CONSOLIDATION IN THE HEALTH CARE INDUSTRY: AN ANTITRUST OVERVIEW

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AN ANTITRUST OVERVIEW

I. INTRODUCTION

As health care markets continue to evolve, we can expect further consolidation among providers and payors alike. Much of the merger and network activity has been driven by the need to lower costs and gain access to capital, and raises little antitrust concern. Antitrust, however, will remain a primary consideration to the extent that a health care merger or network is likely to give rise to market power or cartel-like behavior.

Set forth below are the principal antitrust considerations that health care providers or payors should take in account when merging, developing networks, or otherwise consolidating operations.

II. MERGERS AND ACQUISITIONS

A. Horizontal Mergers: An Overview of Enforcement Activity

1. **Enforcement Priority -** Federal and state antitrust enforcement agencies closely scrutinize "horizontal" mergers or acquisitions, that is, those involving direct competitors.

2. **Hospital Mergers**

   a. **Litigation Track Record.** To date, most antitrust enforcement activity in the health care industry has focused on mergers of general acute care hospitals in direct competition with one another. For several years, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) had been largely successful in blocking the hospital mergers they challenged. See, e.g., *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991); *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990); *FTC v. Hospital Corp. of America*, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 48 U.S. 1038 (1987); *FTC v. Columbia Hospital Corp.*, No. 93-30-FTM-CIV-23D (M.D. Fla., preliminary injunction issued May 21, 1993); *American Medical International, Inc.*, 104 F.T.C. 1 (1984). Since 1995, however, the government has lost a series of

2 Trade Cas. (CCH) & 72,578 (8th Cir. 1999), rev=g, 17 F. Supp.2d 937 (E.D. Mo. 1998); *United States v. Long Island Jewish Medical Center et al.*, 983 F. Supp. 121 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.,* 946 F.Supp. 1285 (W.D. Mich. 1996), aff=d mem., 121 F.3d 708 (6th Cir. 1997) (unpublished slip opinion); *FTC v. Freeman Hospital*, 69 F.3d 260 (8th Cir. 1995); *United States v. Mercy Health Services*, 902 F.Supp. 968 (N.D. Iowa 1995), vacated as moot, 107 F.3d 632 (8th Cir. 1997).

b. **Federal Consent Orders.** The FTC has obtained consent orders in which hospital systems have agreed to divest hospitals in markets alleged to be highly concentrated. See, e.g., *Tenet Healthcare Corp.*, C-3743 (May 23, 1997); *Columbia/HCA Healthcare Corp.*, C-3627 (November 24, 1995); *Columbia/HCA Healthcare Corp. (Healthtrust)*, C-3619 (April 21, 1995); *Healthtrust, Inc. - The Hospital Company*, C-3538 (November 8, 1994); *Columbia Healthcare Corp.(HCA),* C-3627 (March 4, 1994); *Columbia Hospital Corporation (Galen)*, C-3472 (December 16, 1993). The FTC has also had occasion to obtain consent orders governing mergers of rehabilitation hospitals, psychiatric hospitals, and outpatient clinics. See *Healthsouth Rehabilitation Corp./ReLife Inc.*, C-3570 (May 11, 1995) (consent order); *Charter Medical Corporation/National Medical Enterprises*, C-3558 (February 28, 1995) (consent order); *Columbia/HCA Healthcare Corporation/Medical Care America*, C-3544 (January 4, 1995) (consent order). The DOJ, moreover, obtained a consent order from two Florida hospitals that effectively limited their consolidation to tertiary care and outpatient services and Abackroom@ administrative functions. *United States v. Morton Plant Health System, Inc.*, 1994-2 Trade Cas. (CCH) & 70,759 (M.D. Fla. 1994) (consent order).

markets is on the upswing. The State of California, for example, recently filed suit to block the proposed merger of the Summit Medical Center and the Alta Bates Medical Center/Sutter Health Systems under the Clayton Act. *State of California et al. v. Sutter Health, et al.,* No. C99-3803 (N.D. Cal., complaint filed August 10, 1999). A number of states, moreover, have granted clearance to hospital mergers and acquisitions only after obtaining consent orders that would govern the operations of the consolidated entity. See, e.g., *State of Wisconsin v. Kenosha Hospital and Medical Center*, 1997-1 Trade Cas. (CCH) & 71,669 (E.D. Wis. 1996); *Commonwealth of Pennsylvania v. Capital Health System Services et al.*, 1995-2 Trade Cas. (CCH) & 71,205 (M.D. Pa.1996); *Settlement Agreement between the Attorney General of the State of Washington, the Sisters of Providence in Washington and General Hospital Medical Center*, 7 Trade Reg. Rep., (CCH) & 50, 129 (December 16, 1993).

d. **Private Actions.** To date, private actions challenging hospital mergers have been relatively few and have met with limited success. Compare *Advocacy Org. for Patients & Providers v. Mercy Health Services*, 987 F.Supp. 967 (E.D. Mich. 1997) (denying TRO) with *Santa Cruz Medical Clinic v. Dominican Santa Cruz Hosp.,*1995-2 Trade Cas. (CCH) ¶ 71,254 (N.D. Cal. 1995) (post-acquisition exclusive dealing could be challenged).

3. Physician Practice Mergers.

Physician practice mergers can also raise antitrust concerns. See DOJ Business Review Letter to Donald H. Lipson, Esq. (July 7, 1997) (DOJ concluded that proposed merger by 12 of the 14 gastroenterologists in Allentown, Pennsylvania, was likely to lessen competition in the market for gastroenterology services in the Allentown/Bethlehem area); DOJ Business Review Letter to William L. Trombetta, Esq., (August 26, 1987) (DOJ advised that it would likely challenge a proposed merger of two group

have been underscored periodically by federal antitrust enforcement officials. See, e.g., Speech of Mary Lou Steptoe, (Former) Acting Director of the Bureau of Competition, Federal Trade Commission, before the American Bar Association (April 5, 1995) ("Steptoe Speech").

4. Mergers of Health Plans.

Traditionally mergers in health care financing markets have not raised significant antitrust problems because such markets have tended to be relatively unconcentrated and easy to enter. See generally, *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic,* 65 F.3d 1406 (7th Cir. 1995), cert. denied, 516 U.S. 1184 (1996). The DOJ and State of Texas, however, recently challenged the proposed merger of the Aetna and Prudential health Plans. See *United States et al. v. Aetna, Inc. et al.*, 7 Trade Reg. Rep. (CCH) ¶ 50,868 (N.D. Tex. 1999). According to the complaint, the proposed transaction would have made Aetna the dominant provider of HMO and HMO-based point of service plans in Houston and Dallas, with 63% and 42%, respectively, of enrollees in those areas. The transaction also allegedly would have resulted in increased prices or reduced quality of those health plans. The complaint further alleged that the combination of Aetna, Prudential and a third plan Aetna had acquired earlier, NYL Care, would have given Aetna control over a large share of the physicians' businesses, enabling Aetna to depress physicians' reimbursement rates in Houston and Dallas. Over time, the government alleged, this likely would have resulted in a reduction in the quantity and quality of physician services provided to patients.

B. Horizontal Mergers: Antitrust Analysis

1. Central Issue is Market Power. A proposed merger among competitors may violate the antitrust laws if it is likely to create or enhance "market power," that is, the ability profitably to raise price above or reduce output or quality below what likely would prevail in the absence of the merger. The merged entity may exercise

with its few remaining competitors in the market. Antitrust analysis focuses primarily on whether the merger is likely to create or enhance market power, and secondarily on whether the likelihood of market power is mitigated or offset by efficiencies or other procompetitive benefits of the merger.

2. **Market Definition Has Two Dimensions.** A merger must be evaluated in the context of the market or markets affected by it. Market definition has both product (service) and geographic dimensions. For antitrust purposes, the scope of the relevant market is determined by the extent to which customers could, as a practical matter, turn to alternative sources if the merged entity were to raise its prices by a small but significant amount.

3. **Product Market Definition**

a. **Overview**

(1) **Demand Side Substitutability.** Services offered by various types of physicians and other providers often overlap. Hospitals, physicians and outpatient clinics may all compete in the provision of certain services. In evaluating a merger, therefore, it is necessary to take into account the extent to which the merging entities offer services in competition with other providers in the area. For example, the DOJ concluded that the merger of two group practices consisting of pulmonologists in Albuquerque raised little antitrust concern, in part because the pulmonologists competed with a variety of other medical specialists in providing medical services in that city. See DOJ Business Review Letter to James M. Parker, Esq. (October 31, 1994). Similarly, the DOJ approved a Vermont physician network including 43% of the internists in the area because family practitioners were found to be "good substitutes" for internists and the network would include only 23% of the

Business Review Letter to Robert M. Langer, Esq. (July 30, 1997).

(2) **Supply Side Substitutability**. It is also important to assess whether certain providers, which are not now competitors of the merging firms, would be likely to change their businesses or practices to compete with the merged entity if it raised its rates after the merger. For example, in evaluating physician practice acquisitions, one court suggested that physician specialists might shift to provide primary care if prices for the latter services initially increased as a result of the acquisitions. See generally *Blue Cross v. Marshfield Clinic*, supra.

b. **Health Care "Product" Markets**

(1) **Inpatient, General Acute Care Hospital Services as a "Cluster" Product Market.** Over the years, several courts and the FTC have defined the relevant product market in hospital merger cases as the "cluster" of inpatient, acute care services offered by hospitals for which there are no outpatient substitutes. See, e.g., *American Medical International*, supra, 104 F.T.C. at 192-94; *United States v. Rockford Memorial*, supra, 898 F.2d at 1284. While the unique core of hospital services has eroded over time, defendants generally have not challenged this product market definition. In several recent cases, the parties stipulated that the relevant product market was inpatient, general acute care services. *FTC v. Tenet Healthcare Corp.*, supra; *FTC v. Freeman Hospital*, supra; *United States v. Mercy Health Services*, supra. In yet another recent decision, the court adopted this product market definition over the objection of the defendant hospitals. *FTC v. Butterworth Health Corp.*, supra.

United States v. Long Island Jewish Medical Center, *supra*, the Justice Department argued that the tertiary care medical centers at issue should be characterized as "anchors" for managed care networks and, as such, constituted a separate product market. The court, however, rejected this alleged product market definition.

(3) **Multispecialty Group Practice as a "Cluster" Product Market**. The FTC staff has mused that the relevant product market may be a "cluster" of medical services in appropriate circumstances. "An appropriate cluster of medical services may be ... those contained in a multi-specialty group practice." Steptoe Speech at 22.

(4) **Primary Care Services as a "Cluster" Product Market.** The federal antitrust enforcement agencies may also view primary care services as the relevant product market, based on contracting practices and service overlaps. In a recent decision involving the proposed merger of the two largest hospitals in Grand Rapids, Michigan, the court held that one relevant market for evaluating the merger was "inpatient, primary care" services. See *FTC v. Butterworth Health Corp.*, supra.

(5) **HMOs as a Product Market.** In a recent consent judgment, the DOJ alleged that HMO and HMO-POS products comprised a distinct product market. See *United States v. Aetna,* supra. According to the DOJ, HMO and HMO-POS products differ from PPO and indemnity products in terms of benefit design, cost and other factors. These differences, the DOJ alleged, are significant enough that neither employers nor employees view PPO plans as adequate substitutes for HMO or HMO-POS plans.

a. **Dynamic Analysis** - Market definition is a dynamic analysis. Patient discharge data can provide only a "static" picture of the marketplace. See generally *United States v. Long Island Jewish,* supra; *FTC v. Freeman Hospital*, supra. Such information, though useful, is only the starting point of geographic market definition, for the critical antitrust question is whether patients (or their insurers) could and would go elsewhere if the merged entity raised prices above a competitive level by a small but significant increment.

b. **Analysis of Health Care Provider Markets.**

(1) **Critical Loss –** "Critical loss" is key to determining the geographic scope of the relevant market. A critical loss analysis identifies the threshold number of patients who, by seeking care at other hospitals, could defeat a price increase by making it unprofitable. In *FTC v. Tenet Healthcare,* supra, the Eighth Circuit held that the government's alleged geographic market was artificially small inasmuch as it did not include outlying hospitals that were attracting over 22% of patients from key zip codes within the service area of the merger hospitals. The court concluded that the purchasing behavior of patients from these contestable zip codes would discipline or constrain any potential price increase by the merged entity.

(2) **Views of Payors** - Payors= views as to the scope of the geographic market normally are entitled to "some weight." *FTC v. Freeman Hospital*, supra, 69 F.3d at 270 n.14; Payors, however, sometimes have hidden agendas and thus may shade the truth. See generally *FTC v. Tenet Healthcare,* supra, 1999-2 Trade Cas. at 85,194.

care contracting has had the effect of expanding local health care markets, to the extent that managed care plans have shifted, or have threatened to shift, patients to more distant medical facilities in order to secure favorable terms locally. See *FTC v. Tenet Healthcare,* supra (evidence that the growth of managed care in southeastern Missouri was likely to intensify competition among regional hospital providers). Some providers, moreover, have established "outreach" clinics on the periphery of their traditional service areas to attract managed care business from neighboring communities. See *United States v. Mercy Health Services*, supra (relevant geographic market for acute care inpatient hospital services extended beyond the Dubuque, Iowa, area, where the merging hospitals were situated, in part because local managed care plans had shown a propensity to shift patients to outlying facilities and in part because distant hospitals had established "outreach" clinics between them and Dubuque).

(4) **Technological Developments** - New technology may have the effect of expanding geographic markets for certain medical services beyond traditional boundaries (e.g., telemedicine and its impact on radiology services).

5. Market Concentration

a. Market concentration is necessary but not sufficient evidence of market power. Federal and state antitrust agencies use the Herfindahl-Hirschman Index (HHI) as a measure of the degree of concentration in the relevant market. The HHI is determined by adding the squares of the market shares of the competitors in the market. The scale runs from an unconcentrated market for scores below 1,000 to a total monopoly with a score of 10,000.

and 1,800 as indicative of "moderately concentrated" markets that may pose antitrust concerns, and scores above 1,800 as "highly concentrated" markets that are likely to raise substantial antitrust issues.

b. The federal agencies have limited antitrust challenges of mergers among health care providers to those in "highly concentrated" markets.

c. High market concentration is by no means determinative of whether a federal or state agency will challenge a merger. Other factors -- such as entry conditions, the views of managed care plans and other market participants, and potential efficiencies -- will be taken into account by the enforcement agencies in evaluating the likely competitive effects of a merger. At a minimum, however, high levels of market concentration may prompt federal or state agencies to investigate a merger thoroughly.

d. **Calculating Concentration Levels.**

(1) Hospital market shares may be calculated on the basis of staffed or licensed beds, revenues, or patient census.

(2) In physician practice mergers, the government normally will count the number of practicing physicians offering the service or services at issue in the relevant market and treat them as equal producers of output. See, e.g., DOJ Business Review Letter to James S. Matthews, Esq. (March 19, 1996) ("head count" of physicians approximates market share). If patient or revenue data are available, the FTC staff will use such data to refine the market analysis. Steptoe Speech at 23.

agencies have used HMO enrollees as a basis for market concentration calculations.

6. **Entry Conditions**

a. **New Entry** - Mergers that result in high levels of market concentration pose little or no threat to competition if new competitors can easily enter the relevant market or the remaining competitors of the merged entity can readily expand their capacity. Such entry conditions might effectively deter the merged entity from raising prices or engaging in other anticompetitive conduct. *HTI Health Services, Inc., v. Quorum Health Group, Inc., et al.*, 960 F.Supp.1104 (D. Miss. 1997) (finding that entry into the market for primary care physician services was relatively easy). Under the federal Horizontal Merger Guidelines, DOJ and FTC must consider whether new entry would be timely, likely and sufficient to deter or counteract any anticompetitive conduct of the merged entity. According to the Horizontal Merger Guidelines, new entry will be timely, likely and sufficient if new entrants can become effective competitors within two years.

b. **Ease of Entry** - Like market definition, the relative ease of entry is a fact-intensive determination. For health care providers, the likelihood and effectiveness of new entry into the relevant market may depend on a variety of factors, including:

(1) **State or Local Regulation** (CON, professional licensing requirements, earthquake permits, etc.) - In general, state or local regulation of professional services does not pose a significant impediment to new entry; regulation of hospitals and other institutional providers, however, may be substantial in some localities and erect entry barriers. See *FTC v. University Health*, supra.

physicians who are members of merging group practices effectively control the staff privileges process at local hospitals or clinics, new entry may be effectively foreclosed. See DOJ Business Review Letter to William L. Trombetta, Esq., supra.

(3) **Need for Cross Coverage** - It has been argued that physicians may be deterred from entering a market if the cross coverage that their medical practices require is not assured. The Seventh Circuit=s opinion in *Marshfield Clinic,* supra, acknowledged this argument but did not resolve the issue of whether or to what extent the denial of cross coverage by an incumbent clinic to independent physicians might create a significant impediment to entry.

(4) **Extensive Start-up Time for Establishing a Professional Reputation and/or Attracting Referrals**. This factor may be particularly significant in markets for medical specialist services.

7. Views of Market Participants

a. Payors - Federal and state agencies normally give considerable weight to the views of managed care plans and self-insured businesses as to the likely competitive effects of a proposed merger of health care providers. The views of payors often serve as a "reality check" for government officials in evaluating a proposed merger.

b. Competitors and Community Leaders - As a general rule, the views of competitors and community leaders on a proposed merger are given relatively little weight by the federal enforcement agencies. At least one court, however, has placed greater importance on community support for the proposed merger than have the agencies

a general rule, state antitrust agencies tend to give greater weight to the views of the community than do their federal counterparts.

c. **Hidden Agendas** - Payor complaints may be driven by considerations other than the competitive merits of a proposed merger. For example, a managed care plan may oppose a merger of hospitals because it believes that the merger will enable the hospitals to offer a health financing plan in competition with it (and thus will pose a competitive threat). Or, a plan may oppose the merger because it is closely aligned with a competitor of the merging hospitals which fears that hospital competition will intensify as a result of the merger.

8. **Similarity and Differences of the Parties.** Are the merging providers close competitors? All else being equal, where the providers compete for the most part in different geographic areas or offer differentiated services, an antitrust challenge is less likely.

9. **Parties= Perceptions.** What do the parties= internal documents say about competition and the purposes of the merger?

10. **Efficiencies**

a. The Horizontal Merger Guidelines expressly recognize that potential efficiencies must be taken into account in evaluating a proposed merger.

b. Federal agencies will consider efficiencies if they:

(1) are substantial;
(2) could not be accomplished without the merger;
(3) are not offset by cost increases or quality decreases; and
(4) are likely to flow to consumers, not to shareholders or others.

specific efficiencies?

(1) The agencies are <u>less</u> likely to challenge a merger if:

- **Large-Scale Consolidations -** Large scale consolidations of clinical services are envisioned, and the parties have a timely and realistic plan of implementation.

- **Scale Economies Will Be Achieved** - The consolidation will ensure a higher level of quality of service, or (even better) is necessary to provide the service at all.

- **Ability to Contract Efficiently With Managed Care Plans Is Enhanced** - Managed care plans, of course, should corroborate this claim.

(2) The agencies are <u>more</u> likely to challenge a merger if:

- **"Cost Savings" Reflect Output Restrictions** - An "efficiencies" story that is predicated on the argument that "competition doesn't work and any duplication of services is wasteful" is <u>not</u> legally cognizable.

- **Cost Savings Are Possible Without Merger** - The cost savings are based solely or primarily on the joint provision of services that could be achieved <u>without</u> a merger, such as through a joint venture (e.g. laundry, administrative, or data processing services).

d0 "Sliding Scale" Concept - Under the Horizontal Merger Guidelines, the higher the level of market concentration is,

efficiencies needs to be. Efficiencies are more likely to be sufficient to justify a proposed merger if the merger would result in a “borderline” highly concentrated market than if the merger would create a monopoly or near-monopoly.

11 **Community Control and Non-Profit Status** - In *FTC v. Butterworth Health Corp.*, supra, a district court found that the proposed merger of the two largest hospitals in Grand Rapids, Michigan, would substantially increase market concentration for inpatient, acute care services, and that Michigan CON regulation posed a substantial barrier to entry, but denied the government’s motion for a preliminary injunction to block the merger. In addition to citing efficiencies, the court offered the following rationale for allowing the hospitals to merge:

a0 Inconclusive empirical evidence that high concentration in the hospital industry actually results in anticompetitive effects;

b0 As nonprofit entities, the merging hospitals are not driven by the same profit maximizing incentives as for-profit companies;

c0 The merging hospitals had announced a ?Community Commitment” not to exercise their combined market power to raise prices or otherwise act in an anticompetitive manner; and

d0 A post-merger reduction in the size of the discounts extended to managed care plans did not necessarily yield an adverse impact on consumer welfare.

The Sixth Circuit Court of Appeals affirmed the decision in an unpublished per curiam opinion. It should be noted that the courts are divided as to whether nonprofit status or “community commitments” should be considered mitigating factors.

1 **No Overlap.** "Vertical" mergers involve the combination of providers and/or payors that offer complementary or related services, such as the acquisition of physician practices by a hospital or a health plan.

2 **Efficiency-Driven.** The vast majority of vertical mergers are efficiency-driven. The federal enforcement agencies recognize the potential procompetitive benefits of vertical mergers and generally do not interfere with such mergers.

3 **Theory of Competitive Foreclosure**

a0 Some vertical mergers or affiliations, however, pose antitrust risk. Although there are several vertical theories of competitive harm, the one most likely to be applicable to health care mergers is that of competitive foreclosure through the control of necessary upstream inputs. Statement 9 of the DOJ/FTC Health Care Policy Statements cautions that the formation of multiprovider network may foreclose the development of similar, competing networks if the network ties up the providers of a necessary "input" service by means of exclusive contracts. This result might also occur in a hospital's acquisition of physician practices, or, as one (former) FTC official stated, "in the creation or expansion of a multispecialty clinic if it contained a large percentage of primary care physicians which could control most referrals to specialists." Steptoe Speech at 28. A vertical merger thus may jeopardize competition if (i) it effectively requires a potential entrant to enter the upstream and downstream markets simultaneously in order to be successful; and (ii) if such two-level entry is more risky and difficult than entry at a single level.

b0 **Paucity of Case Law** - There is little case law on the merits and applicability of the competitive foreclosure theory. Most of the health care cases in which foreclosure has been alleged have resulted in settlements:

Consent Orders, C-3530 and C-3531, (October 31, 1994) - These cases involved partnerships that were formed by pulmonologists to provide oxygen delivery systems to patients at home. In each case, it was alleged that approximately 60% of the practicing pulmonologists in the relevant geographic market were investors in the partnerships and that these investors collectively had market power in the market for pulmonology services. According to the FTC, the pulmonologists were able to influence the patient=s choice of home oxygen services, and the formation of the partnership, and hence the aggregation of the referral powers, foreclosed competition and created impediments to entry in the home oxygen market. The terms of the consent orders suggest that ventures involving 25% or fewer of the pulmonologists in the market would not create market power. The State of Missouri subsequently brought a similar action against a physician group and a hospital owned by the same physicians, alleging that the defendants had forced or unfairly influenced patients to use the defendants= home oxygen and other services. By terms of a consent judgment, the defendants agreed, among other things, to pay $300,000 to the State. *State of Missouri ex rel. Nixon v. Poplar Bluff Physicians Group, Inc., et al.*, 1995-2 Trade Cas. (CCH) & 71,206 (Circuit Court, Cole Co., Mo., 1995).

(2) **Physician Acquisition Settlements** - Both the State of Missouri and DOJ have obtained consent orders from Missouri hospitals governing their acquisitions of physician practices. In the State=s settlement, the largest hospital in Springfield, Missouri, agreed to limit its hiring of specialists to not more than 40% of the physicians in any given

With respect to specialties where the hospital already controlled more than 40% of the physicians, the hospital agreed to, among other things, lift certain employment restrictions on those physicians and to maintain an open staff privileges policy. *State of Missouri v. St. John=s Regional Health Center*, (December 16, 1994). In the DOJ consent decree, the only hospital in St. Joseph, Missouri, was barred from purchasing additional physician practices in the local area without the prior approval of DOJ. The hospital, however, could continue to recruit physicians from outside the area. *United States v. Health Choice of Northwest Missouri, Inc.*, 1996-2 Trade Cas. (CCH) & 71,606 (W.D. Mo. 1996). Similarly, the State of Massachusetts entered into an Assurance of Discontinuance to resolve antitrust concerns with the merger for two hospital systems, under which the hospitals are prohibited from controlling not more than 40% of the primary care physicians, pediatricians and OB/GYNs in the relevant market. *State of Massachusetts v. Partners HealthCare System, Inc.*, No. 96-1713B (Mass. Super. Ct., Suffolk County, March 29, 1996).

(3) Private Litigation.

HTI Health Services, Inc., supra - Plaintiff hospital sought to enjoin a pending merger of the two largest physician clinics, in Vicksburg, Mississippi, on the theory that the combined clinic would deal solely or primarily with its principal competitor, with which the clinic would be affiliated. The court denied an injunction because the plaintiff failed to show that defendants collectively would have market power as a result of the merger.

Blue Shield United of Wisconsin contended, among other things, that Marshfield Clinic=s acquisition of physician practices in rural Wisconsin gave it the power to foreclose Blue Cross=s HMO from competing with its own health plan in those area. The Seventh Circuit, however, found that the plaintiff failed to prove that the clinic had monopoly power in the provision of physician services, and therefore could not establish that the clinic had foreclosed competition in the "HMO market."

***Western Surgical Center v. Intermountain Health Care* (D. Utah 1995)** - Plaintiff, an outpatient surgery center in Logan, Utah, alleged that IHC=s acquisition of the Budge Clinic in Logan would result in referral of all of Budge=s patients to IHC=s hospital in Logan, and would adversely affect competition in several markets. By terms of a settlement, IHC=s acquisition of Budge Clinic was allowed to go forward on the condition that primary care physician within the Budge Clinic would be available to all managed care plans for a limited period of time. (In a related development, the FTC closed its investigation of IHC=s acquisition of the Budge Clinic without taking any enforcement action, though it advised IHC that it would continue to monitor IHC=s operation of the clinic to ensure that IHC was not exercising market power in the physician services market or otherwise foreclosing competition in the hospital services or managed care markets. FTC Staff Letter to Richard W. Casey, Esq. (January 22, 1997)).

1 **Injunctive Relief: The Federal "All or Nothing" Approach.** As a general rule, the federal antitrust enforcement agencies will seek to block proposed mergers that allegedly pose a threat to competition. DOJ=s settlement of its lawsuit against the Morton Plant/Mease hospital merger is the lone exception to this rule. Under the consent decree in that case, the defendant hospitals were permitted to form a joint venture to combine and market their tertiary and outpatient services, as well as combine a variety of administrative functions, in lieu of a full-scale merger. *United States v. Morton Plant Health System*, supra.

2 **State Regulatory Approaches.** Many states have allowed mergers of hospitals or physician practices in highly concentrated markets to go forward, subject to specific regulatory constraints. Recent examples of this trend include:

a0 ***State of Maine v. Maine Heart Surgical Associates, P.A.***, 1996-2 Trade Cas. (CCH) & 71,653 (Maine Superior Ct., Kennebec County, 1996) - Two groups of cardiothoracic surgeons in Portland were permitted to merge, provided that the merged entity would be prohibited from contracting on an exclusive basis with any hospital or from refusing to participate in a managed care contract where reimbursement would be at or above a level determined annually by the state attorney general.

b0 ***State of Wisconsin v. Kenosha Hospital,*** supra - State attorney general agreed not to block merger of the only two hospitals in Kenosha, Wisconsin, on condition that merged entity pay back more than $17 million to the community over the next five years in the form of free or low-cost health care, or in the form of price cuts; the hospitals were also obliged to save a projected $43.7 million in operating and capital costs over five years, or pay the shortfall to an indigent care fund. (This merger has since been dissolved by the hospitals.)

System Services, supra - This consent decree settling a merger of two medical centers was permitted to proceed subject to a number of conditions and constraints, including the commitment of the combined entity to pass on to consumers 80 percent of the savings realized from merger-specific efficiencies to be achieved over the initial five years.

III PROVIDER NETWORKS AND MANAGED CARE CONTRACTING

With the growth of managed care, many providers have found it advantageous to form networks and collectively market their services. Set forth below are the principal antitrust considerations governing the formation and operation of provider networks.

A0 An Overview of the Analysis of Provider Networks: FTC/DOJ Antitrust Guidelines for Collaborations Among Competitors: On October 6, 1999, the federal antitrust enforcement agencies issued, for public comment, draft Antitrust Guidelines for Collaborations Among Competitors, 64 Fed. Reg. 54484 (1999) ("Collaboration Guidelines"). These Guidelines would apply to, among others, joint ventures or networks among competitors in the health care industry. The Collaboration Guidelines provide that "agreements" among competitors to restrain the conduct of their businesses may be characterized as either *per se* illegal conduct or conduct that is governed by the "rule of reason."

1 Agreements Challenged as *Per Se* Illegal. Agreements among competitors that always or almost always tend to raise price or reduce output are deemed to be *per se* illegal. Types of agreements that have been held to be *per se* illegal include agreements to fix prices or output, to rig bids, or share or divide markets by allocating customers, suppliers, territories or lines of commence. *Id.* at § 3.2.

2 Agreements Analyzed under the Rule of Reason. Agreements among competing providers that are not *per se* illegal are governed by the "rule of reason," an analytical process that seeks to determine the overall competitive effect of the agreement at issue. "Rule of reason analysis focuses on the state of competition with,

question is whether the relevant agreement likely harms competition by increasing the ability or incentive profitably to raise price above or reduce output, quality, service, or innovation below what likely would prevail in the absence of the relevant agreement." *Id.* at § 3.3. Under the Collaboration Guidelines, the agencies may undertake either an abbreviated or a detailed market analysis to resolve this question.

a0 **Abbreviated Analysis** - This mode of analysis, commonly referred to as the "quick look," is appropriate "where the likelihood of anticompetitive harm is evident from the nature of the agreement, or anticompetitive harm has resulted from an agreement already in operation" and there are no overriding procompetitive benefits from the joint venture or network. *Id.* at 3.3. <u>See</u> *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 459-60 (1986) (condemning without "detailed market analysis" an agreement among dentists to limit competition by withholding x-rays from their patients' insurers after finding no competitive justification).

b0 **Detailed Market Analysis –** To determine the legality of a restraint that is ancillary to a legitimate joint venture or network, it may be necessary to conduct a detailed market analysis under the rule of reason. This analysis is similar but not identical to the merger analysis described in Section II of this outline. The federal antitrust enforcement agencies will assess the degree of market concentration as an initial step in determining whether the joint venture or network is likely to create or enhance market power. In addition to high market concentration, the agencies will also examine a variety of other factors, such as whether the parties' arrangement is exclusive, its duration, the entry conditions of the market in which the joint venture or network operates, and the likelihood of anticompetitive information sharing. If this inquiry suggests that there may be anticompetitive effects, the agencies will examine efficiencies or other procompetitive justifications for the

effect. *Id.* at §§ 3.33-3.36.

B0 Joint Pricing and The Need for Economic Integration

1 **The Specter of Illegal Price Fixing.** The per se ban on price fixing prohibits an individual provider from agreeing with one or more of its competitors on rates or fees for services to be offered through the network unless they substantially integrate their financial or clinical arrangements. Under Statements 8 and 9 of the DOJ/FTC Health Care Policy Statements, the requisite economic integration may take the form of substantial risk-sharing or clinical integration among network providers. Joint pricing that is ancillary to such integration is not illegal per se, but is subject to the "rule of reason", a method of analysis which balances the actual or potential procompetitive benefits of the arrangement against its anticompetitive effects. See *Hassan v. Independent Practice Ass'n,* 698 F. Supp. 679 (E.D. Mich. 1988) (IPA's fee-withhold arrangement created financial integration among the physician members and their joint pricing passed muster under a rule-of-reason analysis).

2 **Joint Pricing Without Integration is Per Se Illegal.** To date, both FTC and DOJ have successfully challenged a variety of provider arrangements that involve little or no economic integration. Representative cases include:

a0 ***Southbank IPA, Inc.***, 114 F.T.C. 783 (1991) - Twenty-three OB/GYNs in Jacksonville established an "IPA" to collectively negotiate fee-for-service rates with third party payors. The FTC attacked the "IPA" as a sham inasmuch as there was little or no economic integration among its members. According to the FTC complaint, the IPA negotiated for its members on a fee-for-service basis only. The "IPA" was dissolved under the terms of a consent order.

b0 ***McLean County Chiropractic Assn.***, FTC Dkt. No. C-3491 (April 7, 1994) - Similar to *Southbank*. In this matter, a local association of chiropractors in Illinois

its members, with payors. Although the association claimed that it was seeking to establish a PPO, it allegedly made no effort to integrate the practices or financial arrangements of its members.

c0 ***United States v. Classic Care Network, Inc.***, 1995-1 Trade Cas. (CCH) & 70,997 (E.D.N.Y. 1995) - Consent judgment barred several independent hospitals on Long Island, New York, from collectively negotiating with managed care plans.

d0 ***United States v. Healthcare Partners, Inc.***, 1996-1 Trade Cas. (CCH) & 71,337 (D. Conn. 1996); ***United States v. Health Choice of Northwest Missouri***, supra. In these companion cases, the Justice Department challenged PHOs consisting of the only hospital in town and the vast majority of local physicians. In each case, the complaint alleged that the PHO served as a mechanism to resist managed care. Among other things, the PHOs allegedly set or negotiated fees and other terms of reimbursement for competing physicians, who did not share financial risk or otherwise integrate their practices. The consent decrees prohibit such conduct, but allow the physicians and hospitals to establish a "qualified" health plan, so long as the physicians share a substantial risk of financial loss.

a0 **Capitation and Fee Withholds** - The federal antitrust enforcement agencies have long identified capitation and substantial fee withholds as legitimate forms of risk-sharing. Capitation as a risk-sharing device is rather straightforward; fee withholds are somewhat more obtuse. Fee withholds may or may not create substantial risk-sharing depending on their size, the extent of any fee discounting in the market, the size of the network itself, and local market conditions. Compare FTC Staff Advisory Opinion Letter to Paul W. McVay (July 5, 1994) with FTC Staff Advisory Opinion Letter to George Q. Evans, Esq. (July 5, 1994) (opinions reach different conclusions on the "substantiality" of a 15% withhold depending on market conditions and other factors).

b0 **Other Recognized Forms of Risk-Sharing** - In August 1996, the federal antitrust enforcement agencies revised their Health Care Policy Statements to recognize several additional forms of risk-sharing among network providers:

(1) **"Revenue Sharing"** - the provision of specified services to a health plan for a predetermined percentage of premium or revenue from the plan;

(2) **"Targets"** - the establishment of overall cost or utilization targets for the network as a whole, with network providers= financial rewards or penalties tied to meeting such targets; and

(3) **"Global Fees"** or **"All Inclusive Case Rates"** - a fixed, predetermined payment for a complex and extended course of treatment that involves the substantial coordination of different providers.

4 **Nonfinancial Integration** - Clinical integration among network providers may also be sufficient to bring joint pricing by such providers within the rule of reason. There is, however, scant guidance on the nature and degree of clinical integration

a0 Under the DOJ/FTC Health Care Policy Statements, clinical integration among physicians may include the following elements:

(1) a utilization review and quality assurance program;

(2) physician credentialing and selectivity; and

(3) significant investment of capital, both monetary and human, in the network infrastructure (e.g., a common information system) to help ensure the development of superior practice standards and protocols and achieve efficiencies.

b0 The FTC Staff further addressed "service" integration in a 1997 advisory opinion concerning a proposed network of independent ambulance companies in Michigan. The FTC Staff approved the proposed network because it found that the network would involve "substantial service integration" among the companies that had "the potential for generating significant procompetitive benefits for consumers." Specifically, the companies proposed to develop "integrated mobile health services," which would provide cost-effective and medically appropriate care by employing protocols to coordinate transportation services and triage methods. Each company would make a substantial capital contributions in staffing and developing computer systems for such services. The network would also implement utilization review and quality assurance programs, and would utilize its computer system to centralize its contracting, billing and reporting functions. Furthermore, the companies would engage in joint purchasing, joint training, and joint vehicle maintenance and repair programs. (It should be noted that the ambulance network intended to contract with payors primarily on a capitation basis: It is not clear from the advisory opinion to what extent the network=s intention to contract primarily on a risk-sharing basis influenced the

integration" was sufficient to avoid application of the per se rule). See FTC Staff Advisory Opinion Letter to John A. Cook, Esq. (January 30, 1997).

c0 **"Mixed" Arrangements: Risk/Non-Risk Contracting** - The DOJ/FTC Heath Care Policy Statements provide that joint "non-risk" pricing will be governed by the rule of reason (rather than found to be per se illegal) where a "substantial" portion of the network=s contracting involves the sharing of substantial financial risk and the network uses, in the context of non-risk contracts, the same utilization control mechanisms involved in risk-sharing contracts. See also FTC Staff Advisory Opinion Letter to George A. Cumming, Jr., Esq. (July 17, 1996).

5 An Alternative to Integration: Use of the Messenger Model to Avoid an Agreement on Pricing

a0 **Pricing is Unilateral, not Collective -** By using a "messenger model", providers may avoid the possibility of a price agreement altogether, and thereby avoid antitrust exposure. Under a "messenger model" system, each provider makes a unilateral decision to accept or reject the offer from a payor that has been conveyed by the messenger. The messenger in turn conveys those unilateral decisions to the payor. The messenger does not share individual providers' decisions with other members of the network, for such sharing could facilitate illegal price fixing. **The messenger must serve as a conduit of fee-related information, and not as a negotiating agent for the network's providers.** See FTC Staff Advisory Opinion Letters to Jacqueline C. Cox (July 11, and 27, 1995); *United States v. Federation of Certified Surgeons and Specialists, Inc., et al.*, Civ. No. 99-167-Civ-T-17F (M.D. Fla. complaint filed January 26, 1999) ("a legitimate messenger does not coordinate or engage in collective pricing activity for competing independent physicians, enhance their bargaining power, or facilitate

information among them"); *United States v. Federation of Physicians and Dentists*, Civ. No. 98-475 (D.Del. complaint filed August 12, 1998) ("messenger" alleged to have negotiated the fees of independent physicians in violation of the antitrust laws).

b0 **What Can a Messenger Legally Do? -** The consent judgment in *United States v. Healthcare Partners*, supra, identifies a variety of permissible activities of a messenger. Under the consent decree, a messenger is prohibited from collectively negotiating fees on behalf of competing providers or from facilitating a price agreement among such providers, **but is allowed to**:

(1) convey to a provider objective information about proposed contract terms, including comparisons with terms offered by other payors;

(2) solicit clarifications from a payor of proposed contract terms, or engage in discussions with a payor regarding contract terms other than prices and other competitive terms and conditions, except that the agent or third party (i) must tell the payor that the payor may refuse to respond or may terminate discussions at any time and (ii) may not communicate to the providers regarding, or comment on, the payor=s refusal to offer a clarification or decision not to enter into or to terminate discussions except to providers who requested the clarification;

(3) convey to a provider any response made by a payor to any information conveyed or clarifications sought;

(4) convey to a payor the acceptance or rejection by a provider of any contract offer made by the payor; and

determined response or views of each provider concerning any contract offer made by such payor.

C. Non-Price Agreements Among Providers that are Illegal per se in the Absence of Economic Integration

Other collective action among network providers may be illegal per se. In particular, naked agreements among providers to divide markets or to refuse to deal with payors or others violate the antitrust laws.

1 Market Division

a0 In the absence of economic integration, agreements among network providers to allocate customers, territories or service lines are illegal per se. See generally *Blue Cross v. Marshfield Clinic*, supra, 65 F.3d at 1415-16 (defendant clinic and a competitor found to have engaged in per se illegal market division).

b0 Under certain circumstances, however, "patient sorting" and similar allocative activities may be justifiable as efficiency-enhancing in the context of a legitimate joint venture. See generally FTC Staff Advisory Opinion Letter to Richard J. Sahli (November 8, 1995) (providers jointly operating a rural clinic could lawfully engage in "patient sorting").

2 Concerted Refusals to Deal

a0 Concerted refusals to deal among independent providers also run afoul of the antitrust laws. Federal and state antitrust agencies have successfully challenged provider efforts to create a "united front" to resist managed care. See e.g., *Physicians Group, Inc.*, FTC Dkt. C-3610 (March 12, 1996) (FTC consent order settling charges that physicians in Danville, Virginia, had joined forces solely for the purpose of resisting managed care discounting); *Minnesota v. Southern Minnesota Area Physicians, P.A.*,

(price fixing and boycott charges settled by injunction, payment of a $125,000 fine, and provision of $450,000 in free care).

b0 Hospitals or multispecialty group practices may also be the victims of anticompetitive boycotts, especially where such providers offer medical or financing innovations that threaten traditional fee-for-service medicine. See, e.g., *Medical Staff of Broward General Medical Center*, 114 F.T.C. 542 (1991) (consent order governing alleged concerted efforts of local physicians to prevent Cleveland Clinic from establishing a satellite operation in South Florida); *Trauma Associates of North Broward, Inc.*, 118 F.T.C. 1130 (1994) (consent order governing alleged boycott by surgeons of hospitals to obtain higher fees for trauma services).

D. Provider Networks and Joint Ventures under the Rule of Reason

Proof of substantial economic integration among otherwise competing providers does not complete the antitrust analysis; such integration merely takes agreements among the providers outside the per se ban. The legality of restraints imposed on network providers is governed by the rule of reason.

1. **Ancillary Restraints.** To pass muster under the antitrust laws, restrictions on competition among the provider co-venturers must be ancillary, that is, reasonably necessary to effectuate the legitimate goals of the joint venture. Arguably, the Supreme Court=s decision in *Arizona v. Maricopa County Medical Society*, 457 U. S. 332 (1982), may be interpreted as an ancillary restraint case. In that case, the Court struck down, as per se illegal, a maximum fee schedule for medical services that had been jointly established by the physician members of the Maricopa Foundation. The Foundation was a legitimate venture -- offering utilization review and other services -- but its establishment of a fee schedule for medical services was not found to be sufficiently related to these activities to avoid application of the per se rule.

safeguards to ensure that joint pricing or other collaboration among providers to attain the procompetitive goals of the joint venture does not spillover into areas where the providers remain competitors. For example, the exchange of competitively sensitive information among providers should be limited to that which is necessary to facilitate the procompetitive activities of the network.

3 **Market Power.** If a network is characterized by substantial economic integration, and the competitive restraints imposed by and upon the network=s providers are ancillary to such integration, then the restraints themselves will be evaluated under the rule of reason. A central inquiry under the rule of reason is whether the joint venture itself gives rise to "market power," which is defined as the ability profitably to raise price above or reduce output or quality below what likely would prevail in the absence of the network.

a0 Market share is not synonymous with market power, but, as a general rule, the smaller the combined market share of the providers participating in a network, the less likely market power will be found. For example, the DOJ/FTC Health Policy Statements establish an "antitrust safety zone" for non-exclusive physician networks comprising 30% or fewer of the physicians of each specialty, and exclusive physician networks comprising 20% or fewer of the physicians of each specialty, with active hospital privileges in a given market, where the network physicians have integrated their financial arrangements or clinical practices. If a physician network falls within an "antitrust safety zone," it ordinarily will not be challenged by the federal agencies.

b0 By contrast, a large, all-inclusive provider network will invite inquiry as to whether the network has been established primarily to restrain competition among network providers. See, e.g., DOJ Press Release regarding Stanislaus Preferred Provider Organization

c0 Two DOJ business review letters shed some light on when provider ventures may give rise to impermissible market power. In one matter, DOJ disapproved a proposed network that would include 50-75% of the pediatricians in various communities in New Jersey. DOJ Business Review Letter, to Stephen J. Kern, Esq. and Robert J. Conroy, Esq. (March 1, 1996). In the other matter, the DOJ expressed concern about the potential market power of a proposed network combining 5 of 6 anesthesiologist group practices in Orange County, California, that would serve as the exclusive contracting mechanism for the participating anesthesiologists. DOJ Business Review Letter to Tad R. Callister, Esq. (March 8, 1996).

4 Exercise of Market Power

a0 **Exclusive Dealing** - A serious antitrust concern arises where a network consisting of a large percentage of local providers serves as the exclusive contracting agent for its provider-members, effectively denying payors the ability to contract with some but not all of the network=s providers. The federal antitrust enforcement agencies will challenge a network consisting of the majority of physicians in a market if the agencies believe that the network is or would be, as a practical matter, the exclusive vehicle for managed care contracting for the participating physicians. Two recent cases are instructive:

(1) In *Mesa County Physicians, I.P.A., Inc.*, FTC Dkt. No. 9284 (consent order issued May 4, 1999). the FTC sued an IPA which allegedly included 85% of the physicians in Mesa County, Colorado, seeking, among other things, structural relief. The FTC ultimately dropped its demand for structural relief, and the IPA agreed to a consent order governing its contracting practices in order to settle the litigation.

(2) In *North Lake Tahoe Medical Group, Inc.,* C-3885

alleged that North Lake Tahoe Medical Group, Inc. ("Tahoe IPA"), an independent physician association, restrained competition among physicians and delayed the entry of managed care in the Lake Tahoe Basin in California. Tahoe IPA is composed of ninety one physicians comprising 70% of the physicians practicing in the Lake Tahoe area. The FTC further alleged that Tahoe IPA conspired to fix prices, engaged in collective negotiations over prices with payers, and refused to deal with Blue Shield of California and other third party payers when it did not comply with Tahoe IPA's plans. The consent order prohibits Tahoe IPA from engaging in collective negotiations on behalf of its members, orchestrating concerted refusals to deal, fixing prices, or any other terms, on which its members deal and restricting the ability of any physician to deal with any payer or provider individually or through any arrangement outside of Tahoe IPA. The consent order also requires Tahoe IPA to terminate the membership of physicians who refused to deal (or gave notice of their intent to refuse to deal) with Blue Shield, unless the physicians make a good faith effort to reparticipate and continue to participate in Blue Shield for a period of six months.

(3 A rural network may necessarily include a large percentage of providers in order to achieve efficiencies and provide coverage; such a network may withstand antitrust scrutiny so long as its members do not agree to contract through the network exclusively. See generally FTC Staff Advisory Opinion Letter to William T. Harvey, Esq. (May 19, 1998); DOJ Business Review Letter to Jesse B. Grove, III, Esq. (January 17, 1996) (approving proposed statewide IPA that would

markets, including 100% of otorhinolaryngologists in two markets).

b. **"Most Favored Nations" Clauses** - MFN status is one of the most controversial subjects in health care antitrust law. Although there is a paucity of case law, courts generally have looked upon MFN status favorably, as a means of assuring that payors (and thus their beneficiaries) receive the lowest possible prices for health care services. See generally *Marshfield Clinic,* supra; *Ocean State Physicians Health Plan v. Blue Cross & Blue Shield*, 883 F.2d 1101 (1st Cir. 1989). The federal enforcement agencies, however, have challenged MFN clauses that have been imposed by large provider-controlled plans allegedly for the purpose of stabilizing price levels among their provider-members or for the purpose of foreclosing competition in the market for health care financing. See, e.g., *United States v. Delta Dental Plan of Arizona*, 1995 WL 45479 (D. Ariz) (second amended final judgment); *United States v. Vision Service Plan*, 1996-1 Trade Cas. (CCH) & 71,404 (D.D.C. 1996). A district court refused to dismiss the government=s challenge of an MFN clause in a contract between a provider-controlled dental insurance plan and its participating dentists, which provided that the plan would reduce its reimbursement fees to dentists who received fees lower than those listed on the plan=s fee schedule. The court reasoned that, while the clause appeared to guarantee that the plan purchased dental services for its enrollees for the lowest fees that the dentists were willing to receive, it could have the effect of "excluding potential rivals, retarding expansion by existing competitors, and substantially increasing the costs to consumers of dental insurance and services," as the government claimed. *United States v. Delta Dental of Rhode Island*, 943 F.Supp. 172 (D.R.I. 1996). The dental plan ultimately agreed to a consent order prohibiting its use of MFN provisions. 1997-2 Trade Cas. (CCH) &

E. Application of Foregoing Principles to Physician-Hospital Organizations

1. **Price Fixing.** Although PHOs constitute a legitimate form of marketing and delivering medical services, they can raise a variety of antitrust issues in some circumstances. For example, a price agreement among physician members of the PHO may be challenged as illegal price fixing if the physicians do not integrate their practices or share risk of loss through the PHO. See generally *United States v. Healthcare Partners*, supra.

2. **Market Power.** Formation of a PHO may give rise to market power if the organization includes most or all of the providers in a given market and acts as the exclusive contracting vehicle for such providers. For example, the Justice Department obtained a consent order prohibiting a hospital and its affiliated PHO from impeding competition for obstetrical services in Baton Rouge, Louisiana. According to the complaint, the hospital and the OB/GYN members of its PHO enjoyed a virtual monopoly in the provision of obstetrical services, and sought to maintain supracompetitive prices by dealing with payors only through the PHO. *United States v. Woman=s Hospital Foundation*, 1996-2 Trade Cas. (CCH) & 71,561 (M.D. La. 1996). By contrast, the Attorney General of Maine entered into a consent agreement with a "super PHO," combining four PHOs in different communities, whose formation raised the possibility of market power. The consent agreement adopted a "wait and see" approach. By its terms, the super PHO would be barred from negotiating or contracting with managed care plans if at some later date either the prices offered through the super PHO were above a competitive level, or the level of utilization of health care services through the super PHO was excessive. *State of Maine v. Central and Western Maine Regional PHO, Inc.*, 1996-1 Trade Cas. (CCH) & 71,320 (Maine Super. Ct. 1996).

Antitrust analysis can be complex and fact-intensive. It is often prudent to engage antitrust counsel in the early stages of network or merger planning, so that any antitrust issues can be addressed as effectively and efficiently as possible.