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## Cooperation and Competition Panel – Working Papers

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## Introduction

1. This paper reviews the enforcement of US antitrust (or competition) law in the healthcare sector by the two US federal agencies responsible for antitrust enforcement, namely the Department of Justice (DoJ) and the Federal Trade Commission (FTC). With the announcement that the jurisdiction of UK competition authorities and competition law will extend into the NHS, this paper provides a timely look at the experience of competition law enforcement in healthcare in the US.
2. The paper begins with an introduction to the antitrust enforcement framework in the US and the role of insurance in US healthcare. Subsequent sections review the enforcement action that has been taken against collusion between providers, anti-competitive agreements between providers and hospital, and anti-competitive agreements between insurers and providers. The final section provides a brief look at the remedies that have been adopted for antitrust violations.

## Application of antitrust laws in US healthcare

3. In 1982, in *Maricopa*, the Supreme Court held for the first time that US antitrust laws apply to the healthcare industry.<sup>1</sup> Prior to this ruling, there was an assumption that healthcare providers were exempt from US antitrust laws because they had a natural monopoly on the provision of healthcare services. Since *Maricopa*, the Department of Justice (DOJ) and Federal Trade Commission (FTC) [together “the Agencies”] have enforced the antitrust laws against anticompetitive conduct in the US healthcare industry.
4. This paper focuses on the antitrust enforcement action of the Agencies in three specific areas: conduct of (and agreements between members of) independent physician associations (IPAs), conduct of (and agreements between members of) physician-hospital organisations (PHOs), and agreements between insurers and providers. The final section of the paper briefly discusses the remedies sought by the Agencies against antitrust violators.

## Section 2 - Enforcement Framework of the Agencies

5. The DOJ and the FTC are the two federal administrative bodies that enforce US antitrust laws. Compared to the FTC, the DOJ has a closer working relationship with other Executive Agencies and takes a more criminal, prosecutorial approach to antitrust enforcement. Because of its regulatory function, the FTC has a closer working relationship with Congress and the businesses that it regulates.<sup>2</sup> Despite these differences in enforcement, the FTC and DOJ have worked together in recent years to publish antitrust compliance guidelines for businesses with and cooperate with one another in determining the best course of action to resolve antitrust cases.<sup>3</sup>

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<sup>1</sup> (Arizona v. Maricopa County Med. Soc'y, 1982)

<sup>2</sup> (American Lawyer Media)

<sup>3</sup> (About the DOJ)

6. The FTC is an independent administrative body created by federal statute. The FTC, through its Bureau of Competition, enforces the antitrust laws, investigates potentially anticompetitive conduct, and reviews proposed mergers.<sup>4</sup> The FTC receives the power to investigate and enforce the antitrust laws through two acts, the Federal Trade Commission Act<sup>5</sup> and the Clayton Antitrust Act.<sup>6</sup>
7. If anticompetitive conduct exists, the FTC may choose to bring the case before an Independent Administrative Law Judge (IALJ), with the FTC acting as prosecutor. The decision of the IALJ is reviewed by the Commissioners of the FTC, who may affirm or reject the decision of the IALJ. The decision of the Commissioners may be reviewed by the US Court of Appeals, and ultimately, by the Supreme Court of the United States. Rather than using this administrative procedure, the FTC may choose to directly file civil charges against parties in Federal Court. Alternatively, instead of charging the parties, the FTC may choose to enter into a consent decree with parties, which is a settlement agreement that stipulates certain conditions to which the parties must adhere to remedy anticompetitive conduct.<sup>7</sup>
8. The decisions of the FTC Commission are part of the body of administrative case law. FTC rulings may be reviewed by a Court of Appeals and, on final appeal, by the Supreme Court. However, because the FTC was created by legislative action with the purpose of giving it the ability to set policy in the area of competition law, the FTC is given broad deference by the courts when an FTC decision is under review.<sup>8</sup>
9. The DOJ is a federal executive department that is responsible for the enforcement of law and the administration of justice.<sup>9</sup> The DOJ is headed by the United States Attorney General<sup>10</sup> and the antitrust division is headed by the Assistant Attorney General for Antitrust, both of whom are appointed by the President of the United States. As a member of the President's cabinet, the appointment of the Attorney General must also be confirmed by the Senate.
10. The Antitrust Division of the DOJ works concurrently with the FTC on civil antitrust cases. Unlike the FTC, the DOJ does not have an administrative adjudication procedure. Instead, the DOJ files charges in against antitrust violators in federal court. Also unlike the FTC, the DOJ has the power to file criminal charges. If criminal charges are not an appropriate measure, the DOJ may instead file an injunction in civil court to restrain parties from continuing to engage in anticompetitive conduct. The DOJ may also choose to resolve a competition case through a settlement agreement, in which parties agree to refrain from certain anticompetitive conduct.<sup>11</sup>
11. Along with enforcement action taken by the Agencies, individuals may file antitrust claims in state or federal court for damages that stem from violation of the antitrust laws. Furthermore, state prosecutors (acting on behalf of citizens of a particular state) may file antitrust actions in state or federal court. This paper, however, focuses on enforcement action taken by the Agencies rather than claims filed by individuals or at the state level.

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<sup>4</sup> (Federal Trade Commission, Competition Bureau )

<sup>5</sup> 15 U.S.C §§ 41-58

<sup>6</sup> 15 U.S.C. § 12–27, 29 U.S.C. § 52–53

<sup>7</sup> (Federal Trade Commission, Competition Bureau )

<sup>8</sup> (A Brief Overview Of The Federal Trade Commission's Investigative and Law Enforcement Authority , 2008)

<sup>9</sup> (About the DOJ)

<sup>10</sup> Id

<sup>11</sup> Id.

## The Role of Insurance in the U.S. Healthcare Marketplace<sup>12</sup>

12. The financing of healthcare services in the US is complex and varied. However, certain generalizations about the role of insurance in the financing of US healthcare can be made to place antitrust enforcement into context.
13. In the US, public funds cover about 45% of healthcare costs, private insurance covers about 40% of costs, and the remaining 15% of healthcare costs are consumer out-of-pocket expenses.<sup>13</sup>
14. Although the US healthcare system is largely run by private companies, government regulation and public funding still have a significant effect on the market. The Center for Medicare and Medicaid Services (CMS), a federal agency, is the largest public payer in the United States.

### Publicly-funded Healthcare: Medicare and Medicaid

15. CMS is responsible for the administration of Medicare and, in partnership with state governments, the administration of Medicaid. In 2009 Medicare and Medicaid paid for approximately \$880 billion in health care expense (\$500 billion and \$334 billion, respectively).<sup>14</sup> Medicare provides coverage for approximately 40 million elderly and disabled Americans. Medicaid provides coverage for approximately 50 million low-income Americans and children.<sup>15</sup>
16. Medicare has four parts in total. Part A covers hospital stays and brief stays in nursing care facilities. Most US residents aged 65 and older qualify for Medicare Part A. Medicare Part B is general medical insurance that covers outpatient hospital care and other general medical care, such as doctor's appointments, blood work, and x-rays. Part C gives Medicare beneficiaries the option of receiving their Medicare Part A and Part B benefits through a private insurance company, rather than through CMS. Finally, Medicare Part D is a prescription drug plan that subsidizes the cost of medication for Medicare enrollees. Anyone that is enrolled in Part A or Part B is eligible for Part D. Unlike Parts A through C, Part D benefits are administered by private insurance companies and are not standardized.
17. Beginning in 1983, CMS moved away from a cost-based reimbursement system for Medicare in-patient hospital services (Medicare Part A) and introduced the inpatient prospective payment system (IPPS). IPPS was intended to reduce hospital costs by providing incentives for physicians to contain costs by basing reimbursement on fee schedules of the average cost of treatment for particular diagnoses, rather than on the actual cost of treating particular patients. Since the introduction of IPPS, CMS has developed similar types of payment systems for Part B care to incentivise providers to control costs. Because CMS is such a large buyer in the healthcare marketplace, many private insurers piggyback on the payment systems implemented by CMS.
18. Medicaid is funded by both state and federal governments. The program is administered by the state government with oversight by CMS to ensure compliance with the general Medicaid framework. Unlike Medicare, Medicaid is a means-tested social welfare program, rather than a social insurance entitlement

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<sup>12</sup> (Department of Justice and Federal Trade Commission, 2004), Chapters 3 and 5.

<sup>13</sup> (Department of Justice and Federal Trade Commission, 2004)

<sup>14</sup> (Pickert, 2010)

<sup>15</sup> (Department of Justice and Federal Trade Commission, 2004)

program. Although the establishment of poverty is necessary to qualify for the program, other factors, such as age and disability status, are considered in establishing eligibility. Eligibility qualifications vary by state.

19. The state administration of Medicaid benefits varies widely. For instance, some states choose to delegate the administration of the program to private insurance companies to deliver benefits more efficiently, whilst other states choose to pay providers directly for services rendered.

### **Private Insurance**

20. About 60% of Americans are covered by a private insurance plan provided by their employer.<sup>16</sup> Usually, employers acquire a group plan by bargaining with an insurer on behalf of employees. Some large employers may choose to fund employee health through self-insurance. The remainder of privately insured persons, about 9% of Americans, are insured through individually acquired health insurance plan.<sup>17</sup>
21. Large employers may be able to provide employees with better health coverage than persons with plans from small employers, or plans acquired individually, because large employers have enhanced bargaining power with insurers as a result of having more employees and more resources to devote to researching and acquiring employee coverage. The federal government incentivises employer-provided coverage by providing tax incentives to employers for providing coverage.

### **Managed Care**

22. During the early 1970s, most health insurance plans were fee for service (FFS) indemnity plans. The premiums on these types of plans are high, but the insured receives a full reimbursement for medical costs and are not limited to a particular network of physicians. Instead, FFS indemnity plans cover medical expenses, regardless of what doctor the patient visits. Because the insured and physicians do not bear the full economic costs of their decisions, the use of FFS plans was regarded as resulting in a large increase in medical costs due to the overconsumption and overprovision of healthcare services. In response to the passage of legislation by Congress and rising medical costs, health insurance companies began managing the supply of and demand for healthcare services by directly negotiating with providers and placing conditions patient access to care. These new types of health insurance plans became known as managed care.
23. Managed care organizations (MCOs) have become the predominant type of private healthcare payer. Managed care organizations lower healthcare costs by using a variety of tools to incentivise patient and provider behaviour. Examples of managed care tools include requiring physicians to pre-authorise the use of certain procedures, creating a network of preferred providers, restricting patient access to specialists, emphasizing preventative care, comprehensive disease management for chronic illness, limiting benefits, capitated (per person) payment systems, practice guidelines for providers, and higher co-payments (or complete denial of coverage) when patients seek out-of-network care.
24. In recent years, there has been a backlash against MCOs. Patients have complained about restricted choices, lower quality of care, and limited access to medically necessary procedures, and physician groups have argued that MCOs undermine their clinical judgment as well as their relationship with patients. As a

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<sup>16</sup> (U.S. Census Bureau , 2008)

<sup>17</sup> (U.S. Census Bureau , 2008)

result of these complaints, less restrictive forms of managed care have become much more popular in recent years<sup>18</sup>, such as open provider networks and tiering plans.

25. MCOs act as both buyers and sellers in the healthcare marketplace. MCOs sell healthcare plans to consumers (“the insured”) and buy healthcare services from providers. MCOs are able to provide the insured with healthcare at a lower cost by pooling risk, and using bargaining power to negotiate lower prices with physicians, and by using managed care tools to manage demand and supply for healthcare services. Providers benefit from having access to the MCO’s pool of customers as a guaranteed source of income.

### **The insured**

26. An insured person would typically follow certain patterns of healthcare consumption based on the terms of his health insurance plan and other factors, such as convenience.
27. Most insured Americans have a primary care physician. The insured would go to a primary care physician for annual checkups and the treatment of minor ailments. The insured’s ability to choose a provider depends on the terms of his health insurance plan. For example, certain plans that give the patient more choice may allow a plan member to see a wide variety of primary care physicians and to change physicians at will. A more limited plan may designate a primary care physician for the plan holder based on his geographic location. Typically, an insurance plan that gives a patient more choice will charge a plan holder higher premiums, higher co-payments, or both.
28. If the insured requires treatment from a specialist, some health insurance plans may require that the primary care physician provide the patient with a referral. Again, the amount of control that the health insurance plan has over the patient’s choice of specialist or ability to access a specialist would depend on the terms of the plan.
29. Dental, vision, and mental health care, may not be covered by a basic insurance plan and may require supplemental insurance. Furthermore, other types of care, such as pre-natal care, may not be covered by the terms of some health plans.

### **The Uninsured**

30. In 2008, it was estimated that 15% of Americans lacked healthcare coverage for at least some part of the year<sup>19</sup> and that up to 12% of Americans were “under-insured” because their health insurance did not provide adequate coverage for their medical costs.<sup>20</sup>
31. Uninsured persons are more likely to need serious care for major ailments, because they tend to delay treatment rather than seeking preventative care.<sup>21</sup> The uninsured are also much more likely to seek care at a hospital emergency room because hospitals are not permitted to turn away emergency room admissions, whether or not a patient has insurance.

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<sup>18</sup> (Department of Justice and Federal Trade Commission, 2004)

<sup>19</sup> (U.S. Census Bureau , 2008)

<sup>20</sup> (Cathy Schoen, 2005)

<sup>21</sup> (Department of Justice and Federal Trade Commission)

32. Because uninsured persons are often unable to fully pay for the care that they receive, the remainder of this cost falls on providers, the insured and the taxpayer.

## **Enforcement Action against Independent Physician Associations**

### **Providers in the U.S. Healthcare Marketplace**

33. Physician services comprise 22% of healthcare spending in the United States.<sup>22</sup> Some physicians operate an independent private practice, whilst others become a member of a joint venture with other physicians or a hospital. Physician and physician-hospital joint ventures may provide pro-competitive efficiencies to consumers and reduce transaction costs in contracting between insurers and providers. However, physician and physician-hospital joint ventures may pose anticompetitive concerns when they allow members to fix prices or engage in other anticompetitive conduct.

### **The Agencies have a Policy against Collective Bargaining between Competing Providers**

34. Horizontal agreements between competing physicians, particularly agreements on price and price-related terms, have come under heavy scrutiny by the Agencies for antitrust violations. Some physician groups have lobbied heavily for an antitrust exemption so that physician groups are able to bargain collectively with managed care; however, it is the position of the Agencies that giving physicians the right to collectively bargain will result in higher prices for consumers without achieving any countervailing pro-competitive benefits.<sup>23</sup>

### **Independent Physician Associations resulted from the rise of managed care**

35. During the 1980s, physicians attempted to increase their bargaining power against managed care plans by forming physician network joint ventures (PNJVs). This paper focuses on a specific type of PNJV, the Independent Provider Association (IPA). IPAs are networks of independent physicians that contract with managed care organizations and employers. Physician members generally own IPAs, but hospitals, individual physicians, or physician management companies may also have ownership.<sup>24</sup> An IPA may be structured so that the member-physicians of the IPA are clinically integrated, financially integrated, both, or not at all.

### **The Agencies analyse conduct under two different possible levels of review**

36. Potentially anticompetitive conduct of an IPA may be reviewed under either the *per se* rule or the rule of reason. Conduct is *per se* illegal when it fits into a category of conduct that has been reviewed in the past and has been determined to have no underlying, pro-competitive benefits. The Agencies will not consider efficiencies created by the conduct or other pro-competitive justifications for the practice. When conduct is reviewed under the rule of reason, potentially anticompetitive conduct is weighed against the potential pro-competitive effects, such as improved quality and improved efficiency, of the conduct. If a particular type of conduct has not been reviewed in the past, the reviewing body (the DOJ, FTC, or a Court) must determine whether the conduct at issue should be scrutinized under the *per se* rule or the rule of reason.

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<sup>22</sup> (Department of Justice and Federal Trade Commission, 2004)

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

37. Determining whether to apply the *per se* rule or the more complex rule of reason to the joint pricing arrangement of an IPA depends on whether the IPA is sufficiently financially or clinically integrated to achieve pro-competitive efficiencies and the extent to which joint pricing is reasonably necessary to achieve the efficiencies created by the integration.<sup>25</sup>

### **The Antitrust Safe Harbour**

38. If an IPA meets certain prerequisites, the conduct of the venture will be exempt from antitrust laws, absent extraordinary circumstances.<sup>26</sup> In order for the exemption to apply, the IPA must be substantially financially integrated (see *infra* for information on sufficient financial integration) and must not include more than a certain percentage of physicians in the relevant market.<sup>27</sup>
39. The Agencies have also created a set of guidelines that allow healthcare providers to exchange information on price and cost with competitors and to collectively provide price, fee, and non-fee related information to purchasers when it is likely to produce benefits for consumers. The details of both of these safe harbour provisions are contained in Healthcare Statement 8.<sup>28</sup>

### **In order to escape antitrust liability under the *per se* rule, IPAs must have sufficient financial or clinical integration or adopt an effective messenger model system**

40. Without sufficient financial or clinical integration, the conduct of an IPA will be scrutinized under the *per se* rule.<sup>29</sup> IPAs that collectively bargain with payers on behalf of independently operating physician members, run the risk of antitrust liability if they facilitate price agreement among their members.
41. For example, In *Surgical Specialists of Yakima (SSY)* (consent order 14.11.2004), the FTC charged that SSY, an IPA that lacked financial or clinical integration, facilitated collectively bargaining among its member-physicians with health plans by instructing its members to terminate or threaten to terminate their contracts with payers if the group's demands for significantly higher fees were not met.<sup>30</sup> Similarly, in a more recent case, *Alta Bates Medical Group (ABMG)* (consent order issued 10.07.2009), the FTC charged that the conduct of ABMG, an IPA that lacked financial and clinical integration, facilitated price fixing between IPA members because the IPA entered into agreements with payers on price and other terms without consulting individual physicians about the prices they would unilaterally accept, and without transmitting payers' offers to its individual physician members until ABMG had approved the negotiated prices.<sup>31</sup>

### **The Messenger Model System**

42. The Agencies may also allow an IPA to bargain on behalf of its members if the IPA has implemented an effective messenger model system. Messenger models are "arrangements to allow networks of providers to contract with payers, while avoiding any agreement on price among the providers and sometimes use a 'messenger' to facilitate contracting. The payer usually submits a proposed fee schedule to an agent or

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<sup>25</sup> (Department of Justice and Federal Trade Commission)

<sup>26</sup> *Id.* at 1,2.

<sup>27</sup> *Id.*

<sup>28</sup> For more information please see: <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>

<sup>29</sup> (Federal Trade Commission, 2010)

<sup>30</sup> (Federal Trade Commission, 2010)

<sup>31</sup> (Federal Trade Commission)

third party, who transmits this offer to the network physicians. Each physician decides unilaterally whether to accept the fee schedule and the agent transmits those decisions to the payer. Providers may also individually give the messenger information about the prices or other contract terms that the provider will accept, and the messenger aggregates this information and markets it to payers.”<sup>32</sup> The FTC provides guidance to IPAs that wish to avoid antitrust liability in the use of a messenger model in Healthcare Statement 9.<sup>33</sup>

43. If an un-integrated IPA uses a messenger model improperly and physician-members are able to bargain collectively on price, the Agencies will find that the conduct is anticompetitive under the *per se* rule. For instance, in *Health Care Alliance of Laredo (HAL)*, C-4158 (consent order issued March 23, 2006), the FTC charged that HAL, an un-integrated IPA, lacked an effective messenger model system for several reasons. First, the Board of Managers (“Board”) of HAL authorized and directed the contract negotiation process with payers. The Board failed to messenger rates proposed by individual physician members back to payers, and HAL only approved rates that were set by the Board, rather than rates approved by physician-members. The FTC also charged that the Executive Director of HAL facilitated price fixing by conducting surveys regarding fees and discounts that the members would accept from the health plans.

#### **Indicia of sufficient financial integration**

44. The Agencies provide rule of reason analysis to the conduct of sufficiently financially integrated IPAs because integration is normally a reliable indicator that the network will achieve significant efficiencies, such as lower costs and improved quality of care.<sup>34</sup> According to Healthcare Statement 8, the Agencies will consider the following factors as indicia of sufficient financial integration<sup>35</sup>
- agreements by the venture to provide services to a health plan at a “capitated” rate (ie per patient);
  - agreements by the venture to provide designated services, or classes of services, to a health plan for a predetermined percentage of premium or revenue from the plan;
  - use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:
    - i. withholding from all physician participants in the network a substantial amount of compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost containment goals of the network as a whole; or
    - ii. 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 on group performance in meeting the targets; and
  - agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment can vary greatly due to the individual patient’s condition, the choice, complexity, or length of treatment, or other factors.
45. Sufficient financial integration makes it “incumbent upon the group to share financial risk in such a way that each member has an economic incentive to ensure that the group as a whole produces material efficiencies that will benefit consumers.” If the financial integration creates demonstrable benefits for consumers and

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<sup>32</sup> (Department of Justice and Federal Trade Commission, 2004)

<sup>33</sup> For more detailed information on this topic, please see <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement9.htm>

<sup>34</sup> (Department of Justice and Federal Trade Commission)

<sup>35</sup> Id at 3.

joint pricing is reasonably necessary to achieve these efficiencies, the joint pricing arrangement will comply with general antitrust principles under rule of reason analysis.<sup>36</sup>

#### **Indicia of Clinical Integration:**

46. Since 1996, the Agencies have adopted a policy of encouraging the clinical integration of IPAs and other physician organisations when the clinical integration is likely to result in innovation and efficiency in healthcare delivery that provides benefits to consumers.<sup>37</sup> If the joint venture is sufficiently clinically integrated, its conduct (and conduct of/ agreements between its members) will be analysed under the rule of reason.
47. Indicia of sufficient clinical integration may include: 1) The establishment of mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; 2) selectively choosing network physicians who are likely to further these efficiency objectives; and 3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies. This list is not exhaustive, and the Agencies will also consider forms of clinical integration when it can be established that it is likely to produce benefits for consumers.<sup>38</sup>
48. Joint negotiations on price or price-related terms of clinically integrated providers will be in line with general antitrust principles to the extent that the joint pricing or other conduct is reasonably necessary to achieve substantial efficiencies resulting from the clinical integration. If the purpose of the clinical integration is to fix price in order to subvert the antitrust laws, the arrangement is an unlawful cartel or conspiracy and is *per se* illegal.<sup>39</sup>
49. When a physician group wishes to implement a clinical integration plan that involves joint contracting, the FTC is likely to ask the following questions when determining whether the integration plan is in line with antitrust principles:
  - What do physicians plan to do together from a clinical standpoint?
  - How are these activities designed to improve quality of care, reduce the cost of care or produce other efficiencies?
  - How will the program foster interdependence among physician participants?
  - How will physicians be motivated collectively to achieve the program's goals?
  - How significant will the physicians' investment in the program be?
  - How will performance be monitored and measured?
  - Why is joint price negotiation reasonably necessary to achieve the program's intended goals?
  - What are the likely competitive effects of joint negotiation?<sup>40</sup>

#### **Recent FTC Advisory Opinions on Clinical Integration of IPAs**

50. Recent Advisory Opinions issued by the FTC on specific clinical integration proposals submitted by provider networks clarify what elements of clinical integration plans are key to antitrust compliance.

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<sup>36</sup> (Department of Justice and Federal Trade Commission, 2004)

<sup>37</sup> *Id* at 4.

<sup>38</sup> *Id*.

<sup>39</sup> (Department of Justice and Federal Trade Commission)

<sup>40</sup> (Department of Justice and Federal Trade Commission, 2004)

51. In 2002, the FTC approved joint contracting of the physician-members of MedSouth, Inc. (a multispecialty IPA) as part of a clinical integration plan. The plan had two major parts<sup>41</sup>:
- First, the creation of an electronic clinical database that would allow physicians to access and share patient data.
  - Second, the implementation of clinical practice guidelines and performance measurement of individual physicians, as well as the network as a whole, based on benchmarks and clinical performance goals. Physicians that do not fully participate in the plan or meet quality standards would be disciplined or terminated.
52. MedSouth claimed that the clinical integration was likely to improve patient care and outcomes, reduce medical errors, and improve patient services by enhancing efficiency and reducing cost.<sup>42</sup>All MedSouth physicians would be required to participate in the activities and contract with payers under the plan. However, the plan would be nonexclusive, so payers would still be able to contract with individual physicians if they did not wish to contract with the IPA.
53. The FTC found that joint contracting was reasonably necessary to achieve the efficiencies created by the clinical integration for two reasons:
- First, for the clinical integration to succeed, MedSouth had to assure that all physician-members would participate, and without joint contracting, MedSouth would be unable guarantee physician-member participation in the scheme.
  - Second, joint contracting enabled MedSouth to allocate financial returns to physician-members that would create incentives for members to invest in the integration plan.
54. The FTC found that, on balance, the plan “appears to be capable of creating substantial partial integration of the participating physicians practices, and to have the potential to produce efficiencies in the form of higher quality or reduced costs for patient care services.”<sup>43</sup> However, in its advisory letter, the FTC warned that it would closely monitor the activities of MedSouth to look for anticompetitive activities such as abuse of market power and price collusion by member-physicians for non-network services.
55. In 2007, the FTC revisited the MedSouth case to see if the clinical integration had created any anticompetitive issues. Although the FTC did not take action against MedSouth for antitrust violations, it expressed the following concerns:
- since the approval of the clinical integration in 2002, there had been a steep decline in the number of physicians participating in the scheme, which had decreased the pro-competitive benefits of the clinical integration and justification for joint contracting with payers;
  - the integration plan lacked safeguards to ensure that physician-members were unable to share competitively sensitive information; and
  - the network lacked a mechanism to expel physicians that did not comply with the benchmark and compliance goals of the program.<sup>44</sup>
56. In a case similar to MedSouth, in its 2007 advisory letter to Greater Rochester Independent Practice Association, Inc., (GRIPA) September 17, 2007, the FTC approved a joint contracting arrangement as part of

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<sup>41</sup> (Heather Holden Brooks, 2009).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

a clinical integration proposal between independent physicians and hospital -affiliated primary care physicians and specialists.<sup>45</sup> GRIPA's clinical program was intended to enhance patient care and create efficiencies and involved more than 500 physicians with over 40 specialty areas represented. The clinical integration replaced a joint-contracting program based on risk-sharing arrangement, and the FTC considered the integration to be a "new product".<sup>46</sup>

57. The FTC emphasized the following aspects of clinical integration for approval of GRIPA's plan: "participation by a broad spectrum of specialists and the system of referrals to physicians within the network; a 'serious' effort to encourage physician compliance through monitoring and potential expulsion; the high degree of investment by physicians; the implementation of benchmarks; and the necessity of integration to achieve these efficiencies".<sup>47</sup>
58. The FTC found that GRIPA's joint contracting arrangement would be unlikely to discourage competition because it was nonexclusive ie payers would still be able to contract with individual physician-members if unable to reach an agreement with GRIPA.<sup>48</sup> However, the FTC warned GRIPA that it should not facilitate price agreements between member-physicians on services provided outside of the clinical integration arrangement.<sup>49</sup>
59. Although GRIPA admitted that it intended to charge higher prices for certain services than previously charged under the risk sharing arrangement, the FTC found that the higher prices could be justified by improvements in quality of care.<sup>50</sup>

#### **Takeaways from the recent clinical integration cases involving IPAs**

60. In both the MedSouth and GRIPA cases, several factors were key to the FTC's approval of the clinical integration proposals:
  - IT and clinical protocols: The extent to which the clinical integration actually changes physician behaviour through the use of health IT, clinical guidelines, comprehensive disease management, and other forms of clinical integration.
  - Non-exclusivity: non-exclusive networks are less likely to have anticompetitive effects because they are still able to negotiate with individual IPA members, assuming physician-members are willing to compete on an individual basis with one another for non-IPA services.
  - Composition of the IPA: Clinical integration that involves a broad range of specialists and a large number of clinical diagnoses will be more likely to produce pro-competitive benefits in which the physician-members have a high degree of investment in the program.
  - Clinical integrations that result in a "new product" are more likely to have pro-competitive benefits
  - Monitoring the inclusion in the plan of a monitoring program that disciplines and expels noncompliant member-physicians.
  - Reasonably Necessary: If joint pricing is reasonably necessary to achieve the efficiencies created by the clinical integration.

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<sup>45</sup> (Heather Holden Brooks, 2009)

<sup>46</sup>

<sup>47</sup> *Id*

<sup>48</sup> *Id* at 4.

<sup>49</sup> *Id*

<sup>50</sup> *Id*

## **Enforcement Action against Physician Hospital Organizations**

61. Physician-hospital organizations (PHO) are joint ventures between physicians, or groups of physicians (such as IPAs), and hospitals. Physicians usually have admitting privileges at the participating hospitals. Members of a PHO may be financially integrated, clinically integrated, both, or not at all.
62. A PHO may have one hospital or a network of hospitals participating in the venture. There is great variance in the relationship that participating hospitals have with one another. For example, hospitals may be financially interdependent, loosely associated (for example, member-hospitals may participate in a best practices program), or completely independent from one another.
63. The PHO may be an open network, where most medical personal are permitted to join, or a closed network where the hospital selects physicians based on specific criteria. A physician may have an exclusive or nonexclusive relationship with a PHO. Closed PHOs are more likely to develop exclusive relationships with physicians.
64. PHOs may create antitrust issues in both the hospital and physician markets. PHO conduct and agreements between PHO members are analysed under the rule of reason (see paragraphs 23 and 24, *supra*, for a discussion of per se and rule of reason analysis).

### **Dominant PHOs that lack financial or clinical integration may not engage in price-fixing.**

65. If a PHO with a dominant position in the hospital or physician market lacks sufficient clinical or financial integration, price-fixing or other anticompetitive conduct will violate general antitrust principles. For example, in a 2010 consent decree, the FTC charged that Minnesota Rural Health Cooperative (MRHC), an un-integrated PHO with a dominant position in the hospital market, was engaged in illegal price fixing.<sup>51</sup>
66. When members joined MRHC, they agreed that the group's board of directors would negotiate and contract with health insurers on their behalf and that they would abide by the MRHC contracts. MRHC threatened to terminate its contracts with payers that did not go along with MRHC's rate increases. Payers that wanted to contract with individual MRHC members were told that they must negotiate with MRHC, and payers that attempted to contract with individual physicians or hospitals were referred back to MRHC.
67. The FTC found that because MRHC contracted jointly on behalf of its members, forced payers to accept higher rates by threatening to cancel its contract with payers, and barred payers from contracting with individual MRHC members without going through the MRHC board, the PHO was engaged in fixing pricing that was *per se* illegal.

### **Use of the Messenger Model by PHOs**

68. Like IPAs, PHOs that lack integration may use a messenger model system to avoid antitrust liability when negotiating with payers. (For a discussion of the messenger model system, see paragraph 29, *supra*.) However, if the messenger model fails to prevent price collusion between PHO members, the PHO will be liable under the antitrust laws.

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<sup>51</sup> <http://govpulse.us/entries/2010/06/29/2010-15745/minnesota-rural-health-cooperative-analysis-of-the-agreement-containing-consent-order-to-aid-public->

69. For instance, in a 2003 consent decree, the FTC charged that Piedmont Health Alliance (PHA), a PHO that lacked financial or clinical integration, was engaged in price fixing. Despite adopting a messenger model system, the FTC charged that the Board of Directors of PHA continued to fix prices, by negotiating price-related contract terms and by delivering price information to its members.

**PHOs with Sufficient Financial and Clinical Integration will be evaluated under Rule of Reason analysis**

70. Like IPAs, PHOs that have sufficient financial or clinical integration will be evaluated under rule of reason analysis. (For a discussion of financial and clinical integration, see paragraphs 31 through 36, *supra*.)

**Recent FTC cases that involve the clinical integration of PHOs**

71. Recent FTC advisory opinions shed light on what criteria the Agencies use to analyze the clinical integration of PHOs. In its 2009 advisory opinion to Tristate Health Partners (THP), the FTC approved a proposal by a PHO to clinically integrate members' provision of healthcare services and to contract jointly with health plans and other payers on a fee for service basis. The FTC found that the Tristate plan was a *bona fide* joint venture among Tristate members and had a real potential to reduce costs and improve quality of care for patients. The clinical integration involved over 200 physicians, including generalists and specialists, and one hospital.<sup>52</sup> The clinical integration included the implementation of health IT, practice guidelines, monitoring and feedback of physician performance, medical and disease management, and collaboration with payers on designing the clinical elements of the program.

72. Several key factors were important to the FTC's *approval* of THP's clinical integration program:

- Particularly significant to the FTC decision was that the clinical integration resulted in a set of integrated services (a "new product") that were not available to consumers before the clinical integration occurred. This "new product" was likely to produce significant efficiencies that would benefit consumers, and joint contracting with payers was reasonably necessary to achieve these efficiencies.
- Also significant to the approval of THP's plan is that the clinical integration involved significant investment (including time, money, and capital) from its physician members. Furthermore, the plan also included oversight by THP to ensure that physicians comply with the program's requirements and provided performance feedback to physician-members.
- Although THP members are permitted to jointly contract with payers, THP must also allow payers that do not wish to "buy-in" to the clinical integration to bargain with members of THP individually (for both physician and hospital services.)

73. Unlike the THP advisory opinion, in 2006, the FTC declined to approve the clinical integration plan of Suburban Health Organizations, Inc. (SHO) SHO's clinical integration plan involved the integration of several hospitals and primary care physicians and included the following<sup>53</sup>:

- "Medical management activities" such as patient monitoring and the implementation of care protocols and preventative health care services for cardiovascular disease, asthma.
- "Quality management programs" to determine compliance with guidelines and their effectiveness and to determine means of improving protocols using Web-based technology.
- "Practice support," which included continuing education for physicians and credentialing of staff.

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<sup>52</sup> (Emery, 2009)

<sup>53</sup> Emery, M. W. (2009)

- “Physician incentive plan,” which included bonuses to physicians based on individual performance for meeting performance standards.
74. Despite the purported benefits of SHO’s proposal, the FTC rejected the plan for several key reasons:
- SHO did not explain why the clinical integration needed to involve several hospitals and why the same benefits could not be achieved with the involvement of only one hospital or all of the hospitals implementing the integration plan independently from one another.
  - The SHO relied too heavily on individual hospitals to track, monitor, and discipline physicians for noncompliance with the integration plan.
  - SHO lacked a mechanism to discipline hospitals for not requiring or monitoring physician compliance with the integration plan.
75. The FTC also rejected the plan because its scope was too narrow.<sup>54</sup> For example, only primary care physicians, not specialists, were part of the plan, and it covered too few medical diagnoses. Due to this lack of scope, the FTC concluded that it could not conclude that joint pricing was reasonably necessary to achieve the efficiencies created by the plan.

#### **Distinctions between the SHO and the THP clinical integration plans**

76. There are several distinctions between the THP and the SHO cases that resulted in these divergent outcomes:
- Number of hospitals included in the plan: THP’s plan included only one hospital. SHO’s plan included a number of hospitals, but the organisation was unable to justify the pro-competitive benefits of including more than one hospital in the integration plan. The potential efficiencies of the SHO plan were mainly informational in character, such as the adoption of practice protocols and development of educational materials. Since SHO was unable to demonstrate the need for price-fixing between multiple hospitals in the scheme to achieve these efficiencies, the FTC concluded that the anti-competitive effects of the plan could not be justified.
  - Number of medical diagnoses covered by the plan: The THP plan was much more comprehensive. Unlike the SHO clinical integration plan, the THP plan involved specialists and covered a much wider range of medical diagnoses.
  - Presence of physician monitoring: THP’s plan included oversight by the PHO to ensure physician compliance.
  - Exclusivity: Unlike the SHO plan, THP allowed payers to contract with individual THP member -physicians and member-hospitals if the payer did not wish to “buy-in” to the clinical integration plan.

#### **The Agencies Have a Policy of Encouraging Providers to Integrate when it Creates Benefits for Consumers**

77. In the Healthcare Statements, the Agencies have provided clear guidance to IPAs and PHOs that wish to clinically or financially integrate without violating the antitrust laws. However, the Agencies are open to the provider-led development of new forms of clinical integration that promote innovation and efficiency in the provision of healthcare services that will achieve significant, material benefits for consumers.

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<sup>54</sup> *Id.*

## Enforcement Action against Agreements between Insurers and Providers

78. The McCarran-Ferguson Act of 1949 exempted the “business of insurance” from antitrust laws when state regulation of insurance was present. However, the exemption created by McCarran-Ferguson has been effectively repealed by H.R. 4626: Health Insurance Industry Fair Competition Act, a recently passed federal law, and the “business of insurance” is now subject to the federal antitrust laws. Although this current development is likely to have an impact on future enforcement, certain insurer practices have always been subject to the federal antitrust laws.
79. Agreements between providers and insurers, such as most favoured nation clauses, exclusive dealing arrangements, agreements to exclude or terminate other providers from a network, and “all products” clauses, have always been within the scope of the antitrust laws, because they are not considered to be the “business of insurance” as defined by McCarran-Ferguson. These types of vertical agreements may raise antitrust issues when the entity insisting on the term has market power or the agreement forecloses a substantial portion of the market.

### **Most Favoured Nation Clauses May Pose an Anticompetitive Concern when the Insurer Exercising the Clause has Market Power**

80. Typically, most favoured nation (MFN) clauses are used by payers in contracts with providers to guarantee that other payers that contract with the provider are not receiving lower reimbursement rates.<sup>55</sup> A typical MFN clause may state:
- “Provider represents and warrants that it has not agreed to accept from any other payer a reimbursement rate that is less than what is offered by Payer under this contract. If Provider offers a better reimbursement rate to any other Payer, the Provider must provide prior written notice of such an offer to Payer and give Payer the option to accept the reduced reimbursement rate. Thereafter, at Payer's option, Payer may accept the reduced reimbursement rate or it may terminate the contract immediately upon written notice to Provider.”<sup>56</sup>
81. However, some MFN clauses go further and require that the provider charge other payers a higher rate.<sup>57</sup> This creates a competitive issue, because it creates a price buffer between the payer who receives the benefits of the MFN and the payer’s rivals who are charged a higher rate as a result of the terms of the clause.
82. In the past, MFNs have been upheld by courts on the grounds that they reduce costs for consumers.<sup>58</sup> However, the Agencies have recently taken action against the use of MFN clauses when the payer that benefits from the MFN has market power.<sup>59</sup>
83. MFN clauses can create antitrust issues, under certain market conditions, when they discourage provider discounting, deter innovation, and reduce meaningful consumer choices in health plans, either by

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<sup>55</sup> (Harris, 2007)

<sup>56</sup> *Id.*

<sup>57</sup> (Recent Antitrust Division Enforcement Activities In Healthcare, 1998)

<sup>58</sup> (James, 2006)

<sup>59</sup> *Id.*

facilitating collusive pricing among competing providers or by discouraging providers from offering lower rates or more cost-effective care to rival plans.<sup>60</sup>

### **Recent MFN Cases**

84. In recent years, the DOJ has taken action against the use of MFN clauses in three cases.
85. In 1998, the DOJ filed suit against Medical Mutual (MM) of Ohio to enjoin the insurer from including MFN clauses in its contracts with providers in the Cleveland area. MM was the largest insurer in Ohio. Under its MFN clause, MM required any hospital that contracted with it to charge MM's competitors 15% to 30% more than MM for the services provided by the hospital.
86. The DOJ alleged that MFN insulated MM from price competition with its rivals, which resulted in a higher cost of healthcare for consumers and suppressed innovation. The DOJ also alleged that the use of the MFN clause reduced price competition between hospitals and health plans in the Cleveland area.
87. In a similar case, in 1996, the DOJ brought suit against Delta Dental of Rhode Island for its use of MFN clauses in its contracts with dentists. Delta Dental was the largest insurer in Rhode Island and had contracts with about 90% of the dentists in the state. Services provided to patients insured by Delta comprised a substantial portion of dentists that were members of Delta's network. The majority of Delta's member-dentists agreed to the MFN clause and refused to contract at prices below the reimbursement rate given to Delta with insurance companies that were trying to enter the market for dental insurance in Rhode Island.
88. In a 1994 case, the DOJ brought suit against Vision Services Plan, the largest vision care insurer in the use, (VSP) for the use of MFNs in its contracts with providers. The DOJ alleged that VSP's use of MFNs had reduced the willingness of optometrists that were part of VSP's provider network to provide discounted fees to non-VSP patients which resulted in a higher cost of vision care.

### **Analysis of MFN cases**

89. In all three DOJ suits against the use of MFN clauses in insurer-provider agreements, the insurer had a dominant position in the relevant market.
90. Also, as a result of the MFN clause, the competitors of the insurer exercising the clause were either: 1. unable to negotiate lower prices with healthcare providers, which caused a reduction in price competition in either the insurance market or in the market for provider services; or 2. were unable to enter the insurance market because the MFN clause created a barrier to entry, which resulted in a reduction in competition in the relevant market.
91. Recently, the DOJ has investigated the use of MFN clauses by two large insurers in Tennessee and Western Pennsylvania. Both insurers dropped the clauses from their agreements with providers after commencement of the DOJ investigation.

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<sup>60</sup> (Recent Antitrust Division Enforcement Activities In Healthcare, 1998)

### **Exclusive Dealing Arrangements**

92. Insurers may enter into exclusive dealing arrangements with providers in which the provider agrees to contract exclusively with the insurer. The legality of these agreements under the antitrust laws usually turns on whether they foreclose a “substantial share” of the relevant market.

### **Exclusion/Termination of Providers**

93. The exclusion or termination of a provider from an insurer’s provider network may create anticompetitive concerns if the party asking for the term has a dominant position in the relevant market.

### **All Products Clauses**

94. All Products clauses are used by insurers to require physicians to accept all present and future insurance products and payment methods offered by a particular insurer as a condition of participating in any of the insurer’s products. Physician groups argue that these products limit the ability of providers to negotiate with already powerful insurers. These clauses may pose an anticompetitive issue when the party insisting on the inclusion of the clause has market power.

## **Remedies Sought by the Agencies in Antitrust Enforcement Cases**

### **Actions against IPAs and PHOs**

95. In the past 20 years, the FTC has commenced action in over 30 cases involving illegal collective bargaining between members of IPAs and PHOs with insurers. Of all of the illegal bargaining action commenced by the FTC, only one case has resulted in litigation. (This case is currently on remand from the US Court of Appeals for the 5<sup>th</sup> Circuit.) The rest of the actions against illegal collective bargaining have resulted in the IPA or PHO agreeing to refrain from the anticompetitive conduct through a consent decree with the FTC. (See Section 2, paragraph 8, *supra*, for a discussion of consent decrees). The DOJ has had similar results in its actions against IPAs and PHOs, and the great majority of illegal collective bargaining actions commenced by the DOJ have resulted in either consent decrees or, in cases where litigation has been commenced, settlement agreements.
62. In recent cases involving the use of MFN clauses, the DOJ has resolved these actions by entering into consent decrees or settlement agreements to prohibit the parties from engaging in the anticompetitive conduct.

### **In other areas**

96. Neither the DOJ nor the FTC have taken action against the use of exclusive agreements, exclusionary practices, or all products clauses in agreements between insurers and providers. However, court rulings in privately-filed claims indicate that these practices are antitrust violation if certain conditions are present. Furthermore, many of the vertical issues created by these agreements are regulated by state competition laws.

## **The Future of Antitrust Enforcement in the Healthcare Sector**

97. Each year, the cost of healthcare increases in the United States. To combat rising costs, providers, hospitals, and insurers must work together to develop new systems of delivery that will enhance efficiency and improve quality with fewer resources. These improvements to quality and efficiency can be achieved through financial and clinical integration through joint ventures between providers and between providers and hospitals.
98. However, the Agencies will continue to monitor providers and hospitals that wish to integrate to ensure that new forms of integration are not being used to subvert the antitrust laws. If integration is used as a pretext for price collusion between competitors or to solidify a dominant position in the market, rather than to create realizable benefits for consumers, the integration will not be in line with general antitrust principles.
99. The FTC and DOJ will also continue to monitor vertical agreements between insurers and healthcare providers that result in the foreclosure of competition in either (or both) the insurer market or the market for healthcare services. Due to the repeal of McCaran-Ferguson, the Agencies also have the authority to investigate other types of insurer conduct of (“the business of insurance”).
100. The goal of improving the provision of healthcare through integration requires that the Agencies collaborate with stakeholders in the healthcare marketplace to ensure that the Agencies guidelines for financial and clinical integration are transparent and to receive feedback on the current state of the healthcare market. However, the Agencies must also continue to vigorously enforce the antitrust laws to ensure that consumers are able to benefit from a competitive healthcare marketplace.

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