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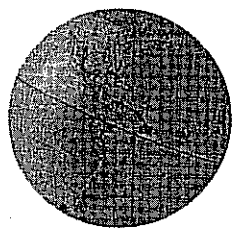

Ongoing Lessons From Poughkeepsie
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Partial Ownership Interests: The Antitrust Concerns and Structural Techniques for Minimizing Them
Ilene Knable Gotts & Robert C. Weinbaum

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Ongoing Lessons From Poughkeepsie

Robert M. Langer & Peter A. Barile III

In the same month that the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice released their Antitrust Guidelines for Collaborations Among Competitors ("Collaboration Guidelines"),[1] the New York State Attorney General won a decisive victory in a case that challenged a collaborative arrangement between two not-for-profit competitor hospitals. The case is an object lesson in the very significant role that state attorneys general play in antitrust enforcement, as well as in the profound difficulties to be had in antitrust counseling when multiple government agencies (including multiple sovereigns) possess the authority to review, approve, and challenge complex transactions.

BACKGROUND

In *New York* ex rel. *Spitzer v. St. Francis Hospital*,[2] the only two hospitals in Poughkeepsie, New York, were held to have engaged in per se unlawful activity in violation of Section 1 of the Sherman Act and the New York Donnelly Act. The New York State Attorney General ("Attorney General") challenged the hospitals' joint negotiations with third-party payors and agreements to allocate certain services. The Attorney General prevailed on the issue of liability at the summary judgment stage, and the parties subsequently resolved the matter by consent decree.[3]

In response to competitive pressure from neighboring hospitals in the 1980s, St. Francis Hospital ("St. Francis") and Vassar Brothers Hospital ("Vassar")

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embarked on a collaborative effort.[4] As certain religious reasons precluded the actual merger of the two entities,[5] the hospitals established a third entity, Mid-Hudson Health ("Mid-Hudson") to facilitate collaboration between the hospitals.[6] While the entities did obtain Certificates of Need ("CONs"), the central issue in *St. Francis* was whether the CON process authorized the precise collaboration. Mid-Hudson was intended to "'have no physical facility or staff of its own' but instead would be 'empowered with shared operational and management authority for each of the sponsoring hospitals.'"[7] The Department of Health ("DOH") issued Mid-Hudson an operating certificate for three services—adult cardiac catheterization, mobile lithotripsy, and MRI.[8] However, Mid-Hudson did much more.

Mid-Hudson allocated the services provided between the hospitals and negotiated jointly on behalf of both hospitals with third-party payors. While the defendant hospitals claimed that this conduct was authorized by state regulators, the Attorney General argued successfully that this conduct was not only beyond the scope of regulatory authorization, but was indeed per se unlawful.

The hospitals' first line of defense was to advocate a broad interpretation of Mid-Hudson's authorized activities in order to avail themselves of the state action immunity doctrine. The hospitals second line of defense argued that the collaborative arrangement at issue demanded rule of reason analysis rather than per se condemnation. The hospitals' arguments failed to persuade the court in both regards.

STATE ACTION IMMUNITY

The state action immunity doctrine provides antitrust immunity in certain situations for conduct that would otherwise be actionable under the antitrust laws.[9] The doctrine has immunized the conduct of state agencies,[10] state courts,[11] state executive officials,[12] local municipalities,[13] and private citizens.[14]

The standards required for state action immunity to attach depend largely upon the identity of the defendant.[15] Where the defendant is sovereign, i.e., the state legislature or state supreme court, the conduct is automatically entitled to state action immunity.[16] In the case of state agencies, municipalities, and other political subdivisions, however, the defendant seeking the shield of state action immunity must be acting pursuant to a clearly expressed state policy to displace competition with regulation.[17] Where the defendant is a private person or entity, a second level of analysis must be satisfied. In addition to acting pursuant to a

clearly articulated state policy, the defendant's conduct must be actively supervised by the state.[18]

The *St. Francis* defendants could not successfully avail themselves of state action immunity doctrine due to (1) a lack of congruence between the hospitals' collaborative efforts and the scope of the CONs issued by the government, and (2) a lack of "ongoing" supervision by state regulators.

Clearly articulated state policy to displace competition with regulation

For the state action doctrine to immunize state agencies, municipalities, and other political subdivisions, the conduct at issue must be taken pursuant to a clearly articulated and affirmatively expressed state policy designed to replace competition with regulation.[19] The conduct need not be compelled by a state statute (although compulsion will suffice); mere statutory authorization will generally satisfy the clear articulation requirement.[20] However, the conduct must be a foreseeable consequence of the authorization.[21]

Active supervision

A second element, "active supervision," must be satisfied before state action immunity will attach to the conduct of private parties. As the Supreme Court explained in *FTC v. Ticor Title Insurance Co .*, this additional element is required in order to ensure that "the anticompetitive scheme is the state's own."[22] In *Patrick v. Burget*,[23] the Court held that statutorily authorized physician peer review proceedings were not sufficiently supervised so as to provide immunity.[24] Writing for a unanimous Court, Justice Marshall explained that "the active supervision requirement mandates that the State exercise ultimate control over the challenged anticompetitive conduct."[25] After *Ticor*, mere veto power over transactions or arrangements will not suffice.[26] To achieve state action immunity, a private actor "must be able to prove that state officials actually fulfilled the active role granted to them under the statute by undertaking the necessary steps to review the specifics of the challenged conduct and evaluating whether it complies with the state regulatory policy."[27]

Why the collaboration at issue was not held to enjoy state action immunity

In *St. Francis*, the Attorney General did not challenge the conduct expressly authorized by the CON process—the joint provision of adult cardiac catheterization, mobile lithotripsy, and MRI. Nevertheless, the state action

immunity analysis turned on an interpretation of that authorization. While the Attorney General took the position that any conduct beyond that expressly authorized by the CON process was subject to antitrust scrutiny, the hospitals maintained that the authorization was indeed broader than the three services, covered the conduct at issue, and entitled the hospitals to antitrust immunity.

The court held that both the joint negotiations with third party-payors and the allocation of services between St. Francis and Vassar passed the first part of the state-action test. As to the joint negotiations with third-party payors, the court observed that "[t]he State clearly delegated to the DOH 'the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services.' "[28] Moreover, "[p]rior to deregulation, the State had a clearly articulated policy of replacing competition with state regulation. This regulation extended to establishing 'schedules of rates, payments, reimbursements, grants and other charges for hospital and health-related services ... .' "[29] Cited by the court as buttressing the statutory articulation was that

> [t]he DOH itself foresaw joint negotiations with third-parties at the time Mid-Hudson sought an establishment CON. In 1996 the DOH's general counsel wrote to Mid-Hudson that "given that the establishment of [Mid-Hudson] was represented and accepted as the precursor to further merging of services and activities, it would appear that joint negotiations of rates is a logical step to achieving those ends."[30]

Similarly, the court held the allocation of services among the hospitals to be pursuant to a clearly articulated and affirmatively expressed state policy to displace competition with regulation. The court observed not only that the provision of hospital services were "heavily regulated," but also "that the DOH was at least aware of [the allocation of services] and did not object" to the collaboration.[31] Since the court would find no active supervision of the collaboration, the court did not reach the issue of whether deregulation would affect the clear articulation prong.[32]

Holding that neither the joint negotiations with third-party payors nor the service allocation scheme passed the second part of the state-action immunity test, the court observed that "[t]he fact the DOH was regulating hospital prices and reimbursements prior to 1997 and arguably continues to set rates for some patients is insufficient to confer immunity for defendants' joint negotiations with third-party payers ... ."[33] Moreover, "[f]ar from exercising any control over defendants' joint negotiations, the DOH notified Mid-Hudson by copying Mid-

Hudson on a January 1997 letter … that 'records pertaining to the creation of [Mid-Hudson] … indicate that the Public Health Council's approval did not contemplate the new entity negotiating on behalf of both hospitals for [a] full array of services … .'"[34] The court also cited language from the Mid-Hudson CON application in which defendants stated that "[e]ach hospital will remain a financially independent structure and will retain all governance responsibilities not specifically given to the new corporation."[35] The court found further guidance in Mid-Hudson's proposed certificate of incorporation, where the hospitals "specified that the jointly-operated services 'shall be financed by, billed for and reimbursed to whichever of said Hospitals physically houses and provides each such service.'"[36] Not only did the state fail to actively supervise the joint negotiation with third-party payors, but the "activities were beyond the scope of the express authority the State granted to Mid-Hudson."[37]

As to the allocation of services, the court held that neither DOH approval of the Mid-Hudson establishment CON nor DOH's failure to object to the allocation scheme constituted the kind of "comprehensive, ongoing involvement" that would justify antitrust immunity.[38] The court observed that there was no continuing state involvement in the allocation of health care services after approval of the Mid-Hudson establishment CON.[39] Moreover, the fact that "Mid-Hudson was created in an environment of pervasive state regulation [was] insufficient to confer antitrust immunity."[40] With deregulation, the court stated, "[t]he State has determined to 'promote competition in the health care marketplace by increasing reliance on market incentives while reducing the role of legislation.'"[41] Thus, "defendants' anticompetitive conduct thwart[ed] the State's policy of promoting competition for hospital services."[42]

PER SE OR NOT PER SE

Contrary to the many arguments offered by defendants, the court declined to analyze the hospitals' collaborative efforts under the rule of reason, and instead condemned the actions as per se unlawful. Horizontal price fixing and market division fall into the category of "agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use."[43] Although the Supreme Court has been moving away from engaging in rigid characterization, and toward requiring a comprehensive market analysis, before condemning business practices as violative of the

antitrust laws,[44] horizontal price fixing and market division remain per se illegal. The joint negotiations with third-party payors were characterized as price fixing, while the allocation of services were characterized as market division. Observing a low "tolerance" for horizontal market divisions accompanied by price fixing,[45] the court dismissed the defendants' arguments that their particular collaborations should be evaluated under a rule of reason analysis.

Price fixing

As the Supreme Court has famously stated, "[u]nder the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se."[46] Since such restrictions on price competition threaten the "central nervous system of the economy,"[47] the "[p]rotection of price competition from conspiratorial restraint is an object of special solicitude under the antitrust laws."[48] However, under certain conditions and among certain parties, horizontal price restraints are not characterized as per se illegal, but are instead given a more thorough competitive analysis. Often central to such an analysis is whether, absent the challenged restraint, the affected product is to be available at all.[49]

The *St. Francis* court ruled that Vassar and St. Francis "fixed prices by jointly agreeing on the terms and rates they will charge for many of the services they provide."[50] Opining that St. Francis and Vassar had "even greater capacity to exert their influence over price than the Socony-Vacuum defendants," the court found the parties' joint negotiations through Mid-Hudson particularly pernicious:

> Pursuant to their joint negotiating strategy, defendants essentially have an opportunity to unilaterally determine a range of prices acceptable to them, much like the maximum fee schedules established by the Maricopa defendants. By using Mid-Hudson as their common and exclusive agent to negotiate with insurers, defendants have prevented determination of the rates and terms of the services they provide by free competition alone. Defendants concede as much. Defendants' chief negotiator … admits in her deposition that from the time Mid-Hudson was established, competition between defendants for the business of third-party payers was eliminated.[51]

The defendants proffered a number of "efficiencies and benefits" of the collaboration to justify the practice. These justifications included:

- reduced duplication of services;
- elimination of competition for equipment and personnel;
- the ability to offer services that could not otherwise exist;
- cost savings through joint purchasing;
- joint professional training and public education; and
- standardized protocols.[52]

Instead of providing the defendants the opportunity to demonstrate the desirability of these benefits, the court condemned the joint negotiations as per se unlawful. The court rejected the proffered benefits as "tantamount to the elimination of free competition."[53]

Market division

"[W]hether the parties split a market within which both do business or whether they merely reserve one market for one and another for the other,"[54] horizontal market division remains "one of the classic examples" of a per se violation of the Sherman Act.[55] This type of restraint "so often prove[s] so harmful to competition and so rarely prove[s] justified that the antitrust laws do not require proof that an agreement of that kind is, in fact, anticompetitive in the particular circumstances."[56]

In *St. Francis*, Vassar and St. Francis had established a collaborative business plan, called the "trades," whereby "specified services were allocated to one hospital or the other."[57] Furthermore, the hospitals "agreed not to compete for customers for these services."[58] Additionally, a "Fairness Formula" was adopted "to ensure that defendants' market share would remain at 1991 levels."[59] The court found such collaboration to be "the paradigm of the horizontal market division that the Supreme Court has deemed per se illegal."[60] While the defendants argued that the collaboration produced "high technology, tertiary, health care services, which otherwise would not have been available without their cooperation" *in the local area*, the court held the collaboration could be justified only if, but for the collaboration, the product "would not be available at all."[61] The court refused to equate a collaboration's introduction of a product to a new *market*, with a collaboration's creation of a new *product*.

Additional rejected justifications

As mentioned, the court rejected the hospitals' efficiency and product introduction justifications. In addition to asserting those defenses, the hospitals argued that their collaborative effort should be examined under the rule of reason. The asserted reasons for rule of reason treatment were:

- joint venture;
- state involvement;
- ancillary restraints;
- lack of judicial experience;
- nonprofit defendants;
- state and federal government acquiescence;
- community supports defendants' plan;
- the "inequitable conduct" of complaining HMOs.[62]

The court rejected all of these proposed reasons for a rule of reason analysis.[63] The court also rejected the defendants' estoppel argument, which was premised upon the conduct considered in regard to the state action immunity claim.[64]

THE LIMITED ROLE OF DEREGULATION

New York deregulated health care on January 1, 1997.[65] Although the court made reference to the fact that the conduct at issue occurred both before and after deregulation, deregulation played a rather insignificant role in the court's analysis of the state action immunity issue. The court did not even reach the issue of whether deregulation would affect the clear articulation prong of the state action immunity analysis.[66]

The St. Francis *decision bears a striking similarity to a critical component of one of this nation's most famous antitrust cases.*

The *St. Francis* decision bears a striking similarity to a critical component of one of this nation's most famous antitrust cases. In *United States v. Socony-Vacuum*,[67] the Supreme Court upheld the criminal convictions of oil producers and distributors for price fixing for engaging in conduct inspired by the National Industrial Recovery Act.[68] As the antitrust aficionado will surely recall, the Court in *Socony-Vacuum* basically described the approvals by the government regulators as mere winks and nods.[69] The Court disregarded the regulatory

approval cited by defendants, because a formal mechanism for approval under the act had been set up by Congress—even though that formal mechanism itself had been discredited by government regulators. Moreover, as a conspiracy is "renewed during each day of its continuance,"[70] the expiration of the act heralded a continuing era of illegality. Thus, conduct inspired by the act, and approved of by the regulators (albeit insufficiently), was held criminal, despite the approval, because of the expiration of the authorizing positive law. Likewise, the defendants in *Ticor* were also caught off guard. Recall that in *Ticor* at issue was whether negative option regulatory schemes provided sufficient "active supervision" so as to implicate the state action immunity doctrine.[71] Such schemes were commonplace at the time, with both private parties and state agencies planning their conduct accordingly. Disregarding the banality of the practice, the Supreme Court surprised many by ruling that an agency's failure to disapprove a tariff filing does not meet the strictures of the "active supervision" prong and is therefore insufficient to confer antitrust immunity upon private parties.[72]

HOW WOULD THE POUGHKEEPSIE JOINT VENTURE BE ASSESSED UNDER THE FEDERAL GUIDELINES?

The Justice Department and the Federal Trade Commission have issued statements of enforcement policy in order to "provide guidance to business people."[73] The 1996 Statements of Antitrust Enforcement Policy in Health Care ("1996 Health Care Statements") "outline the Agencies' approach to certain health care collaborations."[74] In the 1996 Health Care Statements, the Agencies observed that throughout the 1990s, "health care markets [ ] continued to evolve in response to consumer demand and competition in the marketplace."[75] In light of "evolving health care contexts," the agencies released the 1996 Heath Care Statements in "recogn[ition of] the importance of antitrust guidance."[76]

In the recently issued Collaboration Guidelines, both agencies formally recognized that "[i]n order to compete in modern markets, competitors sometimes need to collaborate. Competitive forces are driving firms toward complex collaborations to achieve goals such as expanding into foreign markets funding expensive innovation efforts, and lowering production and other costs. Such collaborations are often not only benign but procompetitive."[77] The agencies drafted the Collaboration Guidelines to be "consistent with the analytical framework in the Health Care Statements."[78] In the Collaboration Guidelines, the agencies also advised that "in some cases, competitor collabora-

tions have competitive effects identical to those that would arise if the participants merged in whole or in part."[79] Of course, the agencies did not object to a proposed virtual merger between St. Francis and Vassar in 1995.[80] As has been discussed, the defendant hospitals proffered a number of justifications for their collaborations. Would the agencies' approach under the guidelines have differed dramatically from that of the state enforcers?

Given the nature of the collaboration between St. Francis and Vassar, the federal agencies may have analyzed the agreements as a horizontal merger rather than as a horizontal conspiracy. According to the Collaboration Guidelines:

> The Agencies treat a competitor collaboration as a horizontal merger in a relevant market and analyze the collaboration pursuant to the *Horizontal Merger Guidelines* if appropriate, which ordinarily is when: (a) the participants are competitors in that relevant market; (b) the formation of the collaboration involvesan efficiency-enhancing integration of economic activity in the relevant market;(c) the integration eliminates all competition among the participants in the relevant market; and (d) the collaboration does not terminate within a sufficiently limited period by its own specific and express terms.[81]

Mid-Hudson integrated St. Francis and Vassar in a manner that arguably met all the above criteria. First, the two hospitals were competitors in the market for hospitals in Poughkeepsie. Second, the collaboration produced efficiencies. Third, the "trades" system virtually limited all competition among the hospitals. Fourth, the creation of Mid-Hudson as a separate business entity created a perpetual strategic alliance.

The 1996 Health Care Statements provide that "[m]ost hospital mergers … do not present competitive concerns."[82] Moreover, in applying the analytical framework of the 1992 Horizontal Merger Guidelines, the agencies "often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects."[83] Such a conclusion has been reached where, among other situations, "the merger would allow the hospitals to realize significant cost savings that could otherwise be realized" or where "the merger would eliminate a hospital that would likely fail with its assets exiting the market." However, because the court analyzed the collaboration as a per se horizontal conspiracy, the court did not entertain such considerations. A rule of reason inquiry guided by the federal agencies' analytical framework may very well have produced a different result.

LESSONS FOR COUNSELING CLIENTS IN THE ANTITRUST-HEALTHCARE FIELD

Private parties and state agencies can work together to insulate health care provider collaborations from antitrust scrutiny

Had the parties applied for and received express permission to collaborate as they did, *St. Francis* would have been a very different case. While obvious, one lesson to be learned is that, in order to best insulate collaborative efforts from antitrust scrutiny, health care providers may wish to consider applying for state approval of their collaborative efforts through the CON process, or comparable health care collaboration statutes. CON approval may be used as a shield against antitrust liability, but only if the approval is crystalline. Health care providers may be able to take advantage of the CON shield, but beware that the CON will not likely be broadly interpreted.

But even clear authorization is not enough. Any collaboration approved by a state agency should be regularly monitored, with regular statements of approval accompanying the monitoring. Mere approval and oversight authority may not suffice given the *St. Francis Hospital* court's interpretation of the "active supervision" prong of the state action immunity doctrine to require "ongoing" regulatory supervision.[84]

CON approval may be used as a shield against antitrust liability, but only if the approval is crystalline.

Over twenty states have enacted legislation to encourage collaboration among physicians, hospitals, and/or other health care providers.[85] These laws are intended to improve the quality of health care services and, at the same time, achieve efficiencies in their delivery. Each statute intends to immunize collaborations that might otherwise bring antitrust exposure. However, after *Ticor*, providers that collaborate pursuant to a state-approved arrangement, and wish to avail themselves of the state action immunity doctrine, must be in a position to demonstrate that statutorily authorized state officials in fact reviewed the challenged conduct on the merits and that state officials determined that the challenged conduct complied with the state's regulatory policy. From a practical standpoint, *Ticor* means that the antitrust liability of private parties depends, in part, upon whether state regulators fulfill their statutory mandate. *St. Francis* extends the supervision required by *Ticor*.

Ticor did not directly address what is unquestionably one of the most difficult state action immunity issues: whether, in order to confer immunity, "active supervision" of a merger, acquisition, or joint venture requires the state to review the transaction on an ongoing basis, following the initial approval by the state. In *St. Francis*, the court made it clear: "ongoing" supervision by governmental authorities is required to satisfy the "active supervision" prong of the state action immunity doctrine in the joint venture context. While a number of the health care collaboration statutes have provided for ongoing regulatory oversight, in light of *St. Francis*, counsel must be mindful of the role which regulators must play to ensure that providers remain immune.

St. Francis *extends the supervision required by* Ticor*: "ongoing" supervision by governmental authorities is required to satisfy the "active supervision" prong of the state action immunity doctrine in the joint venture context.*

What are the minimal elements of a legitimate joint venture?

As previously noted, the *St. Francis* court rejected the defendant hospitals' argument that their collaboration was a legitimate joint venture. The court did so because the collaboration did not result in the creation of a new product. That new products and efficiencies were introduced to the market did not suffice. "Joint venture" has been defined as "a separate enterprise characterized by an integration of operations between and subject to control by its parent firms which results in the creation of a significant new enterprise capability in terms of new productive capacity, new technology, a new product, or entry into a new market."[86] But the *St. Francis* court's view appears to characterize joint ventures as per se illegal in the absence of the creation of a new product. Should the court's distinction—between introducing a product to the market for the first time and actually creating a product—be widely adopted, the field of collaboration that can be characterized as a joint venture will be substantially narrowed.

While "agreements between legally separate persons and companies to suppress competition among themselves and others" may not "be justified by [merely] labeling a product a joint venture,"[87] the Supreme Court has remarked that joint ventures are evaluated under the rule of reason since they "hold the promise of increasing a firm's efficiency and enabling it to compete more effectively."[88] Additionally, the 1996 Health Care Statements recognize that

"[n]ew arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payers' desire for more efficient delivery of high quality health care services."[89]

Moreover, the Collaboration Guidelines call for collaborations such as the one at issue in *St. Francis* to be analyzed as if they are horizontal mergers. If the facts of a particular collaboration are such that merger analysis would be appropriate under the guidelines, the merger guidelines should inform an analysis of the conduct. In anticipation of a challenge to a collaboration between the only two participants in a given market, arguments in support of the procompetitive benefits of the merger need to be marshaled.

State attorneys general continue to be key players in the antitrust-healthcare field

St. Francis is yet another example of "[t]he role of state attorneys general in the development of competition policy in the United States continues to grow and evolve."[90] *St. Francis* demonstrates the independence of the state enforcement prong of the "Antitrust Triad."[91] Applying the Collaboration Guidelines, the federal agencies would likely have approached the Poughkeepsie joint venture differently.

The influence of state antitrust enforcement on national antitrust policy has steadily increased over the past decade.[92] This influence is of particular import in the health care arena.[93] Practitioners must be aware that state attorneys general often have different objectives and enforcement priorities than the federal agencies. Furthermore, and perhaps most significantly, practitioners must be aware that receiving approval from a state regulatory agency is not equivalent to receiving approval (or the absence of disapproval) from state antitrust enforcers. Absent active and ongoing participation by the state agencies in collaborations among competitive hospitals, health care counsel must advise their joint-venturing clients to consider the omnipresent specter of state antitrust enforcement.

NOTES

1. U.S. Dep't of Justice & Federal Trade Comm'n, Antitrust Guidelines for Collaborations Among Competitors (2000) [hereinafter Collaboration Guidelines],*reprinted in* Antitrust Rep., Apr. 2000, at 16. In the words of Chairman Pitofsky, the newguidelines were drafted to "help businesses assess the antitrust implications of collaborations with rivals, thereby encouraging procompetitive collaborations and deterring collaborations likely to harm competition and consumers." Federal Trade Comm'n, Press Release,*FTC and DOJ Issue Antitrust Guidelines for Collaborations Among Competitors*, Apr. 7, 2000, *reprinted in* Antitrust Rep., Apr. 2000, at 14.

2. 94 F. Supp. 2d 399 (S.D.N.Y. 2000).

3. 2000 U.S. Dist. LEXIS10914, 2000-2 Trade Cas. (CCH) ¶ 72,960 (S.D.N.Y. June 30, 2000).

4. *St. Francis*, 94 F. Supp. 2d at 403-05.

5. While Vassar is not church affiliated, St. Francis "is affiliated with the Roman Catholic Church and must comply with the Ethical and Religious Directive for Catholic Care Facilities approved by the Archdiocese of New York." *Id.* at 403. Moreover, the hospitals bond financing sources could not be commingled. *Id.* As a result, with the exception of some minor services, the Mid-Hudson collaboration extended to all services "except those proscribed by the Catholic Church." *Id.* at 406. Many hospitals have entered into this sort of collaboration as a way to "work around conflicts in ownership, such as public-private or religious-secular combinations." Mark Taylor, *Troubles for JOAs: Judge Accuses Hospitals of Using Joint Operating Deals to Fix Prices and Allocate Services*, Modern Healthcare, Apr. 17, 2000, at 3.

6. *St. Francis*, 94 F. Supp. 2d at 403-05.

7. *Id.* at 404.

8. *Id.*

9. For a more detailed discussion of the state action immunity doctrine see generally Robert M. Langer & Peter A. Barile III,*Can the King's Physician Do No Wrong? Health Care Providers and a Market Participation Exception to the State Action Immunity Doctrine*, Antitrust Rep., Oct. 1999, at 2.

10. The Supreme Court has indicated that "[i]n cases in which the actor is a state agency, it is likely that active state supervision would … not be required, although we do not here decide that issue." Town of Hallie v. City of Eau Claire, 471 U.S. 34, 46 n.10 (1985).

11. *See, e.g.*, Hoover v. Ronwin, 466 U.S. 558, 569 (1984).

12. *See, e.g.*, Fuchs v. Rural Elec. Convenience Coop., Inc., 858 F.2d 1210, 1214 (7th Cir. 1988); Charley's Taxi Radio Dispatch Corp. v. SIDA of Hawaii, Inc. 810 F.2d 869, 876 (9th Cir. 1987); Limeco, Inc. v. Division of Lime of Miss. Dept. of Agric. & Commerce, 778 F.2d 1086, 1086-87 (5th Cir. 1985). However, the Supreme Court, in *Hoover v. Ronwin*, 466 U.S. at 568 n.17, explicitly left open the question.

13. *See Town of Hallie*, 471 U.S. at 40.

14. *See* FTC v. Ticor Title Ins. Co., 504 U.S. 621, 633 (1992); California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

15. *See* 1 Julian von Kalinowski et al., Antitrust Laws and Trade Regulation: Desk Edition § 6.02[3] (Matthew Bender).

16. *See* Hoover v. Ronwin, 466 U.S. 558, 569 (1984) ("Where the conduct at issue is in fact that of the state legislature or supreme court, we need not address the issues of 'clear articulation' and 'active supervision.").

17. *See* Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 61-63 (1985) (for purposes of the *Parker* doctrine, not every act of a state agency is that of the state as sovereign); *Town of Hallie*, 471 U.S. at 40 (municipality must satisfy clear articulation requirement).

18. *See Ticor*, 504 U.S. at 631.

19. *See id.*; *Town of Hallie*, 471 U.S. at 40.

20. *See Southern Motor Carriers Rate Conference*, 471 U.S. at 61.

21. *See* City of Columbia v. Omni Outdoor Advertising, Inc., 499 U.S. 365, 373 (1991).

22. *See Ticor*, 504 U.S. at 635.

23. 486 U.S. 94 (1988).

24. *See id.* at 102-03.

25. *Id.* at 101.

26. *See Ticor*, 504 U.S. at 638.

27. Robert M. Langer, *A Practitioner's Guide to State Antitrust Health Care Issues*, Antitrust, Fall 1995, at 34.

28. *St. Francis*, 94 F. Supp. 2d at 409.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.* at 409 ("we need not decide this issue, as we find that defendants fail to meet the second prong of the Midcal test for their conduct both prior to and after the State initiated health care reform").

33. *Id.* at 410.

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.* (quoting Capital Tel. Co. v. New York Tel. Co., 750 F.2d 1154, 1163 (2d Cir. 1984) (ongoing involvement "sufficient" to satisfy "active supervision" requirement)).

39. *Id.*

40. *Id.* at 411.

41. *Id.*

42. *Id.*

43. Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

44. *See* California Dental Ass'n v. FTC, 526 U.S. 756 (1999); NYNEX Corp. v. Discon, 525 U.S. 928 (1998); State Oil Co. v. Khan, 522 U.S. 3 (1997).

45. *St. Francis*, 94 F. Supp. 2d at 416 (citing United States v. Sealy, 388 U.S. 350 (1967)).

46. United States v. Socony-Vacuum, 319 U.S. 150, 223 (1940).

47. *Id.* at 224-26 n.59 (1940).

48. United States v. General Motors Corp., 348 U.S. 127, 148 (1966).

49. *See* NCAA v. Board of Regents of Univ. of Okla., 468 U.S. 85 (1984); BMI, Inc. v. CBS, Inc., 4412 U.S. 1, 19-23 (1979).

50. *St. Francis*, 94 F. Supp. 2d. at 413.

51. *Id.* at 413-14.

52. *Id.* at 414.

53. *Id.*

54. Palmer v. BRG of Georgia, Inc., 498 U.S. 46, 49-50 (1990).

55. United States v. Topco Assocs., 405 U.S. 596, 608 (1972).

56. NYNEX Corp. v. Discon, Inc., 525 U.S. 128 (1998) (citing Palmer v. BRG of Georgia, Inc., 498 U.S. 46, 49-50 (1990)).

57. *Id.* at 415.

58. *Id.* Vassar was allocated "the cardiac catheterization laboratory and the cardiology center; obstetrics; the predominant site for gynecology; cancer admissions dependent on high technology; fifty percent of general surgery; and the medical pediatrics unit." St. Francis was allocated "selected cancer admissions not dependent upon high technology; orthopedics / neurology; MRI; mobile lithotripsy; the predominant site for ambulatory surgery and the laser center; the predominant diagnostic outpatient center; plastic surgery; fifty-percent of general surgery; an expanded emergency room, trauma II; and a guaranteed percentage of the market share of medical admissions."

59. *Id.* However "this plan was ineffective due to the fact medical admission frequently go through the emergency room, which means

the choice of hospital was the patient's, and not the treating physician's."

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.* at 416-19.

64. *Id.* at 419-20.

65. *Id.* at 406.

66. *Id.* at 409 ("we need not decide this issue, as we find that defendants fail to meet the second prong of the Midcal test for their conduct both prior to and after the State initiated health care reform").

67. 310 U.S. 150 (1940).

68. *Id.* at 225-26.

69. *Id.*

70. *Id.* at 227.

71. FTC v. Ticor Title Ins. Co., 504 U.S. 621, 632 (1992).

72. *Id.*

73. Collaboration Guidelines, *supra* note 1, Preamble.

74. *Id.*

75. U.S. Dep't of Justice & Federal Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care [hereinafter 1996 Health Care Statements], *reprinted in* Antitrust Laws and Trade Regulation: Primary Source Pamphlet (Matthew Bender 1999) at 181.

76. *Id.* at 184.

77. Collaboration Guidelines, *supra* note 1, Preamble.

78. *Id.* § 1.1 n.4.

79. *Id.* § 1.3.

80. *St. Francis*, 94 F. Supp. 2d at 418-19.

81. Collaboration Guidelines, *supra* note 1, § 1.3.

82. 1996 Health Care Statements, *supra* note 75, Statement 1.

83. *Id.* Statement 1.B.

84. *St. Francis*, 94 F. Supp. 2d at 410.

85. For a summary of the legislation, see III ABA Section of Antitrust Law, State Antitrust Practice and Statutes 55-29–35 (2d ed. 1999).

86. COMPACT v. Metropolitan Gov't, 594 F. Supp. 1567, 1574 (M.D. Tenn. 1984), *quoted in* ABA Antitrust Law Developments (Fourth) 393 n.3 (1997).

87. Timken Roller Bearing Co. v. United States, 341 U.S. 593, 598 (1951).

88. Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984).

89. 1996 Health Care Statements, *supra* note 75, Introduction.

90. Robert M. Langer & Pamela Jones Harbour, *State Attorneys General: The Third Prong in the Antitrust Triad*, Global Competition Rev. (forthcoming 2000).

91. Robert M. Langer, *Should the Antitrust Division, the FTC, and State Attorneys General Formally Allocate the Market for Antitrust Enforcement?*, Antitrust Rep., Oct. 1998, at 3.

92. *See id.* (advocating consideration of a formal allocation of enforcement authority which may have been premature when first advocated in 1990); *see also* Robert M. Langer, *Cutting Edge Issues in State Antitrust and Consumer Protection Enforcement*, Antitrust Report, Dec. 1995, at 3.

93. *See* Robert M. Langer, *A Practitioners Guide to State Antitrust Health Care Issues*, Antitrust, Fall 1995, at 32; Robert M. Langer, *State Attorneys General and Hospital Mergers*, Antitrust Health Care Chronicle, Summer 1997, at 2❖