ANTITRUST ENFORCEMENT EFFORTS AGAINST HOSPITALS AND PHYSICIAN NETWORKS

HEALTHCARE ISSUES AND ANSWERS

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I. INTRODUCTION

As the healthcare delivery system evolves, one can expect to see even further consolidation and integration among physicians, hospitals and other providers. Whether such consolidation is in the form of a legal merger, or simply a more informal “network” arrangement, much of this consolidation is pro-competitive, provides additional efficiencies in delivering healthcare services, and raises few antitrust concerns. Antitrust law, however, must always be a primary consideration of the parties if the merger transaction under review may give rise to market power, or if a network arrangement among competitors involves little or no economic integration between those providers.

The alphabet soup of provider networks continues to grow. Independent practice associations (IPAs), preferred provider organizations (PPOs), physician hospital organizations (PHOs) provider sponsored networks (PSNs/PSOs), management services organizations (MSOs) and other entities with varying degrees of functional and legal integration are the vehicles through which providers attempt to remain competitive in today’s health care market. This outline looks at the primary antitrust considerations that health care providers and their advisors should take into account in planning a merger or developing a network or other form of integrated system.
Federal antitrust laws applicable to healthcare providers seeking to integrate their operations generally are the Sherman Act, 15 U.S.C. § 1, which prohibits contracts, combinations or conspiracies in restraint of trade; Section 2 of the Sherman Act, which prohibits any person from monopolizing or attempting to monopolize; and Section 7 of the Clayton Act, which prohibits mergers or acquisitions which operate “substantially to lessen competition.” Finally, Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, gives the FTC broad powers to block or prevent commercial activities involving “unfair methods of competition . . . and unfair or deceptive acts or practices in or affecting commerce.” Each of these statutes may be utilized by federal authorities challenging provider consolidation and integration. Which statute governs particular commercial activity depends upon the nature of the proposed conduct.

II. MERGERS AND ACQUISITIONS

A healthcare provider (or any other business entity for that matter) which grows and becomes successful purely through internal growth normally would not raise antitrust concerns. If that same provider expands through mergers or acquisitions, however, the antitrust laws may come into play. Section 7 of the Clayton Act prohibits mergers or acquisitions that may lessen competition substantially or tend to create a monopoly in any market. The Federal Trade Commission (FTC) and the Department of Justice (DOJ) (“The Agencies”) closely watch mergers or acquisitions between horizontal competitors, challenging those mergers that The Agencies feel would result in a less competitive market than prior to the merger.

While the antitrust laws governing mergers apply equally to anyone engaged in commerce, most such antitrust enforcement has focused on the hospital industry. Reportedly

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1 See, 15 U.S.C. §§ 1, 2, 18 and 45, found at appendix.
over 760 hospitals announced merger or acquisitions plans in 1996, an increase of more than 5% from 1995. Almost 40% of private nonfederal hospitals in the United States have been involved in merger or acquisition activity in the last three years. While the DOJ and the FTC actually challenged less than 2% of the hospital mergers taking place in the country, there have been some highly publicized antitrust challenges by those agencies in recent years. In 1992, The Agencies published their Horizontal Merger Guidelines, designed to publicize the methodology by which they would evaluate proposed mergers. Under the guidelines, challenges typically involve a 5 step analysis of the proposed merger by The Agencies.

A. Define the relevant market, both product market and geographic market.
B. Define the merger’s potential competitive impact.
C. Define the ease of entry by new competitors.
D. Determine the existence of efficiencies.
E. Determine the probable consequences if no merger occurs.

No single factor is determinative; rather The Agencies evaluate each one under the particular facts and circumstances of the challenged merger.

A. Define the Relevant Market

A proposed merger among competitors is likely to raise antitrust concerns if it is likely to create or enhance “market power” in such a way that it substantially lessens competition or tends to create a monopoly. The definition of the relevant market has two components: the product

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market and the geographic market. In analyzing both of those components, The Agencies look at whether consumers could as a practical matter turn to alternative sources of supply of the product or service if the newly merged entity were to raise its prices by a significant increment.

1. **Product or Service Market**

Analyzing the relevant product or service market involves analyzing what possible substitutes exist for the seller’s goods. With respect to hospital mergers, The Agencies typically analyze the product market as a single cluster of services defined as “acute, inpatient hospital care”. Over the years providers have largely accepted this definition, and for the most part it represents the state of the art definition for product market for hospital mergers.

One difficulty with the definition of the product market for hospital care is that The Agencies have excluded outpatient services from the definition of the relevant service market, and thus have attached virtually no competitive significance to the large numbers of ambulatory surgical centers (ASC), clinics and other facilities (including even physicians offices) where patients now receive treatment for conditions which formerly required hospitalization. Cataract surgeries, arthroscopic surgery of the knee and shoulder, and other routinely performed procedures which were performed on an inpatient basis scarcely ten (10) years ago are now routinely and predominantly performed in an outpatient setting. Even bone marrow transplants for cancer patients, which typically require intensive hospital level care over a prolonged period, have successfully been performed in ASC/clinic settings.
The effect of the narrow agency definition for hospital services effectively shrinks the market and increases the likelihood that a proposed merger may be held to substantially lessen competition or tend to create a monopoly.

2. Geographic Market

The geographic market definition depends entirely on the facts and circumstances of the proposed merger. The determination is highly case specific and factually intensive, and cannot be easily confined to city or county geographic boundaries. The U.S. Supreme Court has stated that the appropriate geographic market for the purpose of assessing the competitive impact of a proposed merger is the “area in which the [merging entities] operate, and to which [their] purchasers can practicably turn for supplies”. While that statement seems broad and general enough, as one might imagine, the debate about where patients could go to obtain similar services as those offered by the merging entities are often the primary disputes between merging hospitals and the FTC economic experts.

Again, the critical question is whether patients or payors can and will go elsewhere if the newly merged entity raises prices above a competitive level. Evidence of consumer preferences and the willingness of consumers to purchase healthcare services at competing facilities is one of the most important factors that The Agencies and the courts will look at in defining the geographic market. In one recent case, a federal district court agreed with the hospitals’ testimony and approved of the merger of the only two acute care hospitals in Dubuque, Iowa. To

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5 United States v. Mercy Health Systems, 902 F. Supp. 968 (N.D. Iowa 1995), vacated and appeal dismissed as moot, 107 F.3d 632 (8th Cir. 1997). Ironically, while the court of appeals was considering the government’s appeal, the hospitals abandoned their merger plans for unrelated reasons. Thus, the court dismissed the appeal as moot.
support their argument of a broader geographic market, the hospitals offered evidence (1) that Dubuque patients who went to outreach clinics sponsored by competing hospitals outside of Dubuque were willing to drive to those hospitals for follow-up care, (2) that patient-doctor loyalty was not a strong factor in determining the patient’s choice of a provider, and (3) that managed care programs reasonably could transfer their patients to hospitals at a distance from the merging hospitals if they so desired. This “dynamic analysis” of the Dubuque marketplace effectively increased the geographic area served by the hospitals, and resulted in the court dismissing the Department of Justice’s challenge to the proposed merger.

Technological advances may also expand the geographic market well beyond local boundaries. Teleradiology services for example can be provided across state and regional boundaries, and hence a national market probably exists for that product. Similarly, if the product were heart transplant programs around the United States, the geographic market would be national in scope. For parties contemplating a proposed merger, one cannot overstate the importance of a geographic market analysis as one of the most critical aspects in withstanding a merger challenge.

**B. Defining the Merger’s Potential Competitive Impact**

The question to be answered by the enforcing agencies under any antitrust analysis, of course, is ultimately to quantify the potential competitive impact of the proposed merger. The second in the five step evaluation process is an initial evaluation of that impact based on market share and market concentration data. The Agencies and the courts will evaluate the market share prior to and after the proposed transaction as one way to determine the probable competitive impact.
The “impact” analysis is a complex labyrinth of economists, statisticians, lawyers and marketing specialists. The enforcement agencies use a complex formula called the Herfindahl-Hirschman Index (HHI) to evaluate the competitive impact of a proposed merger. The HHI for a given market is calculated by adding the squares of the market shares of all the participating hospitals. HHIs thus can range from 100 (100 competitors each with one percent of the market) to 10,000 (one competitor with 100% of the market). A market with four equal competitors for example, would have an HHI of 2,500. The FTC considers markets with less than a 1,000 HHI to be unconcentrated, while those above 1,800 are characterized as highly concentrated.

The degree of concentration of the market is only a static measurement, however. The relevant measurement under a Herfindahl-Hirschman analysis is the increase in the HHI from pre to post merger. For example, increases in the HHI greater than 100 points in a moderately concentrated market (e.g. a market with 6-10 equally competing acute care hospitals) may create a presumption of anticompetitive impact. On the other hand, increases of only 70 or 80 points in a highly concentrated market (such as when one of four large competitors acquires a fifth small competitor) may not be considered anticompetitive.

The HHI is merely a tool of analysis for the FTC and Department of Justice. As a practical matter for parties evaluating the risks of a proposed merger, it is really only useful in urban communities with more than 8 or 10 hospitals. Given the number of communities with fewer than five hospitals, input from consumers and managed care entities about the potential effects of a merger are typically more important in analyzing the risk of the merger than any calculations of pre and post merger HHI. One recent study noted that only eight hospital mergers were challenged by The Agencies in the entire decade of the 1980’s, and thirteen
mergers during such period with HHI’s ranging from 1,927 to 10,000 were unchallenged by The Agencies.  

C. Defining the Ease of Entry by New Competitors

Whether new competitors can easily enter the relevant market served by the merging entities will influence The Agencies analysis of the merger’s competitive impact. The Agencies will attempt to answer three questions in analyzing the ease of entry: (a) can the new competitor obtain significant market share within a timely period; (b) if so, can the competitor achieve such market share and operate profitably; and (c) would such timely entry by new market participants be sufficient to return market prices to pre-merger levels? According to the horizontal merger guidelines, new entry will be “timely, likely, and sufficient” if the new market entrants can become effective competitors within two years.

As with the definition of product and geographic market, ease of entry is a very fact intensive determination. Outside forces such as a restrictive regulatory climate can affect the burden of proof that must be carried by merging entities. In states with certificate of need (CON) laws, for example, approval of a merger may be affected by the difficulties or delay in receiving CON approval for potential competitors. Such restrictions act as barriers to entry of new competitors, and may jeopardize approval of a merger.

D. Determining the Existence of Efficiencies

If competitors who desire to merge cannot prove that the merger would result in efficiencies and economies of scale that benefit not only the participants but consumers in the

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6 William G. Kopit and Tanya B. Vanderbilt, Unique Issues In the Analysis of Non-Profit Hospital Mergers, 35 Washburn L.J. 254, 256 (1997).
market place, the chances of a merger receiving approval are substantially diminished. The Agencies in the 1992 merger guidelines stated that they would consider claims of procompetitive efficiencies resulting from a merger, including claims of economies of scale, better integration of production facilities, plant specialization, lower transportation costs, and other efficiencies related to specific operations of the merging entities. The Agencies earlier this year went on to state they would consider only those efficiencies a) likely to be accomplished with the proposed merger, and b) unlikely to be accomplished in the absence of the proposed merger.

According to The Agencies, the claimed efficiencies must be verifiable, must not result from anticompetitive reductions in output or services, and must produce benefits net of the costs of the costs produced by the merger. The Agencies will be more likely to challenge a merger if cost savings are achieved through restrictions in output are are based only on the joint provision of services that could have been achieved without the merger. Merger participants must realize that efficiencies almost never justify a merger resulting in monopoly or near monopoly. Efficiency claims are likely to be acceptable to The Agencies only “on the margin”, that is, where the likely anticompetitive effects are not significant.

Courts also have generally shared The Agencies’ skepticism to claims of efficiencies. In Mercy Health, for example, the court found that the hospitals had not sufficiently proved that their claimed efficiencies could not be attained without the merger and had not been properly

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calculated. In short, claims of efficiencies are about as useful as claims that the check is in the mail.
E. Determine the Probable Consequences if No Merger Occurs (a/k/a The We’ll Go Out of Business Defense)

The merger guidelines also specify that The Agencies must consider the impact on the parties if the merger does not occur. The Guidelines note that to the extent that one of the parties is in danger of “imminent failure” such that its assets may exit the market without the merger, then the merger will be determined to be unlikely to create or enhance market power. Whether one of the parties is likely to go bankrupt or otherwise is in danger of imminent failure is a fact question for The Agencies and the courts. The DOJ has acknowledged that a failing hospital is more likely to provide deteriorating levels of care to patients, and that the community interest would not be served by forcing the hospital into bankruptcy. Despite acknowledging its applicability, however, The Agencies and the Courts look with disfavor on this defense.

III. PHYSICIAN NETWORKS

A. Applicable Law

Notwithstanding the large increase in hospital mergers the last few years, an even more typical example of provider consolidation which raises antitrust concerns is the formation of physician and provider networks. Such networks, such as IPA’s, are comprised of anywhere from 2-3 to 2000-3000 competitors, and typically are formed for the purpose of joint provision of care and joint contracting with managed care entities. Some networks even are formed from other smaller networks, perhaps a multi-specialty IPA comprised of constituent specialty IPA’s. Network participants do not integrate their practices, typically do not centralize their billing, and remain competitors in all other areas of their practice. They maintain their autonomy as sole practitioners, or smaller group practices.
Section 1 of the Sherman Act is the relevant federal law applicable to physicians or other providers forming networks that fall short of complete merger or integration. Section 1 of the Sherman Act prohibits contracts or conspiracies in restraint of trade. Criminal violations of section 1 are punishable by imprisonment not to exceed three (3) years, and civil penalties up to $10 million against individuals and entities engaging in anti-competitive behavior in violation of the law. Private causes of action for damages suffered due to a Sherman Act violation are also available. Such actions are subject to treble damage awards, and may be available even if the defendant complies with an antitrust “safety zone”.

Joint negotiation by competitors of contracts with managed care entities, if such negotiation includes negotiating price or price related terms, can constitute illegal price fixing. Price fixing by competitors is one activity condemned as a per se violation of the law. If a per se violation occurs, the reasonableness of the parties’ conduct, or the fact that the conduct may actually be procompetitive is irrelevant; the law is violated. As the FTC itself notes in its 1996 Policy Statements on Antitrust Enforcement Policy, “[a]ntitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal.”

B. Antitrust Enforcement Policies

In the healthcare field, the FTC and DOJ jointly since 1993 have published antitrust enforcement guidelines to give the provider community a better understanding of how those agencies will enforce the antitrust laws. In August 1996, The Agencies issued their third Statements of Antitrust Enforcement Policy since 1993. The Statements are designed to give the

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9 See 15 U.S.C. § 1, found at appendix.
provider community a better understanding of how the agencies primarily charged with enforcing federal antitrust laws views the multiplication of non-integrated contracting networks in the healthcare industry today. For those who hoped for additional clarification of FTC policy towards physician networks, the 1996 Statements provide useful insight. The Agencies themselves articulate their purpose as follows:

“The 1993 policy statements . . . were designed to advise the health care community in a time of tremendous change, and to address, as completely as possible, the problem of uncertainty concerning the Agencies’ enforcement policy that some said might deter mergers, joint ventures, or other activities that could lower health care costs. . . . [T]he Agencies continue to analyze all types of health care provider networks under general antitrust principles. These principles are sufficiently flexible to take into account the particular characteristics of health care markets and the rapid changes that are occurring in those markets. The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire.”

The hallmark of FTC enforcement as provided in the Joint Policy Statements in recent years has been the establishment of “safety zones”, under which otherwise per se violations would be reviewed under a rule of reason. One of the antitrust safety zones promulgated by The Agencies pertains to physician networks joint ventures such as IPA’s and PPO’s. That guideline provides that agreements among physicians to set prices and price-related terms in contracts to

10 The FTC and the Department of Justice jointly share responsibility for enforcing federal antitrust laws; the FTC primarily operates in the civil enforcement context, while Justice handles criminal investigations and complaints. The Agencies work hand in hand, however, and the 1996 Statements continue the FTC practice of issuing antitrust guidelines in conjunction with the Department of Justice.

provide medical services will not be held to be illegal *per se* (absent extraordinary anti-competitive circumstances), if the entities meet the requirements of the “safety zone.”

1. **Pre-1996 Policies**

Prior to the 1996 Statements, the physician network safety zone provided that a physician network which jointly negotiates prices with a payor and contains no more than 20% of the practicing physicians in each specialty in an “exclusive” network, or no more than 30% of the practicing physicians in a non-exclusive network, and where the physicians share “substantial financial risk”, would not be challenged by The Agencies. ¹²

The pre-1996 safety zones provided only two examples of sharing substantial financial risk: (1) when the venture agrees to provide services under a capitation contract, or (2) when the venture creates significant financial incentives for its members to achieve cost containment goals, such as withholding a substantial amount of the compensation due to them, with distribution of that amount only if the cost containment goals are met. The guidelines are careful to point out that other forms of economic integration may amount to sharing substantial financial risk and the above two examples are not exclusive.

The case law and the insight gleaned from business review letters and opinion letters issued from the FTC and DOJ indicate that absent a capitation contract, a 15% to 20% withhold in a fee-for-service contract would constitute substantial financial risk.

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¹² The exclusivity of a network - whether a physician legally can and actually will sign payor contracts outside of the network - is one of the most important factors from an antitrust perspective.
The pre-1996 guidelines also specified that if the physicians share substantial financial risk or if the physician joint venture offers a new product producing substantial efficiencies, then such a physician network falling outside of the safety zones does not necessarily violate the antitrust laws, but will be reviewed under a “Rule of Reason” analysis. Under the Rule of Reason, The Agencies look at and balance the pro-competitive aspects of the venture against any anti-competitive aspects. Thus, if a network contains 40% of the physicians in a specialty, but contracts exclusively for capitation contracts, the enforcement agencies will balance all the procompetitive aspects of the venture against any anticompetitive aspects. Only if the anti-competitive aspects outweigh the pro-competitive benefits of the venture will the conduct then be held to violate the antitrust laws.

2. Messenger Model

The FTC in the last 2-3 years has increased its scrutiny of IPAs and other physician network entities, particularly those operating under the so-called Messenger Model. Under the Messenger Model, physicians who otherwise would be competitors, but who are unwilling to integrate sufficiently to demonstrate that they share substantial financial risk, collect their respective fee information through a third party messenger, and the third party transmits that information to prospective payors. The payor then makes a proposal to the physicians and that proposal is transmitted through the messenger to the physicians individually for their acceptance.

The FTC previously has declared that the only acceptable true Messenger Model will be one in which the messenger does not negotiate any of the price terms of the agreement on behalf
of the individual physicians. If the Messenger Model is used, the antitrust agencies have emphasized in the enforcement guidelines, in business review letters, and in consent decrees with networks under investigation, that the messengers must do no more than simply convey pricing offers. The agent cannot negotiate and providers cannot reach any “agreement” regarding price.

The 1996 Statements do offer some additional messenger flexibility. Providers, for example, may give the messenger in advance a fee schedule or conversion factor representing the provider’s minimum acceptable fee, authorizing the messenger to accept contracts above that amount. Similarly, the messenger may bind providers to contracts with terms equal to or better than contracts previously accepted by the provider in the recent past. The messenger also may prepare a schedule displaying the numbers or percentages of providers at various price levels who are willing to contract at that level. While modest, the additional flexibility reduces the level of risk for most IPA’s utilizing a messenger approach.

Thus, a physician network essentially has two options. First, it may solicit and secure contracts for its members through a properly structured Messenger Model. That exception is a narrow one, and not one particularly attractive to payors who often wish to negotiate through one party, and sign one master contract. Therefore, if a physician network wishes to discuss and negotiate price and price-related terms with payors, it may only do so if it demonstrates it is an integrated joint venture. Up to this point in time, the hallmark of FTC enforcement efforts against physician networks which set or discuss prices has been whether the parties share substantial financial risk. The only realistic way for an IPA to demonstrate such risk sharing has been through exclusive use of capitation agreements, or fee for service contracts with the use of a 15%-20% withhold.
3. **The 1996 Statements**

The 1996 Statements modestly broaden the debate, and accomplish two primary purposes. They 1) slightly expand the scope of the current safety zones, providing an expanded definition of substantial financial risk, and 2) more clearly articulate what reasoning the agency will employ in assessing networks falling outside those safety zones. The second purpose will prove to be most useful to providers, as they assess the degree of risk of their own network.

**a. Substantial Financial Risk**

The expanded scope of the definition of substantial financial risk provides that evidence of substantial financial risk within a physician network may include: (1) capitation contracts, (2) percentage of premium contracts, (3) the use of financial incentives such as withholds or “rewards or penalties”, and (4) global or all inclusive rate contracts. If all of the contracts entered into by a network exhibit one or more of those characteristics, it would be evidence of substantial financial risk, and the FTC would evaluate the transaction under the Rule of Reason.

The most intriguing expansion of the safety zone is the concept of financial rewards or penalties evidencing substantial financial risk. The Statements provide that if a substantial withhold is not used, other evidence of risk sharing is: “establishing overall cost or utilization targets for the network as a whole, with the network’s physician participants subject to subsequent substantial financial rewards or penalties based upon group performance in meeting the targets.”

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It is difficult to understand how the reward/penalty test differs much from the withhold test, except that it appears to allow the network to distribute all income to the physicians in the first instance without a withhold. If targets are not met, physicians presumably would have to come out of their pocket (or out of future payments) for penalties; if targets are met, it’s not clear where the “rewards” would come from, since all monies have already been paid out. At first blush, the new test appears to eliminate the need for withholds, but networks adopting such an approach should be able to demonstrate how penalties will be enforced, and from where rewards will come.

b. Moving Outside the Zone

If the network does not utilize any of the financial risk sharing models described above, it cannot qualify for a safety zone. The network still can obtain rule of reason treatment, however, if other significant indications of integration are present. The Agencies offer helpful insight into the analysis they will employ in evaluating networks which don’t fit into the safety zone. As primary principles, The Agencies note:

“In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as *per se* illegal, if the physicians’ integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be *per se* illegal) by the network physicians are reasonably necessary to realize those efficiencies.

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“Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the networks physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and insure quality. This program may include: (1) establishing mechanisms to monitor and control
utilization of health care services that are designed to control costs and insure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objects; and (3) a significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.” 14

c. Clinical Integration

Perhaps the most significant development in enforcement policy found in the 1996 Statements was buried in a brief discussion at the end of the Statements. The Agencies discuss a new model that merits rule of reason treatment even though it does not involve the sharing of financial risk among its participants. This so called “clinical integration” test is a strict one. It cannot be used by sham networks as a means to avoid substantial financial risk sharing; rather a network must be able to show it has in place and operating many of the characteristics described below. In a hypothetical example cited by The Agencies as an acceptable clinically integrated network, the Statements find numerous characteristics of a non-financial risk sharing IPA as justifying rule of reason treatment. Such an IPA must perform some or many of the following functions:

(1) implement systems to establish goals relating to quality and appropriate utilization of services by IPA participants,
(2) regularly evaluate both individual participants’ and the network’s aggregate performance with respect to those goals,
(3) modify individual participants’ actual practices where necessary,
(4) engage in case management,

14 Id. at p. 20,817.
(5) provide preauthorization of some services,

(6) engage in concurrent and retrospective review of inpatient stays,

(7) develop practice standards and protocols,

(8) actually review care in light of standards and protocols,

(9) make a significant investment in information systems to gather data, measure performance against cost and quality benchmarks, and monitor patient satisfaction,

(10) provide payors with detailed reports on cost and utilization, and success of meeting network goals,

(11) hire a medical director and support staff,

(12) doctors invest appreciable time in developing standards and protocols and will actively monitor care rendered through the network.

Few IPA’s in the country currently have all the attributes described above. Probably few group practices or even HMO networks could measure up to every item of the FTC clinical integration model. Nonetheless, it gives physicians a laundry list of factors to be considered in setting up their network. The greater number of the above functions that a network conducts, the greater likelihood of acceptance by the FTC.

IV. OUTLOOK

The five-day forecast for antitrust enforcement appears brisk. In the hospital merger arena, the failure of The Agencies to challenge more hospital mergers in the last 15 years does not accurately predict the future. The large scale acceleration of hospital mergers in the last 3
years, and the recent challenge by the DOJ of a hospital merger on Long Island \textsuperscript{15} indicates that The Agencies will be vigilant in enforcing federal antitrust laws governing mergers and acquisitions in the healthcare industry.

For physician networks, The 1996 Statements were not the hoped for breakthrough in healthcare antitrust enforcement policy. They do not apply rule of reason treatment across the board to physician networks. While the safety zones for physician networks were expanded slightly, and additional analysis and guidance were offered to assist providers and their advisors in complying with antitrust laws, the result for physicians forming contracting networks is that antitrust laws must still scrupulously be observed, and naked attempts to jointly set prices without significant evidence of integration through financial risk sharing or substantial clinical integration, will be treated as \textit{per se} violations of the law. Networks whose real underlying purpose is to enhance the bargaining abilities of their participants, preserve existing market share, or keep other competitors from entering the market or increasing their market share, are likely to draw antitrust scrutiny and sanction. Networks wishing to avoid such exposure should 1) utilize a pure Messenger Model, 2) make financial risk sharing a centerpiece of their network, or 3) provide a real and significant clinical integration likely to benefit patients and payors.

In the end, the question for all healthcare providers contemplating consolidation through merger or network development, where any antitrust risk exists, is how well do you want to sleep at night?

\textsuperscript{15} Deanna Bellandi, \textit{Back In Business, Modern Healthcare}, June 16, 1997, at 2. The challenge was the first DOJ enforcement action against a hospital merger since 1994.
APPENDIX

FEDERAL ANTITRUST LAWS