* note 22. *See* 1A ANTITRUST LAW ¶¶224-227.

[48] *N.C. Dental*, 135 S.Ct. at 1112 (emphasis added), referring to *Midcal*, *supra* note 22.

[49] *See* 1A ANTITRUST LAW ¶223.

[50] *N.C. Dental*, 135 S.Ct. at 1112.

[51] *Id.* at 1112, quoting *Hallie v. Eau Claire*, 471 U.S. 34, 47 (1985).

that they would pursue private interests while regulating any single field."[52] In the case of municipalities, the *Omni* case had gone one step further, rejecting subjective tests for "corruption" that would have forced a "deconstruction of the governmental process" by engaging in "ad hoc and ex post questions of their motives for making particular decisions."[53]

After examining its earlier decisions, the Court drew a "clear" lesson that "*Midcal*'s active supervision test is an essential prerequisite of *Parker* immunity for any non-sovereign entity—public or private—controlled by active market participants."[54] As a result, the need for active supervision by the state itself turns "not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in retraining trade."[55] Further, "State agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal*'s supervision requirement was created to address."[56]

The court then observed that the Court's statement in *Hallie* "that active state supervision would also not be required" of state agencies was *dicta*, given that the defendant in that case was "an electorally accountable municipality with general regulatory powers and no private price fixing agenda." As a result, the municipality resembled a traditional state agency rather than "specialized boards dominated by active market participants."[57] As a result,

> The similarities between agencies controlled by active market participants and private trade associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules.[58] *Parker* immunity does not derive from nomenclature alone. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. The Court holds today that a state board on which a controlling number of decision makers are active market participants in the occupation the board regulates must satisfy *Midcal*'s active supervision requirement in order to invoke state-action antitrust immunity.[59]

The Court then discussed and rejected the Board's argument that the prospect of treble damages would discourage citizens from public participation on such boards. It noted, first, that this particular case, brought by the FTC, was not such a situation, and provided no occasion to address the separate question of citizen members' liability for damages. Further, the state could always provide for defense and indemnification of such members.[60]

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[52] 135 S.Ct. at 1113.

[53] *Id*. at 1113, citing *Columbia v. Omni Outdoor Advertising, Inc*., 499 U.S. 365, 374 (1991).

[54] *Id*. at 1113, referring to *Midcal*, *supra* note 22. *See* 1A ANTITRUST LAW ¶221f.

[55] 135 S.Ct. at 1114.

[56] *Id*., citing 1A ANTITRUST LAW ¶227.

[57] 135 S.Ct. at 1114. Further, "[t]here is no doubt that the members of such associations often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm." *Id*. at 1114, quoting *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S.492, 500 (1988).

[58] Citing *Hallie*, 471 U.S. at 39, as "rejecting 'purely formalistic' analysis."

[59] *N.C. Dental*, 135 S.Ct. at 1114, citing 1A ANTITRUST LAW ¶227.

[60] 135 S.Ct. at 1115.

The Court also rejected the argument that the Board's decision in this case should be treated as a type of "peer review," which is "essential to the provision of quality medical care," and that the specter of antitrust damages would act as a deterrent to such review. The Court concluded that this argument is more properly addressed to the "legislative branch," apparently referring to either Congress or the relevant state legislature.[61]

Finally, the Court observed that active supervision was lacking in this case. Teeth whitening was not covered by the statutory provisions creating the Board and stating its duties and powers. Further, in this case the Board had acted against putative offenders by means of unilaterally sent "cease-and-desist letters threatening criminal liability, rather than any of the powers ... that would invoke oversight by a politically accountable official."[62] It did not mean to suggest that a more judicially involved process, such as a request for a preliminary injunction, would have qualified as supervision unless judicial review in that context actually reached the competitive merits of the requested action. Nevertheless, the Court also stated:

> Active supervision need not entail day-to-day involvement in an agency's operations or micromanagement of its every decision. Rather, the question is whether the State's review mechanisms provide "realistic assurance" that a nonsovereign actor's anticompetitive conduct "promotes state policy, rather than merely the party's individual interests."[63]

The Court then provided a list of requirements for qualifying active supervision. *First*, the state supervisor "must review the substance of the anticompetitive decision, not merely the procedures followed to produce it."[64] Further, the relevant supervisor "must have the power to veto or modify particular decisions to ensure they accord with state policy," and the "mere potential" for such supervision is inadequate.[65] Finally, "the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case."[66]

B. Dissent

Justice Alito's dissent found the majority's reasoning to be "based on a serious misunderstanding" of the antitrust state action doctrine.[67] For him, the Court took "the unprecedented step of holding that *Parker* does not apply to the North Carolina Board because the Board is not structured in a way that merits a good-government seal of approval."[68]

Justice Alito then stated categorically that "Under *Parker*, the Sherman Act...and the Federal Trade Commission Act...do not apply to state agencies; the North Carolina Board of Dental Examiners is a state agency; and that is the end of the matter."[69] Returning to this issue

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[61] *Id*. at 1116, citing Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 UNIV. PA. L. REV. 1093 (2014).

[62] 135 S.Ct. at 1116.

[63] *Id*. at 1116.

[64] *Id*. at 1116, citing *Patrick v. Burget*, 486 U.S. 94, 102-103 (1988).

[65] 135 S.Ct. at 1116, citing *Patrick*, *Id*; *FTC v. Ticor Title Ins. Co*., 504 U.S. 621, 638 (1992).

[66] 135 S.Ct. at 1117.

[67] *Id*. at 1117 (Alito, J., dissenting, joined by Justices Scalia and Thomas).

[68] *Id*. at 1117.

[69] *Id*. at 1117–1118.

later, he concluded that the state of North Carolina had had an "agency" in mind when it passed the legislation creating the dental board.[70] "As this regulatory regime demonstrates, North Carolina's Board of Dental Examiners is unmistakably a state agency created by the state legislature to serve a prescribed regulatory purpose and to do so using the State's power in cooperation with other arms of state government."[71]

Justice Alito also observed that self-regulation of dentistry long antedated the Sherman Act.[72] Further, when the antitrust laws were originally passed the scope of the Commerce Power was much narrower than it is today. "As a result, the Act did not pose a threat to traditional state regulatory activity," which generally applied only within its own borders.[73] Further, "In 1890, the regulation of the practice of medicine and dentistry was regarded as falling squarely within the States' sovereign police power."

Like the majority, he also parsed earlier decisions, finding instances such as *Parker* itself that found immunity for purely private, self-interested conduct.[74] While *Midcal* had required active state supervision, the party claiming immunity in that case was a private trade association, not a state agency.[75] Justice Alito preferred to liken the dental agency in the present case to the municipality in *Hallie*. He found it "puzzling" that the majority treated the dental Board "less favorably than a municipality."[76] Municipalities, he noted, are not sovereign, while agencies can and do exercise sovereign state functions.

C. Analysis

All members of the Court, including the three dissenters, agreed with the lower tribunals that active supervision was not present. The legal conclusions they drew were starkly different. The majority believed that state authorization was "rarely" sufficient standing alone, that it must usually be accompanied by supervision, and that supervision by a market participant never suffices.[77] Municipalities and agencies in which a controlling number of decision-makers are either disinterested public officials or else persons other than active market participants may qualify. By contrast, the dissenters believed that authorization was sufficient any time the relevant actor had been designated by the state as an "agency," without regard to the interested and active market participation of the agency's decision-makers.

On the exemption from the active supervision requirement given to municipalities, the majority emphasized one set of points—namely, (i) that municipal decision-making is most frequently made by disinterested public officials, (ii) that municipalities are "multi-sector," with regulatory obligations in many areas, and (iii) that most of the state action issues pertain to municipal decisions that are excessively parochial rather than blatant trade restraints such as

[70] *Id*. at 1118.

[71] *Id*. at 1120.

[72] *Id*. at 1118.

[73] *Id*. For development of this proposition, *see* HOVENKAMP, OPENING OF AMERICAN LAW, *supra* note 13 at 296-298.

[74] 135 S.Ct. at 1119–1121, discussing *Parker v. Brown*, 317 U.S. 341, 347-351 (1943).

[75] 135 S.Ct. at 1121.

[76] *Id*. at 1122.

[77] *Id*. at 1112.

price-fixing or market exclusion.[78] For the dissenters, the main significance was that municipalities were non-sovereign institutions of local government, while agencies were created in order to carry out state policy.[79]

On the nature of the likely restraints, the majority's observation that municipalities rarely engage in naked price-fixing or exclusion but are more likely to regulate for parochial or territorial reasons is generally justified by the case law. Typical municipally imposed restraints are things like tying of electric service to waste pick-up, use of land use provisions to limit providers, or limitations on ambulance or airport taxi access.[80] By contrast, *Parker*, *Midcal*, *Goldfarb*, and *N.C. Dental* all involved participant-created price or output control that would have been *per se* unlawful at the time of those decisions. Further, while Justice Alito found it puzzling that the majority should treat agencies less favorably than municipalities, in fact the test that the majority created applied to both. Municipalities are entitled to regulate without independent state supervision because they act largely through elected government officials accountable through the political process. Presumably, if they should cede this power to an "agency" of active market participants—say, a taxicab commission composed of taxi owners—they would also be subject to the supervision requirement under the majority's analysis.

To be sure, municipalities cover a limited territory while state agencies often operate state wide, as the Board of Dental Examiners did. But that distinction has little relevance for purposes of assessing sovereign power. The more important differences are that the municipality is "multi-sector," dealing with nearly the same range of regulatory issues that state government controls. This is particularly true of larger "home rule" cities that typically have most of the regulatory power of states, but limited to their own borders.[81] In that setting the interests of one entrepreneurial group are more likely to be offset by those of a different group. Single-sector agencies, by contrast, typically have members whose interests are aligned—such as practicing dentists, all of whom could profit from a teeth-whitening cartel. Further, municipalities have their own internal political processes, and their decisions-makers are answerable to the electorate.

Both sides also agreed that the Dental Board's actions in this case were an instance of special interest agency "capture." They drew different conclusions from that premise as well. The majority embraced and the dissent rejected a link between the state action doctrine and special interest capture. Indeed, the dissent noted that in *Parker v. Brown*, the grandparent of state action cases, the relevant decision-makers were all market producers.[82]

The dissent drew strong conclusions from the fact that regulation of dentistry was traditionally an intrastate activity that the Sherman Act very likely could not have reached at the time it was passed. That changed with the Supreme Court's *Wickard* case in 1942, which brought such markets within the reach of federal law provided that they had a sufficient effect on

[78] *Id.* at 1112.
[79] *Id.* at 1121–1122.
[80] For analysis of the decisions, *see* 1A ANTITRUST LAW ¶223.
[81] *See Id.*, ¶223c.
[82] *N. C. Dental*, 135 S.Ct. at 1121.

interstate commerce.[83] What the dissent did not note is that the present case was brought under §5 of the Federal Trade Commission Act, because the FTC has no direct authority to enforce the Sherman Act. At the time of *Wickard* and *Parker,* the FTC Act reached only activities "in commerce," but thirty years later it was amended to embrace all matters "in or affecting commerce," thus tracking the *Wickard* language.[84] Congress clearly intended for the FTC Act to reach intrastate activities that affect commerce.

One portion of the dissent's argument seems anachronistic. The dissenters dwelt at some length on *Parker*, which immunized what amounted to a state-sanctioned raisin cartel without assessing any kind of supervision by a disinterested state actor.[85] For decades the Court struggled with the meaning of this decision, at one time suggesting that it required "compulsion."[86] It did not develop the modern two-prong test requiring "clear articulation" and "active supervision" (but not compulsion) until *Midcal* in 1980.[87] Already in *Goldfarb*, however, the Court held that minimum price schedules promulgated by the Virginia Bar Association were not immune, in part because no independent agency—referring in this case to the Virginia Supreme Court—supervised them.[88] On this point *Goldfarb* and the dissent seem quite inconsistent, and the dissent did not attempt to resolve the conflict. In any event, the current majority was certainly not taking an "unprecedented step" as the dissent suggested.[89]

The dissenters' position that once a state-created "agency" is found, state action immunity for authorized conduct is automatic is hardly a foregone conclusion from the case law. The State Bar Association in *Goldfarb* had been designated "a state agency by law" in a 1938 statute creating an integrated state bar.[90] The *Ticor* decision, which also involved state regulatory agencies, is somewhat different. There the "rating bureaus" were simply private cartels of title insurers, and

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[83] *Id.* at 1118, citing *Wickard v. Filburn*, 317 U.S. 111, 125 (1942).

[84] 88 Stat. 2193, 15 U.S.C.A. §45. *See* H.R. Rep. No. 1107, 93 Cong., 2d Sess., 29-31 (1974).

[85] *See N.C. Dental*, 135 S.Ct. at 1118–1121.

[86] *See*, e.g., *Cantor v. Detroit Edison*, 428 U.S. 579, 637 (1976) ("*Goldfarb* clarified *Parker* by holding that private conduct, if it is to come within the state-action exemption, must be not merely "prompted" but "compelled" by state action); *Goldfarb v. Va. State Bar*, 421 U.S. 773, 791 (1975) ("It is not enough that, as the County Bar puts it, anticompetitive conduct is 'prompted' by state action; rather, anticompetitive activities must be compelled by direction of the State acting as a sovereign."). *See* 1A AREEDA & HOVENKAMP ¶217a, *supra* note 9.

[87] *Midcal*, *supra* note 22.

[88] *Goldfarb v. Va. State Bar*, 421 U.S. 773, 791 (1975). The Court spoke in terms of "compulsion" as much as "supervision:"

> Here we need not inquire further into the state-action question because it cannot fairly be said that the State of Virginia through its Supreme Court Rules required the anticompetitive activities of either respondent. Respondents have pointed to no Virginia statute requiring their activities; state law simply does not refer to fees, leaving regulation of the profession to the Virginia Supreme Court; although the Supreme Court's ethical codes mention advisory fee schedules they do not direct either respondent to supply them, or require the type of price floor which arose from respondents' activities. Although the State Bar apparently has been granted the power to issue ethical opinions, there is no indication in this record that the Virginia Supreme Court approves the opinions. Respondents' arguments, at most, constitute the contention that their activities complemented the objective of the ethical codes. In our view that is not state action for Sherman Act purposes. It is not enough that, as the County Bar puts it, anticompetitive conduct is 'prompted' by state action; rather, anticompetitive activities must be compelled by direction of the State acting as a sovereign.

[89] *N.C. Dental*, 135 S.Ct. at 1117.

[90] *Goldfarb*, 421 U.S. at 790

the relevant state agencies rubber stamped their rate requests with little or no review.[91] It is unclear, however, why rubber stamping by the insurance agency is insufficient, given that it is an agency with the authority to make its own unsupervised substantive decisions in this market. If it exercises by rubber stamping, that would be all the law requires under the dissenters' view.[92] In *Cantor,* a state agency, the Michigan Public Service Commission, had approved a privately owned electric utility's practice of providing "free" light bulbs to utility customers, later challenged as a tying arrangement.[93] Nevertheless, the Supreme Court disapproved the arrangement. In sum, the majority's approach was hardly "unprecedented," as the dissent suggested.[94] Rather, it was more responsive to the Court's long list of admittedly fumbling and confusing precedents, while the dissent dwelt at length on *Parker*.

Fundamentally, the dispute between the majority and the dissent centered on the questions of "how much federalism" vs. "how much national competition policy." For the dissenters all the state need do is declare that a group of private actors is an "agency" and that is the end of the matter. Apparently, the state could simply create an agency of taxicab drivers, authorize them to select several among their members as decision-makers, and then give them the authority to fix taxicab prices, with no further oversight required. This fact did not appear to trouble the dissenters because the state as sovereign is competent to deal with the matter itself. On this point, the majority's view seems more realistic about legislative processes. For the dissenters all that was required was the formality that the state designate the association as an agency, perhaps decades prior to the challenged action, as was so in this case.[95]

The dissenters' observation that dentistry was traditionally self-regulated[96] also seems beside the point of the federalism issue, and perhaps even cuts the other way. The Commerce Clause identifies the line between federal governmental and state governmental power, not the line between federal governmental power and private conduct. Entrepreneurial self-regulation implies a division of authority as between the government on one side and private enterprise on the other. Indeed, to the extent that a tradition of self-regulation is relevant it suggests that the states were not involved. This fact should create more room—rather than less—for an expansion of federal power. While federal regulatory power under the Commerce Clause is properly limited by state governmental activity, it is not limited by things that are within Congressional reach and in which the state does not play a part.

For considerations of federalism, the extraterritorial effect or lack of it seems to be much more significant, although the point was ignored by both the majority and the dissent. Ironically, the raisin cartel found to be immune in *Parker* makes a better case for non-immunity than the

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[91] *FTC v. Ticor title Ins. Co.*, 504 U.S. 621 (1992).

[92] Justice Scalia concurred with the Court's finding of nonimmunity in *Ticor*, but warned that the holding would produce "uncertainty and (hence) litigation." *Ticor*, 504 U.S. at 641. He gave the example of private physicians invited to participate in a hospital peer review system and who might not find out until too late that the State's supervision was not "active" enough. *Id*.

[93] *Cantor v. Detroit Edison*, 428 U.S. 579, 637 (1976).

[94] *N.C. Dental*, 135 S.Ct. at 1117.

[95] The statutes in question creating the dental association as an agency were passed in 1957, and amended in 1961, 1971, 1973, and 1981. *See* N.C.G.S.A. § 90-22, NC ST § 90-22.

[96] *N.C. Dental*, 135 S.Ct. at 1118.

dentists' cartel in *North Carolina Dental*. Under the program at issue in *Parker* ten producers of an agricultural commodity could request that the Commissioner create a "prorate" Committee for that product. The Committee was composed of several producers of the commodity, although the Commission had discretion to add two distribution members, such as canners or other handlers.[97] At that point the producer-dominated committee issued production allocation decisions, and all growers in the covered area were required to comply. Most significantly, in *Parker* nearly all of the raisins produced under the quotas were shipped outside of the state of California, making the state's raisin growers an enormous beneficiary of the cartel while visiting the consumer harm elsewhere.[98] Whether the non-dominant "distribution" members of the Committee were injured or benefitted would depend on their markup. Ordinarily intermediaries would suffer from an upstream cartel in the distributed product unless they were compensated by affected producers.

By contrast, in *North Carolina Dental* it seems clear that most of those purchasing teeth-whitening services in North Carolina are also residents of that state. Further, states have their own regulatory provisions as well as their own antitrust laws. These can also be deployed against the anticompetitive acts of state professional associations (whether or not they are denominated "agencies") if the state legislatures or courts so choose.[99]

The majority thought that an important use of federal antitrust policy is to force a layer of transparency through more public control of the state's own governmental processes, quite aside from any question about extraterritorial spillovers. The Court emphasized that:

> Immunity for state agencies...requires more than a mere facade of state involvement, for it is necessary in light of *Parker* 's rationale to ensure the States accept political accountability for anticompetitive conduct they permit and control.[100]

Further, this concern about transparency is important even if the goal is to protect the residents of a state from their state's own anticompetitive decisions. The Court spoke repeatedly of unsupervised private conduct that deviated from the *state's own* interest, stating "Entities purporting to act under state authority might diverge from the State’s considered definition of the public good,"[101] and that the federal antitrust concern is to identify when the private decision-maker "is acting to further his own interests, rather than the governmental interests of the state."[102] Interestingly, the dissenters did not push this point, even though all three (Justices Alito, Scalia, and Thomas) are strongly sympathetic with concerns of federalism and state self-determination.

The dissent also objected that the majority's identification of "capture" with control by market participants was "crude," and that determining when capture has occurred is "no simple

[97] Parker v. Brown , 317 U.S. 341, 346-347 (1943).

[98] *See* HOVENKAMP, OPENING OF AMERICAN LAW, *supra*, note 13 at 297-298.

[99] On state antitrust law, *See* 14 HERBERT HOVENKAMP, ANTITRUST LAW, Ch. 24 (3d ed. 2012).

[100] *N.C.Dental*, 135 S.Ct. at 1111.

[101] *Id.* at 1112.

[102] *Id.*

task."[103] That observation is certainly factually correct, and political history is filled with instances in which even salaried government officials were captured by the entities that they were supposed to be regulating.[104] Perhaps the more pertinent question is whether disciplining the decision-making of self-interested market participants is a worthwhile activity when other decision-makers who are not market participants might act improperly as well.

The best answer is that even imperfect law can be better than no law at all. For example, a policy of removing drunk drivers from the road is worthwhile, even though not every accident is caused by a drunk. Self-interested market participants are highly likely to be compromised in favor of their own industry and may even rationalize that their decisions are best for the public as well. Salaried government officials may or may not be excessively beholden to the industries that they are intended to regulate, but capture cannot simply be presumed, and the political process with its checks and balances provides greater control. This is particularly true of multi-sector government regulators, who face conflicting pressures from competing interest groups.

Finally, the dissent fretted that the rule adopted by the majority would increase the risk of antitrust treble damages exposure to those who serve on state agencies. While that problem seems manageable, it does have to be managed. Damages actions seem to be almost a foregone conclusion. As the majority pointed out, the very objection launched by most dentists to non-dentist teeth whitening, and which provoked the dental association's rule, was that the non-dentists were charging a lower price.[105] This evidence not only creates an inference that higher prices resulted, but also provides a yardstick for measuring the extent of the overcharge.

The most obvious way for state agency officials to avoid antitrust exposure is to ensure that potentially anticompetitive decision-making be supervised by economically disinterested government officials. Another is to ensure that majority control over potentially anticompetitive professional decisions not be vested in market participants. A third is use of the antitrust mechanisms themselves, including the rule of reason for most professional rules that are reasonably intended to promote socially valuable practices, and the *per se* rule for the occasional situation where a professional association oversteps, as occurred in this case.

It is worth noting that standard-setting is ubiquitous in the American economy and is hardly limited to professional organizations. In most cases those setting standards have no immunity, but have simply learned to live within antitrust parameters. The courts, for their part, have learned to appreciate the competitive and other social values of collaborative setting of standards. As a result most, although not all, of such practices survive antitrust scrutiny.[106] Of course, this risk may be acceptable for a market participant but not for a citizen who volunteers as a public service.

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[103] *Id.* at 1123.

[104] E.g., JAMES M. LANDIS, REPORT ON REGULATORY AGENCIES TO THE PRESIDENT ELECT (1960); HOVENKAMP, THE OPENING OF AMERICAN LAW, *supra* note 13 at 308-309.

[105] *See* 135 S.Ct. at 1108.

[106] *See* 12 ANTITRUST LAW ¶¶ 2230-2235.

Finally, the majority did not rule out the possibility of simple state court supervision by judges, provided that the review extended to the substance and not merely the procedure.[107] The Court approved a roughly similar process in *Hoover,* concluding that substantive review by the state supreme court, acting in a quasi-legislative capacity as manager, eliminated the need for a separate supervision requirement.[108] By contrast, *Goldfarb* denied immunity after finding that the state's supreme court did not supervise the bar's practices.[109] This adjustment may require a modification of state administrative procedure acts or collateral legislation so as to provide for more substantive judicial review when a threat to competition is apparent. The court may then be empowered to appoint one or more special masters or other experts to evaluate the proposed rule.

The majority concluded that the states could readily indemnify agency members. Of course, indemnification does not remove treble damages but provides that those damages must be paid by the state and its taxpayers rather than the designated citizen officials themselves. That in itself, however, might be a good discipline against anticompetitive conduct.

III. CONCLUSION

How much can a state default on its sovereign obligations and continue to be called sovereign? The standard that the Supreme Court has developed is actually not all that high. The final decision must come from a government decision-maker with power to review and disapprove, but largely under any standard that the state wishes to articulate. What the state cannot do, however, is simply paste the label "sovereign" or "agency" on a purely private actor.

Neither the *North Carolina Dental* majority or dissent expressed much concern about whether the anticompetitive conduct in question was self-deterring, and thus more addressable through the state's own political processes. The raisin cartel in *Parker* was an economically rational act for the state of California, because the beneficiaries were within the state while nearly all of the victims were elsewhere. Under *Midcal* a state could, if it wished, articulate a policy of supporting cartels of products in which local producers were dominant in the market but buyers were mainly outside. That policy would increase the state's wealth and might even attain voter support as a revenue device. If the state adequately articulated that policy and final decisions were made by a governmental official, that would be the end of the matter insofar as antitrust is concerned. By contrast, assuming that the teeth-whitening cartel is harmful—and the evidence strongly suggested that it was—the net harm in the *Dental* case was experienced mainly by residents of North Carolina who purchased teeth-whitening services. As a general proposition cartels are socially costly because the aggregate harm to purchasers exceeds the aggregate benefit to cartel members.[110]

In that case North Carolina's failure to supervise was injuring its own economy, but why shouldn't it have that right? The important qualifier is that the effects of the cartel must be

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[107] *See Id.* at 1110 ("State legislation and 'decision[s] of a state supreme court, acting legislatively rather than judicially,' will satisfy this standard...").

[108] *Hoover v. Ronwin*, 466 U.S. 558, 569 (1984).

[109] *Goldfarb v. Va. State Bar*, 421 U.S. 773, 791 (1975).

[110] *See* HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE §§4.0-4.2 (5th ed. 2016) (in press).

internalized, with both beneficiaries and the burdened located within the state. Under the two-prong test for the antitrust "state action" immunity this question of internalization is rarely relevant. Federal antitrust law reaches almost everywhere, certainly to a highly commercial profession such as dentistry, notwithstanding that most dentist-patient transactions are intrastate. Further, the two-prong *Midcal* test for state action is well established and does not make the location of antitrust harm relevant. The fact remains, however, that *North Carolina Dental* presents a weaker case for federal intrusion than did *Parker*.

The *Dental* case reflects greater paternalism, protecting North Carolina citizens from their own deficient governmental decisions. Indeed, the majority in the *Dental* case articulated the supervision requirement as querying whether the practice "promotes state policy" rather than the defendant's individual interests.[111] This recalled the query in the *Phoebe Putney* case into whether a non-sovereign actor has "an incentive to pursue [its] own self-interest under the guise of implementing state policies."[112] At the same time, however, the degree of paternalism is relatively modest—no more than necessary to force the state to make its own policy more public to its own citizens.

[111] *N. C. Dental*, 135 S.Ct. at 1112, quoting *Patrick v. Burget*, 486 U.S. 94, 101 (1988).
[112] *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S.Ct. 1003, 1011 (2011).

CPI COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

Supreme Court Requires State Supervision of Professional Boards to Secure Antitrust Immunity

Kenneth W. Field, Michael H. Knight, & Bevin M.B. Newman

Jones Day

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Supreme Court Requires State Supervision of Professional Boards to Secure Antitrust Immunity

Kenneth W. Field, Michael H. Knight, & Bevin M.B. Newman [1]

I. INTRODUCTION

In an important decision, *North Carolina State Board of Dental Examiners vs. FTC*,[2] the U.S. Supreme Court has held that, where a state professional regulatory board is controlled by active market participants in the profession the board regulates, the board cannot claim "state action" antitrust immunity unless it is actively supervised by other state officials who are not active market participants. The opinion has broad implications for state professional boards hoping to avoid antitrust liability and the entities they regulate seeking either to challenge or to invoke their authority.

Having represented the North Carolina State Board in the Supreme Court, Jones Day is especially familiar with the issues and implications raised by the case. *North Carolina Dental*, along with *Phoebe Putney*,[3] is the second time in three years that the Court has rejected a claim of state-action antitrust immunity.

II. BACKGROUND

The North Carolina Legislature created the North Carolina State Board of Dental Examiners "as the agency of the State for the regulation of the practice of dentistry in the State." The Board is empowered to create, administer, and enforce a licensing system for dentists, including bringing actions in the name of the State of North Carolina to enjoin persons from unlawfully practicing dentistry. Of the Board's eight members, six must be licensed, practicing dentists, who are elected by other North Carolina licensed dentists.

Starting in 2006, the Board sent official cease-and-desist letters to non-dentist teeth-whitening service providers and product manufacturers in the state. The letters stated or implied that teeth-whitening constitutes "the practice of dentistry" and warned that the unlicensed practice of dentistry is a crime. Non-dentists thereafter left the market.

In 2010, the Federal Trade Commission ("FTC) filed an administrative complaint challenging the letters as an anticompetitive practice and unfair method of competition under § 5 of the Federal Trade Commission Act. The FTC argued that the Board's actions amounted to concerted action to exclude non-dentists from the North Carolina teeth-whitening services market.

[1] All partners in the Jones Day Antitrust Practice in the Washington DC office.

[2] *North Carolina State Board of Dental Examiners vs. FTC*, No. 13–534 (U.S. Feb. 25, 2015).

[3] *FTC v. Phoebe Putney Health System, Inc.*, (2013).

The Board moved to dismiss on the grounds that it was a state actor and therefore immune from antitrust scrutiny under Supreme Court precedents, beginning with *Parker*,[4] that have interpreted the federal antitrust laws, in light of principles of federalism, not to apply to anticompetitive actions taken by the states in their governmental capacities as sovereign regulators. Under this line of cases, state actors are immune from antitrust scrutiny so long as they are acting pursuant to a clearly articulated and affirmatively expressed state policy of displacing competition with regulation.

The Court further held in *Midcal*[5] that *Parker* immunity extends to non-state actors implementing such a clearly articulated state policy, but only where they also are actively supervised by the State. The Court recently observed in *Phoebe Putney* that *Midcal's* active-supervision requirement is a particularly important condition when non-state actors have "an incentive to pursue their own self-interest under the guise of implementing state policies."

The FTC denied the Board's state-action defense. The FTC, assuming without deciding that the Board acted pursuant to a clearly articulated state policy to displace competition, reasoned that, because the Board was controlled by market participants, it should be treated as a "public/private hybrid" and subjected to the active-supervision requirement, which it failed to satisfy. In 2013, the Fourth Circuit affirmed in all respects.

III. SUPREME COURT DECISION

The question presented to the Court was whether the FTC erred in extending the active-supervision requirement that applies to private parties to a state regulatory board simply because the board's members are also active market participants. In a 6 to 3 ruling penned by Justice Kennedy, the Court affirmed the FTC's decision: "a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal's* active supervision requirement in order to invoke state-action antitrust immunity."

The Court reasoned that the supervision requirement is designed to obtain "realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests." And the Court found that "state agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal's* supervision requirement was created to address." The Court cautioned that its "conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals."

The Court thus emphasized that a board's actual structure, and not its "formal designation," determines whether supervision is required. Regardless of the designation, the analysis turns on "the risk that active market participants will pursue private interests in restraining trade." "Immunity for state agencies … requires more than a mere facade of state involvement, for it is necessary … to ensure the states accept political accountability for anti-competitive conduct they permit and control." In reaching this conclusion, the Court did not, as

[4] *Parker v. Brown*, 317 U. S. 341 (1943).

[5] *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97 (1980).

some commentators had suggested it might, base its analysis on whether Board members were elected by their peers or appointed by elected officials.

In response to concerns that antitrust liability would discourage professionals from serving on state regulatory boards, the Court noted that states can defend and indemnify board members, and further suggested that "board members, may, under some circumstances, enjoy immunity from damages liability." Alternatively, the Court noted, states can provide active supervision.

The court did not review a specific supervisory system, as the Board had not argued that it was actively supervised. Justice Kennedy nonetheless, drawing upon *Patrick v. Burget*[6] and *FTC v. Ticor*,[7] provided useful guidance. He stated that "the inquiry regarding active supervision is flexible and context-dependent" and "will depend on all the circumstances of a case." Active supervision does not require "day-to-day involvement in an agency's operations or micromanagement of its every decision," but must "provide 'realistic assurance' that a nonsovereign actor's anticompetitive conduct 'promotes state policy, rather than merely the party's individual interests.'"

Justice Kennedy further noted that the Court has identified "a few constant requirements of active supervision." A supervisor must not be an active market participant; must "review the substance of the anticompetitive decision, not merely the procedures;" "have the power to veto or modify particular decisions to ensure they accord with state policy;" and make an actual decision, not just have an opportunity to do so, as "mere potential for state supervision is not an adequate substitute for a decision by the State."

Chief Justice John Roberts and Justices Ruth Bader Ginsburg, Stephen Breyer, Sonia Sotomayor, and Elena Kagan joined the majority opinion. Justice Samuel Alito, joined by Justices Antonin Scalia and Clarence Thomas, dissented.

IV. IMPLICATIONS

The Court's opinion is a significant development. As the dissent stressed, without dispute by the majority, state professional regulatory boards throughout the country have long been composed of a majority of active market participants, yet the Court had never applied the active-supervision requirement to such boards (nor had any lower court until the Fourth Circuit's decision in this case). The new regime has important implications for both regulators and the regulated.

As for regulators, states that want to avoid antitrust liability for their professional boards will have three options:

1. States could reduce the number of active market participants serving on their boards. But of course doing so risks diminishing the expertise of the board members. That risk potentially can be mitigated if States select retired professionals, academics in the field, or perhaps even market participants who suspend their practice while they serve on the

[6] *Patrick v. Burget*, 486 U. S. 94, 100 (1988).
[7] *FTC v. Ticor Title Insurance Co.*, 504 U. S. 621 (1992).

board. However, doing so may well prompt additional litigation over whether the active-supervision requirement should further be extended to boards constituted in this manner.

2. States could actively supervise those boards that are controlled by active market participants. Whether states currently supervise those boards may vary across professions and states. Some state professional boards may already be subject to active supervision, such as state bars subject to extensive oversight by state supreme courts; others may be subject to much less oversight, especially for professions that are further from the public and political eye like cosmetologist, barber, and florist boards. Likewise, states will probably differ in whether they want to begin actively supervising additional boards, depending both on their general resource constraints and on their specific ability to meaningfully supervise the work of market participants in a given field.
3. States can give up state-action immunity for their professional boards if they believe that they can sufficiently limit their boards' exposure to substantive antitrust liability for their regulatory conduct. Whether they can do so will turn on the specific types of activity that the boards perform. One important question will be whether such boards' most traditional function—granting and denying licenses to practice for specific individuals—can give rise to antitrust liability on, for example, a group boycott theory. And more systematic actions by boards—such as general rules and regulations attempting to exclude an entire set of competitors from a market—may bring more significant antitrust exposure.

As for market participants who are regulated by these boards, the Court's novel ruling brings both potential benefits and costs. On the one hand, the decision provides a potential basis for regulated parties to challenge a state professional board's unfavorable anticompetitive decisions if the board is controlled by active market participants and has inadequate state supervision.

On the other hand, the decision potentially exposes regulated parties who lobby state professional boards to antitrust liability. So-called *Noerr-Pennington* immunity, based on the First Amendment, protects persons who petition the government from liability for the direct anticompetitive effects of any laws enacted due to their successful petitions as well as for any indirect anticompetitive effects that flow from their attempts to influence lawmakers. But given that the Court's decision here treated state professional boards as analogous to private trade associations for purposes of state-action immunity, courts may similarly conclude that lobbying such boards is more analogous to lobbying a private standard-setting organization for purposes of *Noerr-Pennington* immunity.

CPI COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

North Carolina Board of Dental Examiners v. FTC: How States Will Respond to Improve Competition and Accountability in State Regulatory Boards

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North Carolina Board of Dental Examiners v. FTC: How States Will Respond to Improve Competition and Accountability in State Regulatory Boards

Austin D. Smith, Logan M. Breed, & Robert F. Leibenluft[1]

I. INTRODUCTION

The Supreme Court's recent decision in *North Carolina Board of Dental Examiners v. Federal Trade Commission*[2] will have a real and lasting effect on how state boards regulate and license scores of professions. The case concerned the state action immunity doctrine articulated in the 1943 *Parker* decision, which held that federal antitrust law does not reach anticompetitive actions by states. *Midcal* later clarified that states cannot throw a "gauzy cloak" of immunity over private anticompetitive conduct unless the private parties (1) act pursuant to a clearly articulated state policy to displace competition; and (2) are actively supervised by the state.

North Carolina Dental posed the question whether a state dental board composed primarily of active dentists has to meet *Midcal*'s "active supervision" requirement despite its designation as an arm of the state. The Court sided strongly with federal competition and antitrust law at the expense of formalistic federalism, holding that such boards should be treated like private organizations for *Parker* immunity purposes and are thus subject to both *Midcal* requirements.

States will now be forced to rethink how they delegate their police powers over many occupations that are currently largely self-regulated. There are three general ways that states could react to the *North Carolina Dental* decision: (i) changing the makeup of regulatory boards so that active market participants no longer control them; (ii) providing more active supervision over boards' conduct; and (iii) taking no further action, thereby subjecting some of their boards' conduct to federal antitrust law (which will in turn present its own issues).

While much commentary on the case has focused on the "active supervision" aspect of the case, the other options are also important. Each state is likely to employ a mix of these options, tailoring approaches to their unique needs, and even varying their responses on a board-by-board basis within the same state. However states choose to react, the upshot is that active market participants will no longer be able to so easily shield their actions on professional boards from federal antitrust law.

II. REMOVING CONTROL OF BOARDS FROM ACTIVE MARKET PARTICIPANTS

The *North Carolina Dental* majority first found that state agencies, like cities, are "nonsovereign" actors, and thus not automatically entitled to state action immunity. The majority further found that "prototypical state agenc[ies]," rather than one controlled by active

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[2] *North Carolina Board of Dental Examiners v. Federal Trade Commission*, 135 S.Ct. 1101 (2015).

market participants, receive the same level of immunity as a city and no active supervision is necessary for *Parker* immunity to apply. But when "a controlling number of decisionmakers" on a board are "active market participants in the occupation the board regulates," the board must satisfy both *Midcal* requirements (clear articulation of state policy and active supervision) to qualify for state action immunity from federal antitrust laws; in other words, such boards are treated the same as private trade associations. This included the North Carolina Board of Dental Examiners, where six of the eight board members are practicing dentists.

The first option for states that want to protect their regulatory boards from antitrust scrutiny is to head legal challenges off at the pass by changing who sits on the boards so that "active market participants" do not make up a "controlling number" of its decision makers, obviating any need to look at whether there is any active supervision. Unfortunately, both of those terms are left undefined by the majority opinion—though it does state that it is the existence of economic incentives to restrain competition that matters for determining whether someone is an active market participant. But despite the difficulty of interpreting the Supreme Court's terminology, this option may be attractive to states—at least for some of their boards—because if successfully implemented it would allow the boards to continue to operate largely autonomously, thus minimizing costs to the state of reviewing their decisions going forward.

III. PROVIDING ACTIVE SUPERVISION OF BOARD ACTIONS

States may choose to keep some boards controlled by active market participants. As the Justices discussed at some length during oral arguments, brain surgery patients, for example, probably prefer that neurosurgeons be regulated by those with the most up-to-date and thorough knowledge of their craft—in other words, practicing neurosurgeons themselves, not consumer representatives or former practitioners. These boards will require some form of active supervision to receive *Parker* immunity after *North Carolina Dental*.

The Court's opinion fleshes out the "active supervision" concept more than the terms "active market participants" and "a controlling number," but its exact definition remains hazy. The majority lists four minimum requirements for state oversight to qualify as active supervision:

1. the supervisor must review the substance of the challenged conduct, not just the procedure the board followed,
2. the supervisor must have the power to modify or veto specific decisions to ensure compliance with state policy,
3. there must be more than the "mere potential" of state supervision, and
4. the state supervisor must not itself be an active market participant.

North Carolina did not exercise any supervision at all over the Board of Dental Examiners' anticompetitive conduct at issue in the case, and so the Court declined to go into more detail than laying out those minimum elements of "active supervision." A variety of options are available to states that want to provide active supervision for regulatory boards run by active market participants, though:

- States can appoint a single employee of the state government with relevant expertise in a board's subject area to supervise its activities, and/or house boards within the relevant

state agency and require the director's approval to adopt rules and regulations, as is done in Rhode Island.

- Or states may place their boards inside a state agency that oversees the actions of all professional boards in the state, as is done to different degrees by California and Utah.[3]

Thus, there are a number of models to choose from which provide for more substantive and active supervision than occurred in *North Carolina Dental*, and a number of states likely already have sufficient protocols in place.

IV. ALLOW FEDERAL ANTITRUST LAW TO GOVERN STATE BOARDS

A third possible response to the decision would be for states to let federal antitrust law have relatively free rein to police their boards' anticompetitive action. There is a simplistic appeal to telling boards not to engage in anticompetitive conduct or else they will have to suffer the consequences.

Then again, while the FTC and DOJ might be expected to only challenge anticompetitive board behavior that has broad effects, taking away immunity makes every private party denied a license or harmed by a promulgated rule a potential litigant. Thus, states might also choose to soften this approach by indemnifying individual board members to encourage qualified participants to serve on boards without fear that a wrong step could bankrupt them, an idea the *North Carolina Dental* majority floated. (The Court also pointedly declined to decide whether board members might have individual immunity from antitrust damages claims in some situations.)

Relatedly, some states will probably choose to discontinue a few of their more arcane professional boards. There have been movements in various states over the last few years to remove or consolidate regulatory boards, and *North Carolina Dental* could give them the impetus they need to discontinue, say, Boards of Barber Examiners rather than figure out how best to provide more bureaucratic supervision over them or fund their inevitable legal battles. And while states will decide to keep many of their regulatory boards, they will put added pressure on them to stay away from conduct that could give rise to a colorable antitrust claim.

Some states might look at their system and decide they have a sufficient regime of active supervision (or non-active market participant controlled boards) and thus already comply with *North Carolina Dental*'s requirements. The effect of *North Carolina Dental* on boards in these states will be to encourage them to take existing processes more seriously. For example, one FTC commissioner has pointed out that if the North Carolina dental board had used its state-given authority to promulgate a rule that teeth-whitening services do constitute the unlawful practice of dentistry—rather than immediately sending threatening letters to non-dentist practitioners, an action not subject to any review—the rule would have been reviewed by the state's Rules Review

[3] *See generally* Brief for Neil Averitt, *North Carolina Board of Dental Examiners v. FTC*, 135 S.Ct. 1101 (2015) (No. 13–534).

Commission. Assuming that the Commission approved it, the Board of Dental Examiners would likely have avoided antitrust liability to begin with.[4]

Alternatively, the board could have sought injunctions in state courts against non-dentists offering teeth-whitening services, conduct that would be protected by *Noerr-Pennington* immunity. Regulatory boards now have stronger incentives to carry out their mandates using existing processes that involve active supervision rather than employing informal methods of enforcement (such as cease-and-desist letters) that do not allow for review to take place.

V. IMPLICATIONS AND UNANSWERED QUESTIONS

The general result of all this will be somewhat fewer active market participants on regulatory boards; a greater degree of active, substantive supervision of boards' anticompetitive decisions; boards that have a greater incentive to avoid conduct that would violate antitrust laws; and perhaps even a reduction in the number of questionably useful boards. The chairman of the California Senate's business and professions committee, for example, has stated that providing more active supervision and reducing the number or influence of active market participants are both options that the state is considering in response to the Supreme Court's decision.[5]

In short, *North Carolina Dental* will likely help curb some of the problems with professional boards that economists and others have long documented, though there will also be costs imposed on states as they figure out answers to remaining questions by trial-and-error.

But operationalizing the decision will have its difficulties. The first question will be how to identify an "active market participant." Can a recently retired dentist be trusted to regulate objectively? Or a dentist who takes two years off to chair the state board but then immediately returns to her practice? And once that is determined, states will have to interpret the language about "controlling numbers." How consistently must a bloc of active market participants be able to achieve their desired outcomes to count as a "controlling number" despite being less than a majority? Can the active market participants on a board simply abstain from voting on issues in which they have a financial stake? Litigation will have to answer some of these questions as states try some variation of these potential fixes.

Questions about active supervision also remain. LegalZoom, a website that sells do-it-yourself, customized legal forms for everything from wills to forming corporations, filed an *amicus brief* in the *North Carolina Dental* case describing informal actions (which thus do not trigger any review) taken by state bars against it and other "alternative legal information and service providers," including a cease-and-desist letter the North Carolina State Bar sent to LegalZoom in 2008. The *amicus brief* even alleges that the dental board's practices that ran afoul of the antitrust laws were modeled on those of the state bar. The state bar, for its part, argued in

[4] *See*, *Reflections on the Supreme Court's* North Carolina Dental *Decision and the FTC's Campaign to Rein in State Action Immunity*, Remarks by Maureen K. Ohlhausen, FTC Comm'r (Mar. 31, 2015), at 15–16, *available at* https://www.ftc.gov/public-statements/2015/03/reflections-supreme-courts-north-carolina-dental-decision-ftcs-campaign.

[5] Michael Hiltzik, *Supreme Court ruling puts state regulatory boards in crosshairs*, L.A. TIMES (Mar. 27, 2015, 8:17 PM), *available at* http://www.latimes.com/business/hiltzik/la-fi-hiltzik-20150329-column.html - page=1.

its own *amicus brief* that sending cease-and-desist letters was a more sensible option than suing people it believes are engaged in the unauthorized practice of law without any warning.

It would appear that the North Carolina bar is now on thin ice if it continues sending cease-and-desist letters on its own initiative to LegalZoom or similar entities operating in legal gray areas. How then can the North Carolina bar take action against people and organizations that it believes are engaged in the unauthorized practice of law without immediately inviting an antitrust suit in response? The bar might consider adopting formal rules—which are subject to public comment and must be approved by the state supreme court—defining more precisely the scope of the unauthorized practice of law in North Carolina. Receiving a stamp of approval from the state in such a way would likely qualify as sufficiently active supervision to grant the bar state action immunity for enforcing its rules. Barring that, the state bar is likely to be more hesitant to issue cease-and-desist letters or take other informal action against potential competitors.

Doctors are also likely to face interesting new challenges to their regulatory decisions. There are questions about how doctors on state boards regulate those on the outskirts of the medical profession, such as chiropractors and acupuncturists, and these issues are broadly analogous to tussles between state bars and LegalZoom.

But another area of tension for state medical boards regarding competition is how doctors and nurses work together in situations where both are qualified to provide the same care. Nurses, who are subject to their own extensive regulations and licensing boards, bristle at what they see as purely anticompetitive rules set down by many medical boards prohibiting nurses from offering services they are trained and licensed to provide, or requiring a doctor to "supervise" nurses in their work even though state law does not require it.

These questions implicate the affordability, accessibility, and quality of health care at a time when society is more concerned with these questions than ever. These issues deserve both an insider's medical perspective on best practices, but also a disinterested evaluation of who is qualified to perform those services. Medical boards will likely be forced to adapt to *North Carolina Dental* by granting nurses or consumers more input on their boards, or ensuring that government agencies have the opportunity to substantively review more of the regulations they promulgate.

The *North Carolina Dental* decision also raises interesting questions about situations like those in the *Phoebe Putney* case the Supreme Court decided only two years ago. There, the state of Georgia had created special-purpose public entities known as hospital authorities with the power to operate and maintain hospitals. A unanimous Court found, however, that the hospital authorities as then constituted could not benefit from state action immunity from antitrust law because they failed to meet the first *Midcal* prong—they were not acting pursuant to a "clearly articulated and affirmatively expressed" state policy to displace competition.

Given that state hospital authorities actively participate in their local healthcare market, *North Carolina Dental* tees up the question whether even a clear state policy to let them act anticompetitively would be enough to give them state action immunity, or whether active state supervision would be required as well. The *Phoebe Putney* Court seemed to assume that Georgia

hospital authorities were "local governmental entities" akin to cities and thus not subject to the active supervision requirement.[6] But now that it is clear that a state's designation of what is a governmental entity is not the final word for state action immunity purposes, courts may be asked to address whether such entities might be viewed as "market participants" and therefore subject to antitrust challenge absent sufficient active supervision.

VI. CONCLUSION

In the wake of *North Carolina Dental*, states will likely employ diverse combinations of the responses available to them—changing who sits on boards, providing more active supervision, and simply allowing federal antitrust law to reach boards' conduct and adjusting accordingly—and will vary their approach by agency. States will incur real costs in trying to comply with the Supreme Court's broad (and vague) mandate, which will need to be clarified through further litigation. But the end result will be less anticompetitive conduct from regulatory boards.

[6] *F.T.C. v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1011 (2013).

CPI COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

Antitrust Scrutiny for Licensed Occupations: A Way Forward

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Antitrust Scrutiny for Licensed Occupations: A Way Forward

Bruce Sokler & Helen Kim[1]

I. INTRODUCTION

The Supreme Court's recent decision in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*[2] potentially exposes hundreds of state regulatory and licensing entities nationwide to liability for alleged anticompetitive practices. As was the case with the North Carolina Dental Board, dozens of state boards in dozens of states are made up of market participants and regulate the markets in which their members participate, including entities overseeing professionals such as doctors, dentists, chiropractors, nurses, pharmacists, auctioneers, optometrists, veterinarians, lawyers, architects, funeral directors, accountants, plumbers, general engineers, technical professionals, real estate brokers, social workers, and appraisers.

By granting certain state agencies the same status as private parties for the purpose of state action immunity, the Court's decision opens up the decision-making of these boards—past and future—to further scrutiny. This article explores the impact of the *North Carolina State Board of Dental Examiners* decision on the antitrust status of state agencies and boards with a significant number of active market participants, and discusses how states can authorize their executive agencies and bodies to take actions that limit competition.

II. BACKGROUND

For over 70 years, the Supreme Court has attempted to harmonize the reach of the antitrust laws with federalism and recognizing the powers of state and local governments. Beginning with its decision in *Parker v. Brown*,[3] the courts have fleshed out the contours of a judicially created doctrine of state-action antitrust immunity. In *Parker,* the Supreme Court interpreted the antitrust laws to confer immunity on anticompetitive conduct by the states when acting in their sovereign capacity. However, the exemption is not unbounded. In fact, the Court reaffirmed just two years ago that "state action immunity is disfavored."[4] As *Parker* itself cautioned, "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful."[5]

When dealing with an actor that had been delegated authority by the state, the Court had established a two-part test in *California Retail Liquor Deals Assoc. v. Midcal Aluminum, Inc.*: "A

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[2] No. 13-354, slip op. (U.S. Feb. 25, 2015).

[3] 317 U.S. 341 (1943).

[4] FTC v. Phoebe Putney Health System, Inc., 133 S.Ct. 1003 (2013).

[5] 317 U.S. at 314.

state law or regulatory scheme cannot be the basis for antitrust immunity unless, first, the State has articulated a clear policy to all the anticompetitive conduct, and second, the State provides active supervision of the anticompetitive conduct."[6] The "clear articulation" requirement is satisfied "where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature. In that scenario, the State must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals."[7]

The active supervision requirement demands, *inter alia,* "that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."[8] As the Court put it here, the supervision rule "stems from the recognition that where a private party is engaging in anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State."[9]

Thus, the Court has granted State legislatures and state supreme courts automatic state action immunity for anticompetitive actions, while municipalities receive state action immunity only if the anticompetitive conduct they authorize is pursuant to a clearly articulated state policy to displace competition.[10] Finally, private parties receive state action immunity only if their anticompetitive actions are pursuant to a clearly articulated state policy and are actively supervised by the state.[11] But professional boards, unlike cartels in commodities or consumer products, are sanctioned by the state—even considered part of the state—and so have been often assumed to operate outside the reach of the Sherman Act.

III. *NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS*

The North Carolina State Board of Dental Examiners was established by state law to regulate the practice of dentistry. The Board creates and enforces a licensing scheme for dentists. Six of its eight members must be licensed, practicing dentists. The lynchpin of this case was teeth-whitening services, which the North Carolina statutory scheme does not specify is part of "the practice of dentistry." In the past, teeth-whitening was a service often offered by licensed dentists. Eventually, however, non-dentists began offering such services, often at kiosks located at shopping malls, and usually at prices lower than those charged by dentists.

After dentists complained to the Board, the Board opened an investigation, led by a practicing dentist member. The Board's chief operations officer remarked that the Board was "going forth to do battle" with non-dentists. The Board thereafter issued at least 47 official cease-and-desist letters to non-dentist teeth-whitening service providers and product manufacturers. The letters directed the recipients to cease all activity constituting the practice of dentistry, warned that the unlicensed practice was a crime, and strongly implied (or expressly stated) that teeth-whitening constituted "the practice of dentistry." Later, the Board sent letters to mall operators, stating that kiosk teeth-whiteners were violating the law and advising that the malls

[6] 445 U.S. 97 (1980).

[7] *North Carolina State Board of Dental Examiners*, Slip op. at 9.

[8] *Id.*

[9] *Id*. at 10.

[10] *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985).

[11] *California Retail Liquor Deals Assoc. v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

consider expelling violators from their premises. As a consequence, non-dentists stopped offering such services in North Carolina.

Enter the Federal Trade Commission ("FTC"). They brought an administrative complaint alleging that the Board's concerted action to exclude non-dentists from the market for teeth-whitening services was anticompetitive and in violation of the FTC Act. The Board defended itself principally by arguing that, as a state agency, its actions were immune from federal antitrust scrutiny, a defense the FTC rejected. It ordered the Board to stop sending communications stating that non-dentists may not offer teeth-whitening services and to issue notices to those who had received its previous letters that would indicate, *inter alia*, that recipients had a right to seek declaratory rulings in state court whether teeth-whitening in fact constituted the practice of dentistry.

In a 6-3 decision authored by Justice Kennedy, the Supreme Court upheld the FTC's decision finding that the Board, although a state agency, was not exempt from federal antitrust laws when it had sent the 47 official cease-and-desist letters to non-dentist teeth-whitening service providers. In doing so, the Court made clear that the antitrust laws would apply to—and the state action exemption would not protect—activities of state agencies or boards made up of market participants, absent active state supervision of the Board's challenged conduct. The Supreme Court affirmed the United States Court of Appeals for the Fourth Circuit's opinion upholding the FTC's ruling that state-action immunity was inapplicable.

IV. ACTIVE SUPERVISION

State professional regulatory boards throughout the country have long been composed of a majority of active market participants, yet the Court had never applied the active-supervision requirement to such boards (nor had any lower court until the Fourth Circuit's decision in this case). Previous cases involved state mandates calling for the regulation of entry and good standing in a profession, which easily met *Midcal*'s low bar for clear articulation since all licensing restricts competition by reducing the number of competing professionals in the field.[12] For example, in *Benson v. Arizona State Board of Dental Examiners*, the court considered Sherman Act claims challenging a state dental board's refusal to recognize out-of-state licenses, with the court easily finding clear articulation in the state's statute giving the Board discretion to adopt reciprocity rules.[13]

Thus, the Court's opinion in *North Carolina State Board of Dental Examiners* is a significant development. In *North Carolina State Board of Dental Examiners,* the Board argued that as a bona fide state entity, it need only demonstrate the "clear articulation" prong of *Midcal*,

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[12] *See, e.g., Earles v. State Bd. of Certified Pub. Accountants*, 139 F.3d 1033, 1044 (5th Cir. 1998) (noting that, in establishing a permissive policy with respect to the State Board of Certified Public Accountants Board of Louisiana, "the state rejected pure competition . . . in favor of establishing a regulatory regime that inevitably has anticompetitive effects"); *Benson v. Arizona State Board of Dental Examiners*, 673 F.2d 272 (9th Cir. 1982); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 776 n.2 (1975) (The Supreme Court held that although a state bar association was a state agency for the purpose of "investigating and reporting the violation" of ethical rules promulgated by the Supreme Court of Virginia, it could not enjoy immunity for its price-fixing because it acted contrary to the state's clearly articulated competition policy.).

[13] 673 F.2d 272 (9th Cir. 1982).

and since it was a state agency, the "active supervision" requirement did not apply to it. The majority disagreed, noting that "[s]tate agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal's* supervision requirements was created to address."[14] Justice Kennedy declared that "[w]hen a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest."[15] Since the Board did not contend that its anticompetitive conduct was actively supervised by the state, the Court concluded that the state-action exemption was therefore unavailable.

The "active supervision" requirement—the most notable limit on *Parker* immunity—provides that states may only exempt private parties from the antitrust laws if state officials oversee their acts to prevent them from using their powers for self-interested purposes. This requirement is meant to ensure that states do not "thwart[]" the "national policy in favor of competition" by "casting … a gauzy cloak of state involvement" over the self-interested cartel behavior of private actors.

In *North Carolina State Board of Dental Examiners*, the Court did not set forth bright-line standards as to what constituted "active supervision," characterizing it as a "flexible and context-dependent" inquiry. However, the decision does provide a path forward for states that want to authorize their executive agencies and bodies to take actions that limit competition. The Court noted that active supervision need not entail day-to-day involvement in an agency's operations or micromanagement of its every decision; however, the Court did identify a few constant requirements of active supervision:

- The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it. The Court's decision suggests that this review need not be elaborate or burdensome, and many states have created analogous oversight processes intended to create federal antitrust immunity with programs such as health care certificates of public advantage;
- The supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy so that "control" of an agency does not rest with active market participants;
- The mere potential for state supervision is not an adequate substitute for a decision by the state; and
- The state supervisor may not itself be an active market participant.

If history is prologue, the FTC has probably several other investigations pending that will lead to additional consent decrees. Industries will likely seek modifications in their state board schemes to insert sufficient "light touch" supervision to provide the necessary antitrust protection.

[14] *North Carolina State Board of Dental Examiners*, Slip op at 13.
[15] *Id*. at 14.

In response to the Supreme Court's decision, FTC Chairwoman Edith Ramirez issued a statement expressing pleasure "with the Supreme Court's recognition that the antitrust laws limit the ability of market incumbents to suppress competition through state professional boards." The FTC has a long-standing advocacy program in which it sends statements of opposition to state legislatures considering laws that limit practices to certain professionals, where unnecessary. The Supreme Court's *North Carolina State Board of Dental Examiners* decision gives additional ammunition to the FTC's advocacy and enforcement activities to open up services to lower cost providers.

COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

North Carolina Dental: A Broad Impact on Antitrust Immunity

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North Carolina Dental: A Broad Impact on Antitrust Immunity

Jane E. Willis & Amy D. Paul[1]

I. INTRODUCTION

In February 2015, the Supreme Court of the United States decided the second case in two years regarding state action antitrust immunity. In ruling that the North Carolina Dental Board, which is comprised of active market participants (i.e., practicing dentists), was not a state actor for the purpose of antitrust immunity, the Supreme Court has made a broad category of professional regulatory boards subject to increased antitrust scrutiny. While the decision's practical impact remains to be seen, future results will surely include closer reviews of how state regulatory boards are constituted and increased application of the antitrust laws to actions taken by such boards.

II. CASE SUMMARY

The North Carolina Dental Practice Act ("the Act"), passed by the North Carolina legislature, established the North Carolina Dental Board ("the Board"), which was charged with regulating the "practice of dentistry." The eight-member Board was comprised of six licensed dentists, one licensed dental hygienist, and one consumer member. The dental members were elected by dentists; the hygienist member was elected by dental hygienists. The governor appointed the consumer member. Thus, a majority of the Board consisted of dentists engaged in active practice and elected by other dentists.

The Act did not explicitly specify that providing teeth-whitening services was practicing dentistry. However, dentists complained to the Board that non-dentists were charging lower prices for whitening services, prompting the Board to take action. Deeming these services as "the practice of dentistry," the Board issued almost fifty cease-and-desist letters to non-dentist teeth-whitening providers, warning them that they were engaged in the unlicensed practice of dentistry, which is a crime. The Board's actions had the result of impeding non-dentists from providing teeth-whitening services, which was a detriment to consumers due to reduced availability of lower-cost teeth-whitening services.

The Federal Trade Commission ("FTC") determined that the Board's concerted action to exclude non-dentists from the market for teeth-whitening services in North Carolina violated federal antitrust laws. The Fourth Circuit heard the case and affirmed the FTC's position. The Board appealed that decision and was granted *certiorari* by the Supreme Court.

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In a 6-to-3 decision authored by Justice Kennedy, the Supreme Court affirmed the FTC and Fourth Circuit's positions that because the Board members themselves were active market participants, the Board was not a state actor, and therefore active state supervision was required to confer federal antitrust immunity on the Board's actions.

III. DECISION IMPACT

A. A Broad Category of Professional Regulatory Boards Will Be Subject to Antitrust Scrutiny

The Court's decision provides a clear message to regulatory boards across the country—actions that would otherwise be anticompetitive cannot be shielded from federal antitrust scrutiny merely because the state has established the board that regulates the industry in which it participates. The Court did not distinguish between boards whose members are elected by their peers (other market participants) and boards whose members are selected and appointed by a state official. Thus, for purposes of antitrust immunity, the selection process was deemed irrelevant and the key determination is whether the board members are market participants. Because many licensing boards across the country are structured similarly, the decision's impact has the potential to be widespread.

In March, Commissioner Maureen Ohlhausen gave remarks about the Court's decision.[2] For context, Commissioner Ohlhausen is the former director of the FTC Office of Policy Planning and served on the original FTC State Action Task Force, which was created in 2001 to identify ways to narrow the application of state action immunity. In her remarks, the Commissioner described the decision as "broad" and praised the Court for going beyond mere concurrence with the Fourth Circuit. The Court could have limited its holding to state boards whose members are elected by private individuals or to state boards that act outside the scope of their authority. Instead, the Court's holding applies to all boards that are controlled by active market participants.

Open issues, raised by the dissenting opinion, remain. In particular, the dissenting opinion, authored by Justice Alito, notes practical problems the decision could create, including what it means to "control" the board. Does it simply mean that a majority of the board consists of market participants? Or can a vocal minority of market participants "control" a board? Commissioner Ohlhausen suggested that two viable options for avoiding antitrust liability for state board conduct are to (1) ensure that market participants comprise less than a majority of the board and/or (2) require that all market participants abstain from matters in which they have a financial interest. But this is merely one view. It is likely that the control issue, and other open issues, will be litigated in lower courts as states and their regulatory boards grapple with the Court's decision.

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[2] Remarks by Commissioner Maureen K. Ohlhausen, "Reflections on the Supreme Court's North Carolina Dental Decision and the FTC's Campaign to Rein in State Action Immunity" (Mar. 31, 2015), *available at* https://www.ftc.gov/public-statements/2015/03/reflections-supreme-courts-north-carolina-dental-decision-ftcs-campaign.

B. Sufficient State Supervision Will Vary from Case-to-Case

The Court held that, if a state creates a board controlled by market participants, there must be a showing of active state supervision in order for antitrust immunity to attach. What qualifies as sufficient supervision will largely depend on the circumstances of the case. The Court, however, noted several prerequisites for active supervision, including that the supervising person or entity itself cannot be an active market participant. Other prerequisites include: (1) the supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it; and (2) the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy. Beyond these statements, the Court left open the question of what else may be necessary for active state supervision.

Given the ruling, state regulatory boards may *sua sponte* seek more state involvement in their decisions and activities to lessen any antitrust liability exposure. This state involvement could take various forms. State cabinet departments or other disinterested state officials may provide input and/or oversight over a board's substantive decisions. State legislatures may amend the relevant statutes or pass supplemental statutes to provide some form of active state supervision. The goal of such state supervision would be to ensure that boards consisting of market participants are not making anticompetitive decisions that harm consumers and the public.

IV. CONCLUSION

The Court's decision confirms the need to balance competently regulating professional services with the need to prevent collusive and exclusionary conduct. Considering that professional licensing boards regulate nearly one-third of the U.S. workforce across varying occupations, states across the country are expected to respond to the decision by looking closely at both how their boards are populated and the extent of active state supervision of the conduct of such boards.

COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

The Affordable Care Act Efficiencies Defense in Section 7 Cases: *FTC v. St. Luke's* and Antitrust Unicorns

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The Affordable Care Act Efficiencies Defense in Section 7 Cases: *FTC v. St. Luke's* and Antitrust Unicorns

Kent Bernard[1]

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I. INTRODUCTION

In an earlier article commenting on the District Court decision in the *FTC vs. St. Luke's* litigation,[2] I pointed out that the court recognized that the acquisition of Saltzer by St. Luke's was intended to, and would have had the effect of, improving patient outcomes.[3] The court still blocked the acquisition, however, because it found that there might have been other ways to achieve those improved outcomes and that since St. Luke's had not proven that the acquisition path was the only viable one, it had not chosen the least restrictive alternative. Therefore, St. Luke's had not rebutted the government's *prima facie* case based on the market share of the proposed merged entity.[4]

The Court of Appeals affirmed, stating that while the parties and the court believed that the merger was intended—and indeed would have led to—better patient outcomes, the District Court had correctly found that the huge market share of the post-merger entity created a substantial risk of anticompetitive price increases and that the offered efficiencies were not an adequate defense.[5]

Two rather provocative issues for health care mergers come out of the decisions in this case: (1) The policies and intent of the Affordable Care Act[6] seem to have no effect on the antitrust analysis to be applied in these cases: and (2) High post-merger market shares/HHIs create a presumption of harm that cannot be rebutted except by the nearly impossible task of proving a negative (that there is no less restrictive way to achieve the better patient outcomes). The *prima facie* case has become close to irrebuttable.

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[2] FTC v. St Luke's Health System Ltd., Case No. 1:13 – CV-00116-BLW (D. Idaho January 24, 2014) (hereinafter "District Court Decision"), affirmed, St. Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd., 2015 WL 525540 (9th Cir. February 10, 2015) (hereinafter "Court of Appeals Decision"). The decisions and other filings are collected at https://www.ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa. Citations to the Court of Appeals opinion are to the Westlaw text and pagination.

[3] District Court decision at 3; *see* Bernard, *Patient Outcomes vs. Competition: Squaring the Circle in FTC v. St. Luke's*, 9(2) CPI ANTITRUST CHRON. 5 (September 2014).

[4] *Id.* at 4-5.

[5] Court of Appeals decision at 11.

[6] Patient Protection and Affordable Care Act, P.L. 11-148 (March 23, 2010). *See* Bernard, *supra* note 3, at 2-3 for an overview of those policies.

II. THE POLICY AND INTENT OF THE AFFORDABLE CARE ACT HAVE NO EFFECT ON ANTITRUST ANALYSIS—EFFICIENCIES AS UNICORNS

The case against the merger was straightforward. A market was defined (primary care physician ("PCP") services in and around Nampa Idaho), the market shares and HHIs were computed, and the plaintiff rested, secure in the presumption that such a high market share created such a substantial risk of price increases that it didn't have to prove anything else in order to make out its *prima* facie case. St. Luke's presented a defense, arguing benefits to patient care and implementation of the policies of the Affordable Care Act. The District Court found that (i) even if St. Luke's arguments were correct and (ii) that the merger would increase patient care, those facts did not rebut the plaintiff's case based on market share. The Court of Appeals affirmed. But in so doing, the court has made it virtually impossible to argue successfully not merely for improved quality of care as a defense, but even to argue for overall health costs savings as a defense.

The FTC position is that an argument based on improved quality of care may be legitimate, but that the agency has never actually seen one because (to the FTC) the quality improvements are always "speculative" or the parties cannot prove that the merger is "necessary" to achieve them.[7] On this view a defense based on quality of care really is a unicorn—beautiful to contemplate, but never seen in real life.

In one sense the benefits of a merger are always speculative—they haven't occurred yet because the merger hasn't occurred yet. This applies whether the claimed efficiency is better patient care, or the ability to reduce prices because of economies of scale. It is all "speculative" until it is done.[8] But the idea that the merger must in some sense be "necessary" to achieve the desired result creates an almost impossible burden on the merging parties. What the Court of Appeals decision in this case confirms is effectively a reallocation of the ultimate burden of proof.

On the facts of *St. Luke's* what the parties were challenged to prove is that a merger (which had not yet taken place) would provide benefits not attainable by a series of rather complex contractual arrangements (which had not been negotiated). This is not a situation where a "committed team" had already been assembled in that market and had shown that it could generate the patient quality results sought by St. Luke's.[9] As the Court of Appeals noted: "It is difficult enough in Section 7 cases to predict whether a merger will have future anticompetitive effects without also adding to the judicial balance a prediction of future efficiencies."[10] But the court's answer—to require St. Luke's to present "empirical evidence" to support the need for the merger[11]—is to require a showing that approaches impossibility.

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[7] Speech of Deborah Feinstein, Director, Bureau of Competition, Federal Trade Commission, *Antitrust Enforcement in Healthcare: Proscription not Prescription*, at page 11 (June 19, 2014), *available at* https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf

[8] One could argue that all of Section 7 is speculative. It is an incipiency statute. But if you are going to allow speculation to show harm, you have to allow speculation to show benefits as well or else you have drastically altered the allocation and quantum of the burden of proof.

[9] Cf. Court of Appeals decision at 20.

[10] *Id.*at 18.

[11] *Id.* at 20.

There is a deeper issue here than just what happens in Nampa, Idaho. The Affordable Care Act and the Accountable Care Organizations arising under it, come from a different policy starting point that Section 7. The idea is to improve patient care and thereby reduce costs.[12] But the payment structure has not yet begun to change. The economic incentives are still there to try to raise prices for individual services.[13] So let's concede for the sake of argument that a merger such as this may lead to an increase in the cost of PCP services. But that leads to another question—how much of an increase is too much? A 10 percent increase in the cost of PCP services would raise health insurance premiums by about 1 percent (assuming the whole increase was passed through).[14]

More provocatively, what if the entire predicted increase in PCP costs was offset by the predicted savings on hospital costs (something outside of the decision's analysis entirely)? What if the increase in PCP costs resulted in a net savings on health care costs, because of fewer hospitalizations? These are not purely hypothetical questions. Rowena Rosenblum-Bergmans, vice president of population health for the Western Connecticut Health Network stated "What we have seen in other ACOs is that primary care visits go up, and hospitalizations go down."[15]

The importance of this approach should not be disregarded by antitrust authorities and the courts. It is the expressed intent of the Affordable Care Act to drive more usage (and hence more costs) to PCPs, *thereby* saving on hospital costs, *thereby* saving on overall costs. Under the Affordable Care Act, PCP costs cannot be looked at as a stand-alone silo. They have to be viewed in the context of overall health care expenditures.

This is no longer strictly a quality of care argument—it is one based on dollars and cents and phrased in traditional efficiency terms. What we are asking is whether measurable savings, outside of the defined antitrust product market but related to it as a matter of a separate federal law, can be used as a defense against potential price increases within the defined market. The Affordable Care Act demands an approach that treats health care expenditures as interrelated. The Department of Health and Human Services, in supporting the "Next Generation ACO Model," recently defined the goal as

> [T]he "Better, Smarter, Healthier" approach to improving our nation's health care and setting clear, measurable goals to move the Medicare program—and the health care system at large—toward paying providers based on quality, rather than quantity, of care.[16]

Under this approach an increase in cost per unit of care might well be outweighed by a reduction in the number of units of care needed, and/or also might also reduce the need for other medical care (i.e. hospital services) resulting in net cost savings both at the PCP level and in terms of overall healthcare costs. And, as noted earlier, increasing primary care visits (and

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[12] *See*, e.g., Dick Perrefort*, A "seismic shift" in store for Medicare Patients*, CONN. POST B.1(March 5, 2015); *available at* http://www.ctpost.com/news/article/Seismic-shift-in-health-care-delivery-on-tap-6120906.php

[13] *See* Bernard, *supra* note 3, at 3.

[14] *See* Bernard, *supra* note 3, at 4 and sources cited therein.

[15] Perrefort, *supra* note 12, at B.2.

[16] CMS, Next Generation ACO Model Frequently Asked Questions (March 10, 2015), *available at* http://innovation.cms.gov/Files/x/nextgenacofaq.pdf

therefore costs) is indeed expected to lead to such an overall cost saving result. How would this model be accommodated in the current legal analysis?

These are extremely difficult questions to answer. The Court of Appeals handled them by simply ruling that quality of care arguments are ineffective under the Clayton Act: "It is not enough to show that the merger would allow St. Luke's to better service patients. The Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate."[17] But the prediction of effects is limited to the market as defined. The fair implication of this approach is that the claimed efficiencies must be measured in the same market/silo as the costs. Net overall savings don't count. The parties are left trying to show that the presumption of price increases from the Government's *prima facie* case is inaccurate. It is to the presumption issue that we now turn.

III. HANDLING THE BURDEN OF PROOF

The Court of Appeals laid out the basic "burden shifting" framework for Section 7 cases:

> The plaintiff must first establish a prima facie case that a merger is anticompetitive. The burden then shifts to the defendant to rebut the prima facie case…[I]f the defendant successfully rebuts the prima facie case, the burden of production shifts back to the Government and merges with the ultimate burden of persuasion, which is incumbent on the Government at all times.[18]

According to the Court of Appeals, the District Court held that the government had established its *prima facie* case because of the post-merger St. Luke's (1) market share in the Nampa Idaho PCP market, (2) ability to negotiate higher primary care reimbursement rates with insurers, and (3) ability to charge more ancillary services at the higher hospital billing rate.[19] On market share, the post-merger HHIs were dramatically high, with an HHI of 6,219 and an increase of 1,607. On that basis, the District Court found the merger to be presumptively anticompetitive under the 2010 Horizontal Merger Guidelines.[20] As we will discuss below, this finding effectively ended the case.

On reimbursement rates, the District Court found that St. Luke's "would likely" use its post-merger power to negotiate higher PCP reimbursement rates from insurers. The Court of Appeals held that this was not clearly erroneous.[21] In so doing, it held that this prediction was a finding of fact. This is significant, since the District Court's finding that St. Luke's would raise prices in the hospital-based ancillary services market was given no such deference. The Court of Appeals held that absent an express finding of market power in the ancillary services market "it is difficult to conclude that the merged entity could easily demand anticompetitive prices for such services."[22] The documents cited by the District Court "merely" stated that St. Luke's hoped to increase revenue from ancillary services, not that it planned to charge higher prices.[23]

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[17] Court of Appeals Decision at 20.

[18] *Id.* at 12 (internal citations omitted).

[19] *Id.* at 14-15.

[20] *Id.* at 15.

[21] *Id.*

[22] *Id.* at 16.

[23] *Id.*

It is difficult to see any difference between a hope to increase primary care physician services reimbursement, and a hope to increase revenue from ancillary services. The only ways to increase revenue on the system as viewed by the courts here are to increase reimbursement or increase the volume of services. And this applies both to PCP services and to ancillary services. Yet, as to ancillary services, the Court of Appeals does not treat the District Court conclusion as a finding of fact all, and certainly does not apply the deference of the "clearly erroneous" standard to it. This would be a fascinating issue to pursue if the Court of Appeals hadn't made it clear in the next section of its opinion that no findings as to future prices actually were required at all.

This conclusion may seem somewhat surprising, but it flows naturally from the Court of Appeals' analysis. Regardless of any other facts, to the Court of Appeals "The extremely high HHI on its own establishes the prima facie case."[24] The HHI is a calculation. It is not a finding of fact as to something that has occurred as the result of the merger. It is a calculation of market concentration that leads to an inference of power to raise prices or reduce output. It is worth noting, again, that there is no evidence of actual price changes in the record—whether increases in PCP costs or net savings from increased quality of care—on the record.

So how can a defendant rebut the *prima facie* case created solely by the HHI, especially when the defense/justification for the merger is overall cost savings (going beyond the product market as defined for HHI purposes) and/or better patient care? The strong suggestion from this case is that you cannot rebut the case on the numbers, that the *prima facie* case is in fact an irrebuttable presumption of harm that the transaction violates Section 7. The efficiencies defense, whether in terms of patient care or overall health care cost savings, is reduced again to our unicorn.

The Court of Appeals noted that "However, none of the reported appellate decisions have actually held that a Section 7 defendant has rebutted a prima facie case with an efficiencies defense..."[25] The court went on to state that it remains "skeptical" about efficiencies defenses in general, stating that it is "difficult enough" trying to predict whether a merger will have future anticompetitive effects, without trying to balance a prediction of future efficiencies.[26] Perhaps realizing that this is an extreme position, the court backtracked a bit and assumed that rebuttal of the *prima facie* case is possible, but then required proof that the merger was not, in fact, anticompetitive.

This effectively shifts the ultimate burden of proof and the risk of non-persuasion to the defendant. If the defendant can prove that the merger is not anticompetitive, what does it mean to say that the burden then shifts to the Government? What would the Government have to prove?

The fact that this is effectively a shift of the ultimate burden of proof is further supported by the court's assertion that the defendant must show that any economic efficiencies cannot readily be achieved without the concomitant loss of a competitor (i.e. without the merger).[27] The

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[24] *Id.* at 16.
[25] *Id.* at 18.
[26] *Id.*
[27] *Id.* at 19.

District Court held that St. Luke's failed to produce "empirical evidence" that the merger was necessary to produce the claimed benefits, and the Court of Appeals found that not clearly erroneous.[28] But surely this requires too much. In fact, it is difficult even to conceive of what such "empirical evidence" might be. If there were no merger, but rather a network of contracts among all of the primary care physicians to share risk and reward, this would be a loss of competition too. Are we presuming that the *ex-ante* state of the market was perfectly competitive, or that an atomistic market is by definition the most competitive and that therefore any increase in concentration leads to increases in costs?

By refusing to allow consideration of any other factors beyond economics and limiting that consideration to a single silo'd market, the FTC and the courts are not simply ignoring the policies of the Affordable Care Act, they are in fact relying on the unexpressed presumption that the markets for health care services behave the same way as the markets for widgets: that more providers means lower costs. There is evidence that this is an invalid, or at least unproven, presumption in health care.[29] The assumption that health care is a traditional commodity for antitrust analysis deserves exploration rather than simple acceptance.[30]

IV. CONCLUSIONS

There are two major lessons from the Court of Appeals decision in this case.

1. In cases such as this, the presumption raised by a high HHI is effectively irrebuttable. Any attempted rebuttal must be on purely economic terms, must be limited to the metes and bounds of the market set out, and must demonstrate by empirical evidence that the proposed transaction is the least restrictive alternative to reach the desired outcome.
2. Policies and values that are not immediately reducible to dollars and cents in the defined product market are irrelevant, even if those values are set out in more recent statutes (such as the Affordable Care Act).

It is important to note that these conclusions, and this limited view, have not always represented the law. Back in 2001 Genzyme and Novazyme merged. They were the only two companies doing research on a particularly difficult, and fatal condition, Pompe disease. At the time, there was no treatment available for the disease.[31] The merger took place in 2001, and the investigation was closed in 2004 with no action taken. The question that ultimately proved to be decisive was whether allowing the merger made it more or less likely that an effective treatment for Pompe disease would be discovered and brought to market.

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[28] *Id.* at 20.

[29] Some 36 states still have Certificate of Need laws, allowing the government to determine if there is a need for a new facility before allowing it to be built. The concept is that more facilities could lead to higher costs and duplication of services. The idea is to coordinate the provision of services. The understanding was that more providers could result in higher, rather than lower costs. *See* National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs (updated July 2014), *available at* http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx. *See* generally Bernard, *supra* note 3, at 2.

[30] Indeed it is the thesis of this article that such an assumption is not accurate. *See* text accompanying notes 12-16, *supra*.

[31] For a description of the case, *see* Bernard, *Innovation Market Theory and Practice: an Analysis and Proposal for Reform*, 7 (1) COMPETITION POL'Y INT'L 159, 176-178 (Spring 2011).

Under the approach taken by the FTC and the courts in St. Luke's such considerations would have been treated as irrelevant. A merger to monopoly would have been deemed to create a presumption of illegality. It would be impossible to prove that there was no possible less restrictive alternative. And the fact that the merger in fact did increase the chances of finding an effective medical treatment for Pompe disease would be disregarded since it is not reducible to dollars and cents, and it would be extraordinarily difficult to product empirical evidence in advance that the merger would increase the chances of medical success. If that were the approach applied, it would have been a very bad choice. In April 2006 the FDA approved the first treatment for Pompe disease. It was made by Genzyme.[32]

My point is not that the facts of St. Luke's are on a par with those in Genzyme. I only want to suggest that by allowing such a strong presumption of illegality based solely on market share in a tightly defined silo, and by so severely limiting the possible defenses (even those in strictly economic terms), the FTC and the courts risk creating a structure where the expressed concerns and policies of the Affordable Care Act are deemed to be outside of the range of proper consideration in these cases. The need to consider a broader range of factors, and a broader range of potential costs and cost savings, was pointed out in the *St. Luke's* case by a group of hospitals that provide care to low income persons.[33]

Antitrust has had to be reconciled with other values in the past. In the recent financial crisis, mergers in the financial sector were allowed (even encouraged) that never would have passed traditional antitrust analysis.[34] Other factors not only were taken into account, they were deemed to be decisive. Perhaps the Affordable Care Act policies need to be taken more seriously in our antitrust analysis today, and not simply treated as a unicorn.

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[32] *See* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108645.htm .The combined research program produced a successful result that neither company seemed close to achieving by itself.

[33] Amicus Brief of America's Essential Hospitals, *available at* https://www.ftc.gov/system/files/documents/cases/140619stlukeessentialamicusbrief.pdf .

[34] *See* Bernard, *U.S. Antitrust 2025: How Have We handled the Bulletproof Cartels?* CPI ANTITRUST J. (December 2010).

CPI COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

FTC v. St. Luke's: Is the Efficiencies Defense Dead or Alive?

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FTC v. St. Luke's: Is the Efficiencies Defense Dead or Alive?

Deirdre A. McEvoy & Kathrina Szymborski[1]

I. INTRODUCTION

A recent Ninth Circuit ruling holding that the merger of St. Luke's Health System, a not-for-profit health care system operating seven hospitals throughout Idaho, and Saltzer Medical Group, the largest independent multi-specialty physician group in Idaho, violated Section 7 of the Clayton Act has garnered much attention in the health care industry. Two main areas of debate have emerged since the ruling came down in February 2015: (i) the role of efficiencies arguments in merger analyses and (ii) the compatibility of the Affordable Care Act with classic antitrust laws.

II. THE TRIAL

The case, *St. Alphonsus Medical Center, et al. v. St. Luke's Health System, et al.*, concerns St. Luke's 2012 acquisition of Saltzer. The District Court initially denied a preliminary injunction to block the $16 million deal brought by two rival hospitals, St. Alphonsus Medical Center and Treasure Valley Hospital. After the Federal Trade Commission ("FTC") and the Idaho attorney general joined the suit in March 2013, however, the Court concluded that the acquisition violated the Clayton Act and the Idaho Competition Act, and ordered divestiture.

The FTC maintained that the joining of St. Luke's eight adult primary care physicians ("PCPs") in Nampa, Idaho, with Saltzer's 16 Nampa PCPs would result in a reduction of competition between St. Luke's and Saltzer in the market for adult primary care in a single city, Nampa, Idaho. According to the FTC's complaint, those 24 PCPs gave St. Luke's nearly 80 percent of the Nampa market for adult primary care, which would allow the merged entity to command higher reimbursement rates from health insurance plans and increase costs to consumers. The FTC also alleged that the merged entity could charge higher prices for ancillary services, such as x-rays and diagnostic tests.

St. Luke's and Saltzer, in contrast, argued that the merger would benefit patients by creating a team of employed physicians with access to the electronic medical records system used by St. Luke's. Moreover, they argued that the transaction was in line with the federal policy articulated in the Patient Protection and Affordable Care Act ("ACA"), which encourages creating large, integrated physician-hospital networks to reduce the cost of health care.

After a 19-day bench trial, Judge B. Lynn Winmill of the U.S. District Court in Idaho ruled in favor of the FTC and the State of Idaho. Defining the relevant market as adult primary care and the geographic market as Nampa, Idaho, Judge Winmill agreed with the plaintiffs that the merged entity would control 80 percent of services in that market and, consequently, would

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have the ability to increase prices for health insurance plans and ancillary services. The judge also rejected defendants' proposal that the Court require St. Luke's and Saltzer to negotiate separately with third-party payers to alleviate concerns over bargaining power. Instead, the Court ordered divestiture.

Although the District Court found that the merger would eventually "improve the delivery of health care" in the Nampa market, it found that St. Luke's anticipated efficiencies were insufficient to carry its burden of rebutting the plaintiffs' *prima facie* case. Indeed, the District Court found that the efficiencies touted by St. Luke's were not "merger specific." The Court found that the same positive outcomes could be realized through other means—though not identified by the Court—that "do not run afoul of the antitrust laws and do not run such a risk of increased costs."

III. THE APPEAL

St. Luke's and Saltzer appealed the District Court's order to the U.S. Court of Appeals for the Ninth Circuit, reiterating that the merger would allow for improvement in "the quality of healthcare and [a] move to a value-based rather than volume-based system of payment for services—in accord with federal policy as reflected in the Affordable Care Act." They identified several errors:

1. A lack of evidence of anticompetitive effects.
2. That the lower court should have been required to assess whether the anticompetitive effects were outweighed by the pro-competitive benefits that it acknowledged the transaction would produce.
3. The District Court wrongly imposed a burden on St. Luke's to prove that the merger's efficiencies could not have been accomplished in a less restrictive way.
4. There was an issue with the framing of the geographic market.
5. The divestiture was too extreme a remedy.

The Ninth Circuit affirmed the District Court's opinion. It saw no reason to disturb the lower court's conclusion that "St. Luke's would likely use its post-merger power to negotiate higher reimbursement rates from insurers for primary care services." It also agreed with the District court's framing of the geographic market, and disagreed with St. Luke's assertion that the District court erred in ordering divestiture.

Notably, the Ninth Circuit found insufficient evidence in the record to support the District Court's finding that the merger could lead to higher rates for ancillary services. Nonetheless, the Ninth Circuit affirmed the District Court's ruling that the FTC had established a *prima facie* case with respect to the merged entity's increase in market power in the PCP market and likely anticompetitive effects of higher reimbursement rates and costs to consumers.

The Ninth Circuit's rejection of St. Luke's efficiencies defense has resulted in vigorous debate among antitrust counsel, health care practitioners, and academics. On appeal, St. Luke's repeated the argument that the merger would benefit patients by, for example, creating a team of physicians with access to St. Luke's electronic medical records system. The panel agreed with the District Court that these efficiencies were not specific to the merger; such tools are also available

to independent physicians. It asserted that "[i]t is not enough to show that the merger would allow St. Luke's to better serve patients," noting that the District Court "did not find that the merger would increase competition or decrease prices."

Even if the claimed efficiencies had been merger-specific, the Ninth Circuit concluded that the defense would fail nonetheless. The panel said appellants would have to prove that the acquisition would not hurt competition, which they did not do. According to the Court, an anticompetitive merger cannot be excused "simply because the merged entity can improve its operations."

IV. PETITION FOR *EN BANC* REHEARING

St. Luke's and Saltzar asked the Court to rehear the case *en banc*, pointing to three main errors in the Ninth Circuit's opinion. First, they argued that the panel did not give appropriate weight to the merger's positive effects on the quality of health care. Second, they contended that the panel adopted an improper methodology for determining the relevant geographic market. Lastly, they maintained that portions of the opinion were internally inconsistent and suggested that the panel misunderstood the District Court's decision. The Ninth Circuit denied the petition for rehearing *en banc* on April 21, 2015.

Notably, St. Luke's and Saltzer's petition for rehearing *en banc* was backed by 17 antitrust professors and the International Center for Law and Economics, which filed an *amicus brief* in support of the *en banc* petition. The professors argued that many of the panel's positions were at odds with the Horizontal Merger Guidelines and rulings in other circuit courts. They noted that the Ninth Circuit's opinion would ultimately make consumers worse off by preventing beneficial mergers.

The *amicus brief* took particular aim at the panel's treatment of the efficiencies defense. The professors argued that the decision "will signal to market participants that the efficiencies defense is essentially unavailable in the Ninth Circuit, especially if those efficiencies go towards improving quality." They expressed concerns that companies contemplating an efficient merger might choose to abandon the transaction—even if it promotes consumer welfare—for fear that an efficiencies defense would be rejected.

The professors further argued that the Ninth Circuit incorrectly assumed that price effects are the only cognizable efficiencies. Rather, the professors said that courts assessing efficiencies must consider the quality of the products in question. The "relevant concept is *quality-adjusted price*, and a showing that a merger would result in higher product quality at the same price would certainly establish cognizable efficiencies."

In addition to criticizing the panel's position on the efficiencies defense, the professors argued that the ruling discourages health care integration—which the District Court specifically recognized is necessary to improve health care in this country. Indeed, the District Court noted that the merger would have improved and shifted health care in Idaho to a model focused on population health rather than fee-for-service. The professors argued that, as a result of the opinion, "both patients and payors will suffer in the form of higher costs and lower quality of care." "This can't be—and isn't—the outcome to which appropriate antitrust law and policy aspires," the professors declared.

V. CAN AN EFFICIENCIES DEFENSE EVER SUCCEED?

As the *amicus brief* demonstrated, there is a great deal of debate surrounding the efficiencies defense. The ruling in this case shows that merging parties relying on an efficiencies defense—not just hospitals and physician groups in the health care industry—face high hurdles. There is even uncertainty as to whether such a defense is available at all.

The Merger Guidelines were revised in 1997 to strengthen the role of efficiencies. The Guidelines were expanded to specify that, in addition to lower price, other efficiencies to consider when analyzing a merger include "improved quality, enhanced service, or new products." However, no antitrust defendant to date has successfully used an efficiencies defense to rebut a *prima facie* case of anticompetitiveness.

The St. Luke's case presented ideal circumstances for increasing the weight given to efficiencies. The current health care climate following the passage of the ACA encourages reform and integration by health care practitioners. Even the district judge acknowledged that the merger was an attempt "to assemble a team committed to practicing integrated medicine in a system where compensation depended on patient outcomes." Moreover, many commentators have observed that the merger here may have been the best way to achieve integration. After all, Saltzer had repeatedly attempted and failed to integrate through less-formal affiliations.

The Ninth Circuit's rejection of the efficiencies defense in the context of this merger challenge has led some observers to proclaim the ruling as a sign that the efficiencies defense is dead. The Court noted at the outset of its efficiencies analysis that the U.S. Supreme Court has never expressly recognized the efficiencies defense for Clayton Act §7 claims. Citing Judges Robert Bork and Richard Posner, the panel said it was "skeptical about the efficiencies defense in general and about its scope in particular." It said it would be difficult for any defendant to rebut a *prima facie* case of anticompetitive effects with an efficiencies defense.

Although the ruling shows that success based on an efficiencies defense is an uphill battle, there are a few takeaways for litigants relying on this argument. First, it is important to identify efficiencies that can only be achieved through the merger in question. Recall that here the centralized electronic records system was not enough, because independent physicians not subject to the merger could also access such tools. Second, antitrust defendants should explain how and why the merger will benefit consumers, with a particular focus on the increased competitive benefits and cost savings the deal would generate. The Ninth Circuit gave the example of a merger between two small companies in order to match the prices of a large rival or combine complementary assets to compete more effectively. Third, litigants must be prepared to show the court why a merger is the least restrictive method for achieving any touted benefits.

Perhaps, however, the place for efficiency arguments after the *St. Luke's* ruling is at the agency level. As University of Michigan antitrust professor Daniel Crane wrote in his 2011 article *Rethinking Merger Efficiencies*, although "efficiencies arguments are seldom dispositive" for antitrust agencies, the agencies are "significantly more receptive to efficiencies claims than they were a decade ago." Moreover, in June 2014, Director of the Bureau of Competition Deborah Feinstein wrote that the FTC will "carefully consider evidence that [a] transaction will benefit consumers through improved quality, new services and/or decreased costs" in "every investigation of healthcare provider transactions." Thus, merging entities are likely to have better

luck winning approval through efficiencies at the agency level rather than battling it out in court after the FTC has already made a *prima facie* case of anticompetitive effects.

VI. CONFLICT BETWEEN ANTITRUST LAW AND THE ACA

In addition to testing the strength of the efficiencies defense in general, this case highlights the tension between health care reform and antitrust enforcement. One of the core goals of the ACA is a health care system that provides better care at a lower cost. To meet this goal, many health care systems across the country have acquired medical groups. This case is the first FTC challenge to such a merger since the passage of the ACA. As it made its way through the courts, observers watched closely to see whether courts would allow greater consolidation in health care to achieve the integrated care mandated by the ACA.

There is little dispute that large, integrated physician-hospital networks can reduce the cost of health care and improve care, leading to a value-based rather than volume-based system. This is precisely what St. Luke's and Saltzer argued in defense of their merger. Indeed, St. Luke's president and CEO Dr. David C. Pate said in a company statement that what was at stake in the appeal was the ability to create integrated health systems in small and midsize markets,

> in order to improve the quality of health care and move to a value-based system of payment for services that will improve health, allow for new and better models of care, expand access to patients on Medicare and Medicaid, and lower the overall costs of care—a move that is encouraged and promoted by the Affordable Care Act.

FTC commissioner Julie Brill countered that there are many ways to achieve integration and that the ACA is not a "free pass" to a merger challenge. The Ninth Circuit apparently agreed and stated that its role was simply "to determine whether this particular merger violates the Clayton Act"—"not to determine the optimal future shape of the country's health care system."

The bottom line? Health care providers considering mergers to meet the ACA's goals of integration must still play by classic antitrust rules.

COMPETITION POLICY INTERNATIONAL

CPI Antitrust Chronicle
April 2015 (2)

St. Luke's-Saltzer: Where Does the Ninth Circuit Opinion Leave Quality-Enhancing Provider Integration in Allegedly Concentrated Markets?

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St. Luke's-Saltzer: Where Does the Ninth Circuit Opinion Leave Quality-Enhancing Provider Integration in Allegedly Concentrated Markets?

Monica Noether[1]

I. INTRODUCTION

On February 10, 2015, the Ninth Circuit Court of Appeals issued its opinion in the St. Luke's–Saltzer matter, upholding district court Judge B. Lynn Winmill's opinion that St. Luke's Health System's (St. Luke's) acquisition of the Saltzer Medical Group (Saltzer) should be undone through a divestiture of Saltzer.[2] Judge Andrew Hurwitz, on behalf of the Panel, summarized the Court's decisions that the "district court did not clearly err" in its conclusions regarding three issues in dispute:

- "Nampa, Idaho was the relevant geographic market;"
- "the plaintiffs established a prima facie case that the merger will probably lead to anticompetitive effects in that market;" and
- "the defendant did not rebut the plaintiffs' prima facie case where the defendant did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition."

The Panel disagreed with Judge Winmill's opinion that "prices in the hospital-based ancillary services market," would rise due to market power created by the acquisition, concluding that the District Court made no findings regarding market power in such a market.

[1] Monica Noether, Ph.D. is a Vice President at Charles River Associates, where she specializes in antitrust analysis and other issues pertaining to the health care industry. The views expressed herein are the views and opinions of the author and do not reflect or represent the views of Charles River Associates or any of the organizations with which the author is affiliated.

[2] Saint Alphonsus Medical Center–Nampa Inc.; Saint Alphonsus Health system Inc.; Saint Alphonsus Regional Medical Center, Inc.; Treasure Valley Hospital Limited Partnership; Federal Trade Commission; State of Idaho, Plaintiffs-Appellees, and Idaho Statesman Publishing LLC; The Associated Press; Idaho Press club; Idaho Press-Tribune LLC; Lee Publications Inc., Intervenors, v. St. Luke's Health System, Ltd.; St. Luke's Regional Medical Center, Ltd.; Saltzer Medical Group, Defendants-Appellants. U.S. Court of Appeals for the Ninth Circuit, No. 14-35173, February 10, 2015, Opinion. (St. Luke's-Saltzer Appeal Opinion). On April 21, 2015, the 9th Circuit issued an order denying defendants' petitions for panel rehearing and for rehearing en banc.

Below, I focus primarily on a discussion of the Appeal Panel's third decision, regarding the likely effect of efficiencies brought about by the merger. I also comment briefly on the Court's discussion of the likely effects on ancillary services.[3]

II. THE FRAMEWORK FOR EVALUATING EFFICIENCIES

The Horizontal Merger Guidelines indicate that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete….Efficiencies also may lead to new or improved products, even if they do not immediately and directly affect price."[4] The Guidelines also counsel that, in order to be relevant to the antitrust analysis, efficiencies must be "merger-specific." That is, they must be "unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects."

The District Court concluded that "the Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes."[5] While the Panel did not expressly disagree with that finding, it did note that while "better service to patients after the merger…is a laudable goal…the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations."[6]

Several commentators have written about the legal issues in this case and more generally associated with what many perceive is an asymmetry between the plaintiff's burden to demonstrate its *prima facie* case of likely anticompetitive effects and the defense's requirement to demonstrate that pro-competitive effects predominate. For example, a group of law and economics professors and the International Center of Law and Economics recently filed an *amicus curiae* brief urging the Ninth Circuit to rehear the matter *en banc,* largely based on the argument that the burden placed by the courts on defendants to demonstrate the merger-specificity of efficiencies was too high.[7] More generally, FTC Commissioner Joshua Wright has

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[3] A more complete background on the facts and issues presented in this case can be found in Monica Noether, *The St. Luke's-Saltzer Antitrust Case: Can Antitrust and Health Care Reform Policies Converge*? 4(2) CPI ANTITRUST CHRON. (April 2014 (2)) [Noether, 2014] as well as a variety of other sources.

[4] U. S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines §10 (August 19, 2010).

[5] Saint Alphonsus Medical Center–Nampa, Inc., Treasure Valley Hospital, Limited Partnership, Saint Alphonsus Health System, Inc., and Saint Alphonsus Regional Medical Center, Inc. v. St. Luke's Health System, Ltd. Case no. 1:12-CV-560-BLW. Federal Trade Commission; State of Idaho v. St. Luke's Health System, Ltd.; Saltzer Medical Group, P.A. Case No. 1:13-CV-00116-BLW. Memorandum Decision and Order. January 24, 2014.

[6] St. Luke's–Saltzer Appeal Opinion, §III.D.2, p. 29. Surprisingly, the Panel also noted that "even if we assume that the claimed efficiencies were merger-specific, the defense would nonetheless fail." It is unclear whether the Panel was opining that the merger benefits would not be conveyed on to consumers or that it did not believe that quality improvements are relevant efficiencies.

[7] Saint Alphonsus Medical Center–Nampa Inc.; Saint Alphonsus Health system Inc.; Saint Alphonsus Regional Medical Center, Inc.; Treasure Valley Hospital Limited Partnership; Federal Trade Commission; State of Idaho, Plaintiffs-Appellees, and Idaho Statesman Publishing LLC; The Associated Press; Idaho Press club; Idaho Press-Tribune LLC; Lee Publications Inc., Intervenors, v. St. Luke's Health System, Ltd.; St. Luke's Regional Medical Center, Ltd.; Saltzer Medical Group, Defendants-Appellants. Appeal from the U.S. District Court for the District of

voiced concern with the welfare implications of what he argues are different standards imposed upon plaintiffs and defendants in merger cases.[8]

III. EFFICIENCIES IN THE CONTEXT OF HEALTH CARE MERGERS

Rather than addressing the legal debate associated with the appropriate efficiency standard, I focus here on the critical policy issue of whether it is likely that alternative affiliation strategies, short of merger or acquisition, can be equally effective in creating the conditions necessary to achieve the various laudable goals of health care reform. In particular, hospitals and other health care providers are all currently grappling with how to make progress toward the "Triple Aim" of improving the individual patient care experience, improving "population health," and slowing the rate of increase in per capita health care spending.[9] Both public and private payors are increasingly substituting "value-based payments" based on achieving good *outcomes* for traditional fee-for-service payments that are based solely on *inputs*, in an attempt to make health care more cost-effective.[10]

Whatever jargon is used to describe these widespread reform initiatives, any cursory review of health care or general press reveals the universal belief by providers that vertical and horizontal integration is key to making progress. A recent article enumerated four characteristics of successful integrated managed care models:

1. a vertically and horizontally integrated structure,
2. a prepayment method of reimbursement that puts providers at risk,
3. an advanced IT system, and
4. a culture of physician leadership.[11]

Idaho, No. 14-35173. Brief for Professors and Scholars of Law and Economics and International Center of Law and Economics in Support of Defendants-Appellants Urging Rehearing En Banc, April 6, 2015.

[8] "Merger analysis is by its nature a predictive enterprise. Thinking rigorously about probabilistic assessment of competitive harms is an appropriate approach from an economic perspective. However, there is some reason for concern that the approach applied to efficiencies is deterministic in practice. In other words, there is a potentially dangerous asymmetry from a consumer welfare perspective of an approach that embraces probabilistic prediction, estimation, presumption and simulation of anticompetitive effects on the one hand but requires efficiencies to be *proven* on the other. Joshua Wright: Dissenting Statement of Commissioner Joshua D. Wright, *In the Matter of Ardagh Group S.A., and Saint-Gobain Containers, Inc., and Compagnie de Saint-Gobain,* FTC File No. 131-0087, April 11, 2014. [Ardagh dissent.]

[9] Donald Berwick, et al., *The Triple Aim: Care, Health and Cost*, 27(3) HEALTH AFFAIRS, 759-769 (2008), *available at* http://content.healthaffairs.org/content/27/3/759.full.pdf+html.

[10] The Centers for Medicare and Medicaid Services ("CMS") recently announced that it expected to tie half of all traditional Medicare payment to alternative payment models and 90 percent to quality or value metrics by the end of 2018. (Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, January 26, 2015 press release, *available at* http://www.hhs.gov/news/press/2015pres/01/20150126a.html). A recent national survey of physicians by Deloitte found that they expect about 50 percent of their compensation to be tied to value within 10 years. Mitchell Morris, M.D. *Preparing for the Inevitable: The Path to Success in a Value-Based World* (2015), *available at* http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-chs-value-based-world-021615.pdf.

[11] Becker's Hospital Review, *4 key characteristics of successful integrated managed care models* (April 10, 2015).

In opening remarks at the recent Hearings on Examining Health Care Competition organized by the Federal Trade Commission and Department of Justice, Dr. Ezekiel Emanuel, a former special advisor on health policy to the Director for the Office of Management and Budget and National Economic Council, noted that "….you need some scale to be able to do integration….It costs money to upgrade IT. To do process improvement. To employ health workers. To be able to provide more care at home…." However, he also described this consolidation as a necessary, but not sufficient, precursor to true integration in which "people would have the infrastructure, the capital, to actually innovate on the continuum of care…." and "to operate in a value-based, risk-based payment system."[12]

This last shift—to a payment system that rewards providers for their outputs (of high quality, effective health care)—is the move that is particularly critical for a real transformation of health care.[13] It is also the change that many providers believe is impossible to attain without the combination through ownership of hospitals, physicians, and perhaps other providers. Indeed, the recent two-day FTC-DOJ hearings mentioned above focused on the potential for different forms of integration to achieve the transformation of health care delivery. Commentators have described the relationship between a continuum of integration and the amount of financial risk that an integrated entity could assume.[14]

This debate about the merger specificity of the integration efficiencies is at the heart of the antitrust dispute in St. Luke's-Saltzer. In particular, the St. Luke's-Saltzer matter focuses on the horizontal combination of physicians through hospital acquisition of multiple physician groups. Both the District Court and the Appeal Panel found that there was "no empirical evidence to support the theory that St. Luke's needs a core group of employed primary care physicians…to successfully make the transition to integrated care."[15] Rather, they appeared to conclude that looser affiliations that maintained competition between the St. Luke's physicians and the Saltzer Medical Group could still enable the investments necessary to develop and operate the information infrastructure, care protocols, physician monitoring, and feedback tools necessary to improve the delivery of health care services to the residents of Nampa, Idaho.

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[12] Ezekiel Emanuel, Opening Remarks to Examining Health Care Competition, an FTC-DOJ Workshop, February 24-25, 2015, pp. 8-16, *available at* https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf. [Emanuel Remarks]

[13] Many have noted in the absence of a shift away from fee-for-service payment system, providers have incentives to deliver more, rather than more efficient or higher quality, health care. For example, Brent James and Lucy Savitz describe Intermountain's implementation of a protocol designed to reduce the rate of delivery by elective induction that succeeded in reducing the payments associated with elective inductions by $50 million annually. However, it only reduced Intermountain's own costs by $41 million. Brent James and Lucy Savitz, *How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts*, 30(6) HEALTH AFFAIRS 1185-1191 (2011), *available at* http://content.healthaffairs.org/content/30/6/1185.full.pdf+html?sid=cb8e5301-5113-4ea0-a53f-4b7f15e5fd21.

[14] *See*, for example, the presentation of Lisa McDonnel of UnitedHealthcare Networks, *Alternative to Traditional Fee-for-Service Models, available at* https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition.

[15] Saint Alphonsus Medical Center–Nampa, Inc., Treasure Valley Hospital, Limited Partnership, Saint Alphonsus Health System, Inc., and Saint Alphonsus Regional Medical Center, Inc. v. St. Luke's Health System, Ltd. Case no. 1:12-CV-560-BLW. Memorandum and Order, December 20, 2012.

Even more importantly, they apparently believed that looser affiliations, presumably achieved through contracts, could foster the move from fee-for-service reimbursement to value-based payments. But as Commissioner Wright has cautioned, "the merger-specificity requirement could be interpreted narrowly to exclude any efficiency that can be recreated with any form of creative contracting"[16] regardless of whether the contract is practical.[17]

The St. Luke's-Saltzer Courts' conclusions ignore the fact that the very health care delivery systems that are frequently touted as the poster children for successful delivery of integrated care all have large "core group[s] of employed primary care physicians." For example, Kaiser Permanente Medical Group employs over 17,000 physicians;[18] Mayo Clinic has 4,200 staff physicians and scientists;[19] and Intermountain's Medical Group Clinics employ 1,300 physicians.[20] Chicago-based Advocate Health, which is often touted as an example of a successful model of integrated care delivered primarily through independent physicians, includes 1,100 employed physicians.[21] Even plaintiff, St. Alphonsus, apparently employs about 300 physicians.[22]

Thus, it appears that even those health systems that affiliate with physicians in arrangements short of employment also rely on a substantial core group of employed physicians. These examples are confirmed by recent studies. A new analysis by the Rand Corporation of physician responses to alternative payment methodologies notes that surveyed physician practices "were changing their organizational models—predominantly by affiliating or merging with other physician practices or aligning with or becoming owned by hospitals—in response to new payment models."[23] Similarly, a summary by two well-known health economists of several studies on the current progress of Accountable Care Organizations in achieving the goals of health care reform asserts: "Larger physician groups deliver care that is higher quality and more efficient…."[24]

While the St. Luke's-Saltzer Courts were correct to note that currently existing empirical work does not conclusively demonstrate a definitive causal link between integration through ownership/employment and the successful implementation of the principles of health care

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[16] Ardagh dissent, *supra* note 8.

[17] In Noether, 2014, *supra* note 3, I discuss the economic theory regarding the situations in which contracts tend to be inferior to ownership.

[18] Kaiser Permanente by the Numbers, *available at* http://www.kaiserpermanentejobs.org/infographic.aspx.

[19] Mayo Clinic Facts, *available at* http://www.mayoclinic.org/about-mayo-clinic/facts-statistics.

[20] Intermountain Medical Group Clinics, *available at* http://intermountainhealthcare.org/services/medicalgroup/Pages/home.aspx.

[21] About Advocate Medical Group, *available at* http://www.advocatehealth.com/documents/newsroom/AMG%20Fact%20Sheet%20-%20FINAL.pdf.

[22] "Saint Alphonsus is establishing an integrated Health Alliance of 1200 physicians, 75 percent of whom are independent." Answering Brief for Plaintiffs/Appellees the Federal Trade Commission and the State of Idaho. Saint Alphonsus Regional Medical Center, Inc. *et al.* v. St. Luke's Health System, Ltd. *et al.* On Appeal From the United States District Court For the District of Idaho Case No. 1:12-cv-00560-BLW *et al.* (page 60).

[23] Friedberg, Mark W., *et al. Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica, CA,* RAND Corporation, 41 (2015), *available at* http://www.rand.org/pubs/research_reports/RR869.

[24] Lawton Burns & Mark Pauly, *Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s*, 31(11) HEALTH AFFAIRS 2407-2416 (November 2012) *available at* http://content.healthaffairs.org/content/31/11/2407.full.pdf+html?sid=49d183dd-b616-4545-938c-d4d01d164105

reform, that is not surprising given the current state of transition in the industry. As Dr. Emanuel concluded his remarks at the FTC/DOJ Health Care Competition Hearings by cautioning, "Let's not over-rely on the past models we have had, because I don't think they're going to be as predictive going forward as we would like….[O]ur past models for what constitutes competition may not apply in a new and changing environment."[25]

IV. THE EVALUATION OF CONTRACTUALLY RELATED PRICE INCREASES

The Panel disagreed with the District Court's finding that "St. Luke's would 'exercise its enhanced bargaining leverage from the Acquisition to charge more services at the higher hospital-based billing rates.'"[26] Rather, it concluded that this finding "is not supported by the record." It indicated that the Court made no findings with respect to market power in the market for ancillary services; nor did it provide evidence that St. Luke's intended to raise ancillary prices anticompetitively. Moreover, the Panel noted that documents cited by the Court regarding St. Luke's desire to increase revenue in ancillary services could have many competitively benign explanations.[27]

As I explained in my previous discussion of the District Court Opinion,[28] Medicare reimbursement policy fosters a substantial differential between payments to freestanding physicians' offices and those affiliated with hospital outpatient departments. Regardless of its merits, this differential does not imply that hospitals possess market power in the provision of outpatient services, but rather reflects a historic concern over the higher costs associated with potentially higher acuity patients as well as the infrastructure necessary to provide services on a 24-7 basis.

To the extent that private payors have adopted similar payment approaches, they likely have done that as part of an aggregate package of reimbursement policies aimed to achieve an overall medical spending level for their members. The Panel appears to have recognized that if St. Luke's acquisition of Saltzer led to an increase in ancillary spending because of the higher rates that St. Luke's contracts allow, without market power in ancillary services it would be unable to maintain this higher reimbursement with managed care organizations beyond its current contracts.

This distinction between price increases occasioned by merger-induced increases in market power and those that result temporarily from existing contract provisions is important. While the latter may cause temporary non-market based price disruptions, these disruptions are likely to be rectified in the next contract renegotiation absent any change in market power.[29]

V. CONCLUSION

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[25] Emanuel Remarks, *supra* note 12.

[26] St. Luke's-Saltzer Appeal Opinion, § III.C.3, p. 21.

[27] St. Luke's–Saltzer Appeal Opinion, § III.C.3, p. 19.

[28] Noether, 2014, *supra* note 3.

[29] Many believe that the spate of recent hospital acquisitions of physician practices has been fueled solely by the substantial reimbursement differential. If this is true, the solution is not to use the antitrust laws to prevent these mergers, but rather, as the White House recommends, to address any inappropriate payment differentials. *See*, Margot Sanger-Katz, *When Hospitals Buy Doctors' Offices, and Patient Fees Soar*, N.Y. TIMES (February 6, 2015), *available at* http://www.nytimes.com/2015/02/07/upshot/medicare-proposal-would-even-out-doctors-pay.html.

Evolution of the delivery of and reimbursement for health care services is clearly in a state of unfinished transition. The Ninth Circuit Panel decision in St. Luke's-Saltzer runs the risk of furthering a "chicken-and-egg" problem with respect to continued progress toward the widespread development of delivery organizations that can effectively assume financial risk to deliver value-based health care. Without clear evidence that such organizations often function optimally when they are horizontally and vertically integrated through ownership, the antitrust laws may not permit them to advance. If they do not progress, it will be difficult to develop the evidence necessary to demonstrate their effectiveness.