ANTITRUST ENFORCEMENT IN IMPERFECT HEALTH CARE MARKETS:

A STATE PERSPECTIVE

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I. INTRODUCTION

It is an honor to appear here before such an impressive group of practitioners and government enforcers to discuss the sometimes difficult and perplexing issues regarding antitrust enforcement in health care markets.

Because these markets tend to be local in character, and extremely important to consumers in our states, state antitrust enforcers have given priority to health care matters. Indeed, the modern era of antitrust enforcement in health care began, of course, when the Arizona attorney general challenged the maximum price fixing schemes of two medical societies in Maricopa and Pima Counties in Arizona.[1] Since then, it is probably fair to say that most people in state enforcement offices take for granted that competition is, and ought to be, the primary force dictating the price and quality of services in these markets. The failure of national health care reform has left the states with no choice but to look for solutions to providing cost-effective health care to all of our citizens.

But, I think it is vitally important for all of us to understand that "competition" as the organizer of health care markets is a fairly recent development. Before the deregulation fervor of the late 1970's and early 1980's, it was commonly assumed that competition would not work, or would not work very well, in health care markets because the markets were

dysfunctional in a number of ways. The fact that the actual consumers of health care often do not pay for the services rendered, that much of health care is purchased directly by the government on behalf of unpaying consumers, and that providing quality health care service often involves an intricate web of provider relationships, all suggested that the neoclassical model of perfect competition did not and does not fit health care markets very well. Even though we have all gone charging into the brave new world of competitive health care markets, and many government enforcers view it as their mission in life to ensure that competition continues in these markets, it is important to understand that, there are many who viewed these markets even today as dysfunctional in ways similar to twenty years ago. It is equally important to understand that state attorneys general have enforcement and advisory roles regarding health care issues that go beyond antitrust enforcement. And although antitrust enforcement is critically important to meeting some of these goals, meeting all the goals, such as universal coverage or even rectifying certain structural market defects, will require more substantive reform.

My goal today is to put state health care antitrust enforcement in the context of the broader mission of state attorneys general. First, I will briefly describe the evolution of state antitrust enforcement in health care markets over the

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[1]Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

past few years. Second, I will briefly describe the concomitant lessening of state regulation of the health care system and the attorney generals' role in that system using Wisconsin' experience as a case in point. Finally, I will discuss how, notwithstanding the multiple "health care" hats worn by state attorneys general, antitrust enforcement in the health care arena is conducted in a professional but creative manner.

II. OVERVIEW OF STATE ENFORCEMENT

As everyone in attendance will recall, it was 1982 in Maricopa when the Supreme Court initiated the modern era of health care antitrust enforcement by rejecting the claims of two physician groups that their attempt to fix maximum prices should be exempt from the per se rule because medicine was a "learned profession" and for a variety of other reasons. The decision put to rest lingering questions as to whether a physician's medical practice constituted "trade" under the Sherman Act and decided once and for all that the antitrust laws could be applied to the activities of health care professions generally.[2]

In the wake of Maricopa, many of us in state antitrust enforcement offices were inundated with requests for appearances before medical groups seeking to understand the new world of

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[2]Compare Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982) with American Med. Ass'n v. United States, 317 U.S. 519, 528 (1943) (antitrust laws applied to American Medical Association, but unclear to what extent law would apply to health

antitrust enforcement in the medical profession. I was not a terribly popular speaker back then as I delivered my "shock therapy" message of possible prison terms, huge fines and forfeitures and triple damages for doctors and other professionals who dared to talk to their now "competing" doctors about prices and other aspects of their businesses.

The health care community's worst fears about antitrust enforcement seemed to be coming true as state enforcers began addressing violations that came to their attention. For example, during the 1980s, Washington brought a number of cases against health insurance plans in which providers were determining the reimbursement rates.[3] Other states addressed boycott conduct by competing doctors who refused to join newly-emergent HMOs[4] or were more directly attempting to coordinate physician pricing.[5] Other states brought actions resulting in consent orders barring doctors from engaging in attempts to raise prices through boycotts targeting insurers.[6] (Just ten days ago, the New York attorney

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care professions generally).

[3]See, e.g., State of Washington v. Watcom Medical Bureau, No. 85-2-00516-0 (1985); State of Washington v. Skagit County Medical Bureau, No. 85-2-19549-3 (King County Superior Court 1985).

[4]See, e.g., State of Wisconsin v. Arellano, Case No. 88-CV-378 (Dodge County, Wis. 1987).

[5]Minnesota v. Central Minnesota Health Care Alliance, No. 73-CO-92-001109 (Stearns County District Court 1992); Minnesota v. Mid-Minnesota Associated Physicians, 1991-2 Trade Cas. (CCH) ¶ 69,531 (Douglas County District Court 1991); Minnesota v. Southern Minnesota Health Alliance, No. C090766 (Blue Earth County District Court 1990) (consent decrees required dissolution of collective bargaining organization for competing providers).

[6]Colorado, ex rel. Woodard v. Colorado Union of Physicians,

general challenged the alleged price fixing by two hospitals in Poughkeepsie via a joint agent used by the hospitals.) Yet, notwithstanding these civil actions, there has been a notable absence of state criminal antitrust cases in the health care area and a notable presence of judicious use of civil remedies by state enforcers in these quickly evolving markets. This suggests to me that we were successful in gettin g the message out to the health care community and that the fears of the health care community about antitrust enforcement were largely overstated.

Similarly, prior to 1990, the states often worked informally with hospitals contemplating mergers to ensure that the charitable, non-profit nature of the merging hospitals would be maintained.[7] With the Supreme Court's pronouncement in the American Stores[8] decision in 1990 that the states could obtain divestiture and other injunctive relief under section 16 of the Clayton Act, the states began in earnest to review and, where appropriate, to challenge mergers between hospitals and mergers involving other health care entities. Many state-negotiated consent decrees permitted mergers to proceed conditioned on language restricting or prohibiting certain exclusionary or

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1990-1 Trade Cas. (CCH) ¶ 68,968 (1990); Minnesota v. Mid-Minnesota Associated Physicians, 1991-2 Trade Cas. (CCH) ¶ 69,531 (1992).

[7] See, e.g., Sisters of St. Joseph/St. Luke's Hospital, (Memorandum of Understanding with Washington Attorney General 1989) (MOU allowed merger but required continuation of non-profit status, local control, minimum amounts of charity care and revenue caps and prohibited discriminatory and predatory conduct).

discriminatory conduct.[9] Certain decrees allowed hospital mergers to proceed provided the merged entity observed revenue caps.[10] Even hospital mergers approved pursuant to state Certificate of Public Advantage ("COPA") statutes have incorporated various prospective, mandatory injunctive relief

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[8]California v. American Stores Co., 495 U.S. 271 (1990).

[9]See, e.g., Partners Healthcare System/North Shore Med. Ctr., No. 96-1713B (S. Ct. Mass. 1996) (merger permitted subject to limitations on percentage of primary care physicians acquired and related referral restrictions); Minnesota v. Children's Health of Saint Paul, No. 4-94-CV-513 (D. Minn. 1995) (consent judgment permitting merger also required open staff and good faith negotiations with purchasers, restricted exclusive contracting and self referrals, and prohibited discrimination against low paying patients); Daughters of Charity/Baptist Health System (Settlement Agreement--Florida) (1995) (hospital affiliation permitted provided hospitals do not condition contracts for essential hospital services on purchasing other services); Texas v. Columbia/HCA Healthcare Corp., No. 9504873 (Travis County District Court 1995) (consent judgment permitted acquisition but required certain divestiture, limited managed care contracting, and restricted tying and exclusive contracting arrangements); Burbank Hosp./Leominster Hosp. (Settlement Agreement--Massachusetts) (hospital affiliation permitted provided hospitals spend specified amounts on charity care).

[10]State of Wisconsin v. Kenosha Hospital & Medical Center, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1996) (consent decree permitted merger conditioned on return of claimed efficiencies to consumers and restrictions on discriminatory and exclusionary conduct); Commonwealth of Pennsylvania v. Capital Health System Services, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa. 1995) (consent decree permitted merger conditioned on return of claimed efficiencies to consumers, revenue caps and prohibition of certain exclusionary conduct); Southcoast Health System, No. 96-13190F (S. Ct. Mass. 1996) (merger permitted provided rate free effective for three years and community-based board maintained); Commonwealth of Pennsylvania v. Providence Health System, Inc., 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree similar to Capital Health); Cape Ann & Northeast Health Systems, Inc., No. 94-3286 (S. Ct. Mass. 1994) (assurance of voluntary compliance); State of Minnesota, ex rel Humphrey v. Health One Corp., 1992-2 Trade Cas. ¶ 69,986 (D. Minn. 1992) (consent decree imposed cap on inpatient revenues).

provisions.[11] In many cases, these hospital merger investigations were jointly undertaken by a federal agency and the state involved.[12] However, such joint investigations do not always lead to identical enforcement decisions as was recently the case in the Long Island Jewish Hospital case brought by the Antitrust Division but not joined by the New York Attorney General.[13] The norm, however, is that the state and federal agencies work closely together supporting each others cases.[14]

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[11]Richland Memorial Hosp./Baptist Med. Ctr. (Certificate of Public Advantage--South Carolina 1997) (COPA permitted hospital partnership conditioned on five-year rate freeze, achievement of cost savings and funding of charity care); Deaconess Med. Ctr./Columbus Hosp. (Certificate of Public Advantage--Montana 1996) (COPA permitted merger but imposed cost, margin and revenue controls and prohibited certain discriminatory and exclusionary conduct); Memorial Mission Hosp./St. Joseph's Hosp. (Certificate of Public Advantage--North Carolina 1995)(COPA permitted joint operating agreement conditioned on profit and revenue limits, provision of charity care, and restrictions on exclusivity and discriminatory conduct). See also Maine v. Central and Western Maine Reg'l PHO, 1996-1 Trade Cas. (CCH) ¶ 71,320 (Me. S. Ct. 1996) (consent order sets terms for cooperative agreement among four hospitals to jointly negotiate with payers and prohibits exclusivity and tying arrangements). See also Benefis Health Care, (opinion letter from Montana Attorney General Joseph P. Mazurek, November 24, 1997), Antitrust & Trade Reg. Rep. (BNA) No. 1843, at Vol. 74 (January 15, 1998).

[12]See, e.g., United States v. Morton Plant Health System, 1994-2 Trade Cas. (CCH) ¶ 70,759 (M.D. Fla. 1994) (consent decree enjoins merger but allows combination of some services but requires inpatient acute care services to remain separate).

[13]United States v. Long Island Jewish Medical Center, 1997-2 Trade Cas. (CCH) ¶ 71,960 (E.D.N.Y. 1997).

[14]The states have filed amicus briefs in appeals from significant hospital merger decisions. See, e.g., FTC v. Butterworth Health Corp., 1992-2 Trade Cas (CCH) ¶ 71,571 (W.D. Mich. 1996), aff'd, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. Mich. 1997); U.S. Mercy Health Services, 1995-2 Trade Cas. (CCH) ¶ 71,162 (N.D. Iowa 1995), vacated as moot, 1997-1 Trade Cas. (CCH) ¶ 71,729 (8th Cir. 1997).

More recently, state enforcers have reviewed various physician practice mergers,[15] and conditioned some on rate limitations.[16] Mergers among health plans have similarly been addressed by state enforcers.[17]

Suffice to say the enforcement of the states has been quite extensive and reflects the belief of state antitrust enforcers that competition can provide price discipline in health care markets and positively impact consumer choice. Indeed, as antitrust enforcers we like to believe that antitrust enforcement can cure most of what ails a particular market, sort of a governmental "chicken soup." We do not always know how competition works or how it ultimately will benefit consumers but we have a belief that it is at least better than the alternatives: regulation of markets by government bureaucrats or collusion by

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[15] See, e.g., State of Wisconsin v. Marshfield Clinic, 1997-1 Trade Cas. (CCH) ¶ 71,855 (W.D. Wis. 1997) (consent decree permitted merger of two multispecialty clinics but prohibits acquisition of additional primary and specialty care practices of varying periods and limits exclusive contracting and covenants not to compete).

[16] See, e.g., State of Maine v. Maine Heart Surgical Associates, P.A., 1996-2 Trade Cas. (CCH) ¶ 71,653 (Me. S. Ct. 1996) (consent agreement permits physician merger provided physicians limit rates to those paid by managed care plans in the Boston area).

[17] See, e.g., Harvard Community Health Plan, Inc./Pilgrim Health Care, Inc. (Assurance of Discontinuance 1995) (two health plans permitted to merge but required to return claimed savings to consumers and provide various types of charitable care and to submit to some oversight by attorney general regarding physician practice contracts and acquisitions); Blue Shield/Baystate (Settlement Agreement--Massachusetts 1992) (health plan merger permitted conditioned on payment of $2 million into fund for uninsured children and funding of study reasons for failure of

self-interested market participants.

[DIGRESSION ON FED-STATE COOPERATION]

III. STATE REGULATION -- A PARALLEL UNIVERSE TO STATE ANTITRUST ENFORCEMENT

Coupled with the increase in state antitrust enforcement in the 1980's was a sometimes fitful but steady diminution in the degree of state regulation of the health care system. Poorly conceived state regulatory schemes were gradually dismantled as we came to rely increasingly on the market to price and allocate health care services. Yet, because certain key market imperfections in health care markets continued to exist, it is likely that deregulation probably went too far in some cases.

A. The Wisconsin Deregulation Experience

For example, at a policy level there was an aura of unreality to the introduction of competition (enforced through the antitrust laws) to the Wisconsin health care system because so much of that system was, in the mid-1980's regulated by the state. For example, prior to 1983, no health care plan could operate in Wisconsin unless every doctor was permitted to participate in that health care plan. Moreover, hospital rates were, more often than not, controlled or influenced by state officials usually in consultation with representative hospitals which often competed with each other. Hence, even as we contemplated a huge new

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Baystate).

enforcement effort in health care markets, we realized that the state action doctrine, in a narrow sense, and public policy deregulating health care markets, in a larger sense, would also play a significant role in these rapidly evolving markets.

Our office became directly involved in the public policy debate which led, in 1983, to the repeal of the state prohibition on closed panel plans and, through an aggressive state bidding process for health insurance for state employees, provided the stimulus for aggressive competition among newly-formed, closed panel HMOs and PPOs. These two state law changes caused a massive reorganization of the health care markets in Madison, where a high proportion of the residents were state employees, and to a lesser extent in Milwaukee, the state's largest urban center.

But, even as the state was deregulating doctor services aggressively, it continued an ambivalent posture towards competition among hospitals and certain other health care entities. In the mid-1980s, hospitals were permitted to coordinate their pricing through hospital rate-setting agreements promulgated by a committee consisting primarily of hospital representatives, but also including certain state officials. When it became apparent that there were obvious antitrust problems with an arrangement, where although state officials sat at the table, the private parties essentially decided what the prices would be, the state lurched to the other extreme and set up a hospital Rate-Setting Commission similar in structure to state Public Service

Commissions to dictate rates to state hospitals.[18]

The lack of confidence in competitive hospital rate-setting implicit in this approach flew in the face of the state's attempts to deregulate other parts of the health care industry. Indeed, the mind set of the people who ran the Wisconsin Hospital Rate-Setting Commission in the mid-1980s, could only be described as antithetical to competition. The general counsel for that commission once told me in a moment of candor that he would just as soon prefer that all the hospitals in the state merge into one entity because his job would be a lot easier if he could determine prices for one entity, rather than for several hundred. Moreover, even as it became apparent that direct price controls on hospitals were not the answer to escalating costs in the health care industry, the state somewhat bizarrely decided to continue price controls on urban hospitals (which faced intense competition from their rivals) even while relaxing price controls on rural hospitals (which typically did not have much competition at all). Fortunately, this commission was abolished and replaced by a much less regulatory Cost Containment Commission which could not control the economic decisions of health care entities beyond certain capital expenditures. Eventually, even the Cost

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[18]I should note that our experiences in this area led us to co-author an amicus brief in support of the Commission in FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992) arguing essentially that the level of supervision of title insurer ratemaking by the Wisconsin Office of the Commissioner of Insurance was not sufficiently active to invoke the state action doctrine.

Containment Commission was abolished.

Lest one concludes that the schizophrenia in state health care regulation is a distant memory, I should remind you of the adoption by approximately twenty states of Certificate of Public Advantage ("COPA") statutes. These statutes purport to provide immunity to certain health care actors when they collaborate with competitors under certain circumstances. The apparent purpose behind many of these statutes is that enforcement of the antitrust laws against certain types of collaboration among health care providers may inhibit necessary or socially useful collaboration by such providers.[19] The statutes purport to give immunity from state antitrust law and, in most cases, from federal antitrust liability via the state action doctrine. However, in many cases, including Wisconsin,[20] the "active supervision" required by the state action doctrine appears to be lacking.[21] In many respects, COPA legislation is an attempt by competitors in health care markets to roll back antitrust enforcement usually without a commensurate increase in state regulation, thereby leaving the markets subject to regulation by the market participants

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[19]See T. Kondo & D. Forster, The Role of Antitrust Immunity in the Washington State Health Care Market, Report to the Washington State Legislature at 57-58 (December 15, 1995).

[20]Sec. 150.85, Wis. Stats.

[21]FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992). It should be noted that over thirty states filed an amicus brief in support of the Federal Trade Commission before the Supreme Court arguing that the Insurance Commissioners in Wisconsin and Montana had not "actively supervised" the conduct of the title insurance companies involved sufficient to meet the "active supervision"

themselves.

B. Market Imperfections and Non-Market Goals

I recount this history of somewhat indecisive and, indeed, somewhat schizophrenic state regulatory policy because we ought not lose sight of the fact that antitrust enforcement does not exist in a vacuum. Even as we have come to rely more on the market mechanism to price and allocate health care services, state policy appears at times to grope for ways to soften the impact of market forces and to meet other non-market goals. Even if there was time to do so, I would not attempt to defend some of these more current attempts at state regulation. However, these attempts may reflect a lack of ease with a purely market-driven health care system for two primary reasons.

First, most of the market imperfections which existed in health care markets prior to deregulation, and, in fact, were the reason for much of the regulation, continue to exist. For example, health care consumers often have little ability, or incentive, to shop for low-priced health care because their employer, or the government, usually foots the bill. Similarly, it is notoriously difficult for consumers to assess the quality of their health care providers in advance of needing the services. In recent years, consumers have increasingly been asked to internalize pricing decisions (through increasing deductibles and

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prong of the state action doctrine test.

co-pays) and improvements have been made in quality reporting enabling consumers to make better judgments about alternative providers. Yet, even as this progress is made, recent studies have shown as deductibles and co-pays have increased, more and more consumers, especially the healthy ones, have voluntarily opted out of their employer's health insurance plans.

This leads to a second, perhaps more important point that we all recognize that there is something fundamentally different about health care than most other goods and services. Our health care system has, for generations, been designed to serve everyone, regardless of ability to pay. Although never totally successful, the system has been designed to serve these noble ends through an intricate array of subsidies and institutional arrangements unlike any other industry. In short, we are reluctant to deny service to people who need it and yet there is no universal mechanism to force every person (or their proxy in the form of the government or employer) to pay for such services ex ante.

In workably competitive markets, we assume that a large number of consumers will choose not to purchase a product at the prevailing market price (often represented as the demand curve to the right of the market clearing price). But, with respect to health care, we are unwilling to countenance a health care system which makes needed services unavailable to those lacking in the means, or the foresight, to purchase them in a pure market setting. Hence, through a complex network of state and federal

government programs, charitable institutions, teaching hospitals, and intricate arrangements among providers, cobbled together a system which attempts to achieve the conflicting goals of optimal cost and quality and universal availability.

In essence, we say to our health care system: "Minimize costs, maximize quality and choices, and provide services for everybody, regardless of the ability (or willingness) to pay." We do not ask any other market to do this.

But antitrust enforcement alone cannot reform these markets such that these goals are met in full. Antitrust enforcement attempts to prevent anticompetitive conduct within an existing market and attempts to prevent the emergence of market power through mergers and other anticompetitive acts. It can only, very indirectly, alter the conditions under which those markets operate.[22] In short, antitrust law takes markets essentially as they are, warts and all.

IV. MULTIPLE ROLES OF STATE ATTORNEYS GENERAL

Even as health care markets were deregulated at the state level, and traditional competition policy was engrafted onto the health care system, the longstanding market imperfections and non-market goals inherent in the health care system remained apparent to the attorneys general. These somewhat contradictory forces

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[22]Carstensen, The Reconstruction of Legal-Economic Relations: Achieving Workable Competition, 8 Loy. Consumer L. Rep. 153-66

caused an inherent schizophrenia in the system. Even as state attorneys general began to enforce the antitrust laws with vigor in health care markets, state legislatures struggled with the appropriate mix of market and regulatory tools needed to meet all of the goals expected to be realized by the health care system. As a result, they often imposed a wide variety of enforcement and advisory roles on their state attorneys general.

In essence, state attorneys general were required to wear multiple hats when dealing with the health care industry. Not only do state attorneys general enforce the antitrust laws, they also often: represent their Departments of Health; actively participate in the Certificate of Public Advantage and Certificate of Need processes (if they exist in their state); possess both statutory and equitable powers to protect the integrity of charitable trusts which run most health care institutions, especially hospitals; represent large university teaching and research hospitals and related doctor groups; prosecute health care fraud and abuse; defend state-employed health care providers in malpractice claims, and represent and advocate before state insurance commissioners regarding health insurance matters.

Given this parallel universe of responsibilities, it is not surprising that state attorneys general often surface in a number of capacities regarding particular health care transactions. Notwithstanding this, it has been my experience, generally, that

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(1995-96).

antitrust enforcers in state attorneys general's offices approach antitrust investigations, especially merger investigations, from the fairly narrow, but professional, perspective as to whether a violation of law can be established. Most state antitrust enforcers have become quite familiar and skilled at applying the NAAG Horizontal Merger Guidelines.[23] Simply put, because any challenge to a merger, or other potential violation, would have to meet the standards imposed by the antitrust law, there is not a lot of room for consideration of other concerns in making the initial cut as to whether a violation can be proved.

On the other hand, in those situations where a transaction may cause anticompetitive effects, state enforcers may be quite creative in working out relief provisions which can, at least temporarily, restrain the exercise of market power. Such criticisms generally have in mind provisions such as those contained in consent judgments entered in hospital merger cases such as the one involving the two hospitals in Kenosha, Wisconsin.[24] Some have suggested that these decrees are often "regulatory" in nature, apparently suggesting that they intrude too greatly on the post-merger business decisions of the merged entity.[25] As conditions permitting the merger to proceed, these

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[23] 4 Trade Reg. Rep. (CCH) ¶ 13,406 (1993).

[24] See cases cited supra note 10.

[25] Compare R. Langer, State Attorneys General and Hospital Mergers, Health Care Chronicle (Summer 1997) with C. Hisiro & K. O'Connor, State Attorneys General and Hospital Mergers: A Response, Health Care Chronicle (Fall 1997).

provisions typically require the merged entity to:

1. Return efficiencies claimed by the parties to be specific to the merger;
2. Maintain an open hospital staff; and
3. Refrain from certain forms of tying and discrimination conduct.

The greater willingness on the part of the states, as compared to the federal agencies, to consider such provisions has led to the criticism that these decrees are "regulatory" or somehow vaguely inappropriate in a consent decree. I believe this view is misplaced. These provisions can be defended on strictly antitrust grounds. But I do think it is fair to say that state attorneys general are more willing to accept such provisions because of our multifaceted role in health care matters in our states. Notwithstanding this, I think it is important before this group to respond to the criticism directly.

First, it is obvious that the transactions involved are not initiated by the government, but by the parties involved. Moreover, the alternative to a negotiated settlement was, in virtually every case, a challenge to the transaction itself. In short, the state's role in these cases has been reactive, not proactive in a regulatory sense.

Second, these kinds of consent judgments are only worked out in cases where there is significant anticompetitive issues. Appealing once again to my Wisconsin experience, I can tell you

that, more often than not, we simply close an investigation without further action. We do not use the threat of litigation in marginal cases to obtain onerous consent judgment provisions. For example, just within the past few weeks, our office closed an investigation of the merger of two large, multi-specialty physician practices in Madison. The University of Wisconsin Medical Foundation, the Physician Practice Group of the University of Wisconsin, consisting of over six hundred doctors, acquired a two hundred plus doctor multi-specialty clinic with the principle business and academic purpose of augmenting their primary care practice system. Although the merger raised some issues within the City of Madison, it appeared to be procompetitive in the twelve counties surrounding Madison.

Similarly, with respect to the multi-specialty physician practice merger initiated by Marshfield Clinic in north central Wisconsin, we concluded that the most serious potential anticompetitive effect of the merger was the possibility that the market would "tip" to Marshfield's benefit in the Wausau area, given Marshfield's dominance in the area surrounding Marshfield.[26] The consent judgment in that case was narrowly tailored to prevent certain acquisitions by Marshfield over the next few years, so as to prevent that tipping. Although we could have conceivably obtained additional provisions, we had little interest in becoming a regulator of these markets. On the other hand, we

thought it very important for the public interest that we preserve the conditions necessary for some degree of competition.

Third, the relief provisions in the hospital merger cases I mentioned, can all be defended on the grounds that they are tailored to specifically address possible anticompetitive effects of the proposed transaction. Most of the provisions requiring an open hospital staff and restricting tying of services and discrimination against certain purchasers, are fairly standard safeguards of the competitive process. Indeed, in the Kenosha Hospital case, we had been investigating complaints that the Kenosha Hospital had been excluding rivals from various essential services in the City of Kenosha prior to the announcement of the merger.

Fourth, the provisions requiring the return of efficiencies and capping prices are also defensible as a restraint on the increased market power that the merged entity may enjoy after the merger at least for the short to intermediate run. In fact, as you know, enforcement decisions in these areas essentially turn on predictions as to whether the merged hospitals can exercise market power. This issue is, in turn, closely related to the size of the relevant geographic market and the likelihood of entry. Even though the discharge data may suggest a relatively small geographic market, the emergence of managed care suggests that the geographic market and the likely participants in it might expand

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[26] See case cited supra note 15.

greatly over the intermediate to long run. Although we can debate whether the geographic market ought to be a circle with a radius of twenty miles, forty miles or one hundred miles, we ought not lose sight of the fact that, at least in the short run, the merged entity is likely to have significant additional market power in those communities where the merger involves the only two competing hospitals. In short, provisions capping hospital prices and requiring the return of efficiencies, are an attempt to simulate in the short to intermediate run what the merged parties often contend will be the long term result of the merger, i.e., that is, a more competitive market. The fact that such price caps and efficiency returns are also consistent with other state goals for the health care system -- such as provision of charity care -- is an added bonus, but not the primary focus of state antitrust enforcers.

Fifth, another factor driving these consent judgments is the lingering uncertainty surrounding some of the decisional law regarding mergers. These include not only the typical hospital merger battleground issues of geographic market definition and efficiencies, but now, apparently, at least in the Sixth Circuit, the non-profit status of the merging parties and their subjective intents post merger.[27] Frankly, with the federal agencies losing their last four hospital merger cases, the consent judgments in

[27] FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), aff'd, 121 F.3d 708 (6th Cir. 1997).

state merger cases appear to be a very positive contribution to the public interest. I believe the difficulties the federal agencies have had challenging hospital mergers are reflective of the federal courts' uneasiness about whether health care systems can, or even ought, to operate in a purely market-driven environment. For example, the Butterworth court rather explicitly brought into play the subjective, non-traditional criteria of the non-profit status of the merging entities. In the face of this type of judicial indecision and lack of discipline applying antitrust principles, I think it is perfectly appropriate for the states to entertain creative mandatory injunctive relief provisions that are in the public interest. The idea that antitrust enforcement can only be effective if it is a binary choice -- challenge or don't challenge -- may miss opportunities for outcomes in the public interest.[28]

CONCLUSION

My goal today has been to put state health care antitrust enforcement in the context of the broader mission of state attorneys general. As is apparent, notwithstanding the multiple hats worn by attorneys general, the states will continue to be

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[28]Some have suggested that the federal agencies approach merger enforcement from this binary perspective. Although this is true to some extent, one need only look at the Morton Plant consent judgment (see case cited supra note 12) to see that the federal agencies are at least as creative as the states in their use of injunctive relief provisions in their consent judgments.

aggressive enforcers of the antitrust laws and advocates for sound competition policies at the state level.

As a final note, I should underscore that notwithstanding the difference in approach between the federal agencies and the states on some of these matters, the states and the federal agencies work together very closely in many of these investigations. We often do interviews together, share experts and develop case theories in tandem. Indeed, NAAG, DOJ and the FTC recently adopted a joint statement concerning the conduct of merger investigations and settlement discussions in all merger cases, including those involving health care markets. Hence, even though it is probably fair to say as a general matter the states are more willing to take "half a loaf" during the end game of a merger investigation, we will continue to work together to serve the public interest.[29]

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[29]The views contained herein are those of the author only and not necessarily the views of any state attorney general or the National Association of Attorneys General.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

STATE OF WISCONSIN,

Plaintiff,

v.

KENOSHA HOSPITAL AND MEDICAL CENTER and ST. CATHERINE'S HOSPITAL, INC.,

Defendants.

Civil Action No.

96-C-1459

FINAL JUDGMENT

WHEREAS the State of Wisconsin filed a Complaint in this matter on December 30, 1996, as a direct purchaser of inpatient acute-care hospital services in Kenosha and surrounding counties and as parens patriae to protect its general economy, pursuant to section 7 of the Clayton Act, 15 U.S.C. § 18;

WHEREAS Kenosha Hospital and Medical Center ("KHMC"), St. Catherine's Hospital ("SCH"), and Dominican Healthcare, Inc., entered into an Alliance Agreement on December 1, 1995, by which they agreed to form Siena Healthcare System, Inc. ("Siena"), to manage and operate KHMC and SCH as an integrated community health-care delivery system in the southeast Wisconsin and northeast Illinois area;

WHEREAS Siena is expected to generate total cost savings of at least $43.7 million over the five-year period following its implementation, consisting of approximately $24 million in capital and duplicative-services avoidance and approximately

$19.7 million in operational savings, to improve the quality of health care for area residents, and to increase access to health-care services for residents of Kenosha and surrounding counties, including the indigent and the otherwise underserved;

WHEREAS the Office of Attorney General of the State of Wisconsin ("Attorney General") is responsible for enforcement of the federal antitrust laws and is authorized to bring suit on behalf of the State as a direct purchaser of inpatient acute-care hospital services and as parens patriae to protect its general economy;

WHEREAS KHMC and SCH have cooperated fully with the Attorney General's investigation of the proposed consolidation;

WHEREAS the Attorney General has concluded its investigation of the proposed consolidation of the two hospitals and believes that, without this Final Judgment, the consolidation could raise competitive concern under the federal antitrust laws;

WHEREAS KHMC and SCH desire to assure the Attorney General and the community that they intend to operate Siena in accordance with the Siena mission and to continue the hospitals' traditional commitment of providing high-quality, affordable health care to the community;

WHEREAS KHMC and SCH, desiring to resolve the Attorney General's concerns without trial or adjudication of any issue of fact or law, and before the taking of any testimony, have consented to entry of this Final Judgment; and

WHEREAS this Final Judgment is not an admission, or

probative, of liability by KHMC, SCH, or Siena as to any issue of fact or law and may not be offered or received into evidence in any action, or otherwise be construed or interpreted, as an admission, or as being probative, of liability; it is hereby ordered:

I. JURISDICTION

1. This Court has jurisdiction over the subject matter of this action and each of the parties consenting to this Final Judgment. The complaint states a claim upon which relief may be granted against the defendants under section 7 of the Clayton Act, 15 U.S.C. § 18.

II. DEFINITIONS

As used in this Final Judgment:

2. "Kenosha Hospital and Medical Center, Inc." ("KHMC") means the nonstock, nonprofit, tax-exempt corporation organized under the laws of the State of Wisconsin that operates a hospital with the same name at 6308 Eighth Avenue, Kenosha, Wisconsin 53143; and any entities operated or controlled by KHMC that provide services provided by KHMC at the time of entry of this Final Judgment.

3. "St. Catherine's Hospital, Inc." ("SCH") means the nonstock, nonprofit, tax-exempt corporation organized under the laws of the State of Wisconsin that operates a hospital with the same name at 3556 Seventh Avenue, Kenosha, Wisconsin 53140. For purposes of this Final Judgment, "SCH" includes its sponsor, Dominican Health Care, Inc., and all entities operated or

controlled by SCH that provide services provided by SCH at the time of entry of this Final Judgment.

4. "Siena" means the nonprofit, nonstock corporation that KHMC and SCH will create pursuant to their December 1, 1995 Alliance Agreement, and includes all physicians and other health-care providers employed, or whose business operations are controlled, by Siena. All provisions in this Final Judgment that apply to Siena also shall apply to KHMC and SCH.

5. "Member hospital" means KHMC or SCH.

6. "Ancillary services" means home-health services and durable medical equipment.

7. "Health plan" means all types of organized, health-service purchasing programs, including, but not limited to, networks or managed-care plans offered by third-party payers or providers, that purchase hospital and other health-care services.

8. "Health-care provider" means physicians, hospitals, laboratories, physician networks, and ancillary health-care providers.

9. "Acquire" means to purchase the whole or the majority of the assets, stock, equity, capital, or other interest in a corporation or other business entity, or to obtain the right or ability to designate the majority of directors or trustees or otherwise control the management of a corporation or other business entity.

10. "Kenosha and surrounding counties" means Kenosha, Racine, and Lake Counties.

11. "Attorney General" means the Criminal Litigation and Antitrust Unit of the Wisconsin Office of Attorney General.

III. TERMS

12. Anticipated Savings and Price Reductions

KHMC and SCH intend to merge and consolidate services into Siena, increase efficiency, and reduce the cost of delivering health-care services so that the cost to the community of those services will be lower than they would have been absent the Siena alliance.

12.1 As set forth in Exhibit 1, Siena shall achieve in 1996 constant dollars at least $43.7 million in savings by the end of five years after closing. Siena shall pass on the operational savings and the capital-avoidance savings (as reflected by unincurred depreciation expense), shown on Exhibit 1 to consumers or other purchasers of health-care services by one or more of the following means: (a) providing low-cost or no-cost health-care programs for the community not already provided by KHMC or SCH, (b) expanding low-cost or no-cost health-care services for the community already provided by KHMC or SCH, (c) reducing prices or limiting actual price increases for existing services affecting Siena's case-mix adjusted net patient revenue per equivalent admission ("Revenue") so that the increase in Revenue is less than the increase in the Consumer Price Index for Hospital and Related Services, or (d) other methods agreed upon by Siena and the Attorney General. Prior to passing on to consumers or purchasers savings in the form of low-cost or no-

cost health-care services, Siena shall provide its proposals for doing so to the Attorney General in writing, and the Attorney General shall be deemed to have approved the proposals unless it objects to specific proposals, providing its reasons to Siena in writing, within ten business days after receiving Siena's proposals.

12.2 A schedule setting forth the savings of at least $43.7 million over the five-year period following implementation of Siena, including $24 million in capital and duplicative-services avoidance, $19.7 million in operational savings, and the required pass through of operational and capital-avoidance savings to consumers or customers, is attached to this Final Judgment as Exhibit 1.

12.3 Each year, as part of the report required by Subparagraph 21.1, Siena will prepare and submit to the Attorney General a report monitoring its duty to avoid $24 million in capital and duplicative-services expenditures listed in its efficiencies report.

12.4 If Siena fails to generate and pass on to purchasers or consumers the annual operational-savings target amounts in any year of the five-year period, the shortfall amount shall be carried forward into subsequent years until the required operational-savings target amount has been generated and passed on by Siena. If Siena exceeds the annual targeted operational-savings and pass-through amount of operational savings to purchasers or consumers in any given year, the excess amount

shall be credited toward Siena's target for the next fiscal year.

12.5 If, by the end of five years after closing, Siena has not avoided $24 million in capital and duplicative-services costs and generated $19.7 million in operational savings as shown on Exhibit 1, Siena shall pay in cash an amount equal to $43.7 million less the amount of capital and duplicated services avoided and operational savings generated into an Indigent Care Fund established by Siena, but under the supervision of the Attorney General. The Indigent Care Fund shall be used for programs provided by Siena and approved by the Attorney General to meet the health-care needs of the indigent or underserved population of Kenosha and surrounding counties after consultation between Siena and the Attorney General about such programs. Such programs may include, but not necessarily be limited to, preventive health-care services, child immunizations, mammograms, prenatal care, and alcohol and drug-abuse treatment programs. If Siena has not achieved $43.7 million in savings by five years after closing, Siena shall have an opportunity to demonstrate, to the satisfaction of the Attorney General, that unforeseeable circumstances beyond its control prevented achievement of the savings, and the Attorney General may reduce accordingly the cash payment set forth in this subparagraph.

12.6 As methods for ensuring and documenting the operational savings and the passing on of the target savings to consumers and purchasers:

12.6(a) Siena's Revenue for patients treated during

each of the five years after entry of this Final Judgment shall not exceed the combined hospital Revenue of the member hospitals for calendar year 1996 (the "base year"). To the extent the Revenue for a given year is less than the base year Revenue, the difference shall be counted toward the annual pass-through targets as shown in Exhibit 1. To the extent the Revenue for a given year is greater than the base year, Siena shall reimburse the excess by lowering its rates in the next fiscal year by a sufficient amount to repay the excess Revenue. If, at the end of five years Siena has not met the cumulative pass through targets, Siena shall lower its rates to the extent necessary to pass through the amount of the unmet target.

12.6(b) Siena's case-mix adjusted net patient operating expense per equivalent admission ("Expense") for patients treated during each year of the five years after entry of this Final Judgment shall not exceed the combined hospital Expense of the member hospitals for the base year. To the extent the Expense for a given year exceeds that of the base year, the excess amount shall be added to the next-year's annual operational savings target. Siena may instead reimburse the excess by lowering its patient rates in the next year by a sufficient amount to meet its prior year's unmet Expense target. The Attorney General may exempt Siena from adding the excess to future targets or from reimbursing the excess for good cause shown by Siena. If all or part of the excess was caused by the provision of low-cost or no-cost-services to the community, that amount shall be credited

toward the operational savings target. To the extent the Expense for a given year is less than that of the base year, the difference shall be counted toward the operating savings targets as shown in Exhibit 1.

12.6(c) In determining compliance with Subparagraphs 12.6(a) and (b), base year Revenue and Expense shall be adjusted (up or down) for changes in the Consumer Price Index for Hospital and Related Services.

Siena shall describe its compliance with Subparagraph 12.6 in its annual report described in Subparagraph 21.1. Siena shall provide the Attorney General with information reasonably needed and requested by the Attorney General to monitor its compliance with this Subparagraph.

12.7 Subparagraphs 12.4 through 12.6 shall apply only during those fiscal years during which the State of Wisconsin or the federal government does not substantially regulate hospital rates.

13. Nondiscrimination in Contracting With Managed Care and Related Health Care Facilities

13.1 Siena shall not enter into any contract with any health plan that prohibits it from providing services to any other health plan.

13.2 Siena shall not restrict the ability of any physician not employed by it, or with which it does not have an exclusive contract as permitted by Subparagraphs 14.2 and 14.3, to provide services or procedures at locations other than Siena. This provision, however, shall not prohibit Siena from taking

reasonable action necessary to ensure that such physician adequately covers his or her practice and patients at Siena.

13.3 Siena shall not restrict the ability of any physician not employed by it, or with which it has no exclusive contract as permitted by Subparagraphs 14.2 and 14.3, to participate in any health plan of his or her choice. Any health plan or network in which Siena has ownership or membership may engage in good-faith selective contracting with physicians and not enter into provider contracts with all providers desiring to contract with it.

14. Competitive Access to Siena Facilities

14.1 Except as provided in Subparagraphs 14.2 and 14.3, Siena shall not enter into any exclusive contract with any health-care provider by which, with respect to physicians not employed by it, it requires that provider to render services only or primarily at a member hospital, or by which, including physicians employed by it, it permits only one physician or group of physicians to be the sole or primary provider of particular services at a member hospital.

14.2 Siena may honor those exclusive contracts into which either KHMC or SCH had entered as of December 8, 1995, the date Siena was announced. It may not renew or expand those contracts after the nominal termination date of those contracts, regardless of any automatic renewal, "roll over," or "evergreen" provision unless they comply with Subparagraph 14.3. Siena may require physicians employed by it to provide services only at

member hospitals.

14.3 Siena may enter into exclusive contracts for hospital-based services with anesthesiologists, radiologists, radiation oncologists, cardiologists using Siena's cardiac diagnostic and cardiac catherization labs, pathologists, nephrologists providing renal-dialysis services at Siena, and emergency-medicine physicians if it seeks competitive bids for the contract at least once every three years and the bidding specifications require that the exclusive contractor not refuse unreasonably to participate in any health plans that have provider contracts with Siena. All exclusive contracts in effect at the time this Final Judgment is entered will be re-bid not later than March 31, 1997.

14.4 The Siena Board of Directors shall provide for an open medical staff, ensuring access to all highly qualified physicians. In determining clinical privileges, Siena shall not discriminate against any applicant for medical staff privileges based on that applicant's status as an employee or affiliate of a Siena competitor, although Siena may take reasonable steps to ensure that such applicants do not have access to competitively sensitive Siena information. In determining medical-staff membership and clinical privileges, Siena may enter into exclusive contracts to the extent permitted by Subparagraph 14.3, and may consider factors relating to the level of health-care quality provided at its facilities, apply its medical-staff bylaws, comply with all requirements of the Joint Commission on

Accreditation of Healthcare Organizations necessary for accreditation, and apply the privilege categories set forth in Exhibit 2. The Siena medical-staff bylaws shall be substantially similar to those in effect at KHMC at the time this Final Judgment is entered, and shall be consistent with this Final Judgment both initially and in any changes made during the duration of this Final Judgment, and shall not be substantially changed without the prior approval of the Attorney General. Siena shall provide copies of its medical-staff bylaws, together with all written form materials provided to physicians relating to its staff credentialing process (e.g., application forms, policies, instructions, and criteria) to the Attorney General with each Annual Report required by Subparagraph 21.1 and whenever any of them are amended.

14.5 All physicians with medical staff membership at KHMC or SCH, and all physicians with applications pending for medical staff membership who meet current credentialing requirements, shall have medical staff membership at Siena, provided that all subsequent decisions concerning privileges or corrective action shall be consistent with the Siena medical-staff bylaws in effect at the time of any such renewal or corrective action. Siena shall not deny any physician access to its medical-staff application process. Siena shall not reject the application for, terminate, suspend, or limit the staff privileges of any physician based on his or her lack of qualifications or for any quality-of-care concern without first

providing the physician with due process pursuant to the medical-staff bylaws, including, without limitation, a statement of the reasons for its action and an appeal to the Siena Board of Directors. Siena shall make a final decision on each application for staff privileges within 90 days of its receiving all information necessary for making that decision. Pending applications and those that were pending on November 30, 1995, shall be decided within 60 days after entry of this Final Judgment. This subparagraph shall not apply to any application for privileges to render services for which Siena has an exclusive contract as permitted by Subparagraphs 14.2 and 14.3.

14.6 Siena shall negotiate in good faith with all health plans serving or that plan to serve Kenosha and surrounding counties that approach it in good faith seeking a provider contract, and shall attempt, in good faith, to contract with all such health plans that offer competitively reasonable terms. Siena shall not refuse to contract with any health plan solely because it proposes or uses a capitation or other risk-bearing or risk-shifting reimbursement methodology. This subparagraph, however, does not require Siena to contract with any particular health plan or with all health plans. Should KHMC or SCH move any services from one hospital to the other, Siena shall provide that service to any health plan that had a provider contract with either KHMC or SCH as of December 8, 1995, pursuant to the terms of that provider contract.

14.7 Siena shall not enter into provider contracts with

any health plan in which it has an ownership (or membership, if a nonprofit entity) interest on terms significantly more favorable to it and which it receives because of Siena's financial interest if those terms would place other health plans at a significant competitive disadvantage and the favorable terms granted Siena's plan cannot be justified because of efficiencies resulting from economic integration between Siena and that plan.

14.8 Siena will not use employment, the location of a physician or group practice, or the location where patients will receive any necessary follow-up care to determine referrals from the member hospitals' emergency rooms. Siena may consider quality of care in determining referrals. Siena shall provide the referral policy used to inform unassigned patients of the availability of follow-up care to the Attorney General within 30 days from entry of this Final Judgment or at such time as Siena adopts such a policy. Should the Attorney General object to the policy, it and Siena shall attempt to reach a mutually satisfactory solution. This subparagraph shall not preclude any health plan operated by Siena from limiting referrals to providers with provider contracts with that plan.

14.9 Except with regard to exclusive contractors permitted by Subparagraphs 14.2 and 14.3 and physicians employed by Siena, if Siena controls or operates a health plan, it shall not base medical-staff appointment and privileging decisions or other decisions affecting a physician's access to, or working conditions at, Siena on whether that physician enters into a

provider contract with either Siena's plan or with a competing health plan, or on whether the physician is employed by or has staff privileges at a competing hospital or health system.

14.10 Siena shall not condition the sale of hospital services provided by it to any purchaser on the purchaser's agreeing with Siena to (a) purchase other services from Siena or its employed physicians (unless those services are provided by physicians with whom Siena has an exclusive contract as permitted by Subparagraphs 14.2 and 14.3), or (b) deal with any health plan operated by Siena. Siena shall not reduce its rates for hospital services to purchasers on the condition that they purchase other services from Siena, from physicians employed by Siena, or from KHSC if, because of the differential in rates, the purchasers' only viable economic option is to purchase other services from Siena, its employed physicians, or KHSC.

14.11(a) Siena shall not enter into any agreement or understanding with any physician by which that physician refuses to refer patients to, accept patient referrals or transfers from, provide back-up and specialty coverage for, or consult in the treatment of any patient with, any other physician or health plan. This provision shall not apply to physicians with which Siena has an exclusive contract permitted by Subparagraphs 14.2 and 14.3, or in the situation where the patient is a patient of a health plan or network and the referral would be to a physician that does not have a provider contract with that plan.

14.11(b) Siena shall not discriminate against

physicians employed by competing organizations in scheduling operating room times or usage of other hospital facilities. This provision shall not apply to physicians with which Siena has an exclusive contract as permitted by Subparagraphs 14.2 and 14.3.

15. Employment of Physicians.

15.1 Siena shall not employ more than 30 percent of the physicians within a 20-mile radius of Kenosha practicing in any of the following medical specialties: family practice/internal medicine, pediatrics, or obstetrics/gynecology, except as provided in Subparagraph 15.2. If, however, any other health-care provider employs more than 30 percent of the physicians within a 20-mile radius of Kenosha in the above specialties, Siena may employ the same percentage. If, on the date of entry of this Final Judgment, Siena employs more than the 30 percent permitted above, it is not required to divest physicians, but it cannot hire additional physicians in that specialty until the percentage falls to 30 percent or less. In specialties in which Siena employs the only physicians in Kenosha, Siena shall attempt in good faith to ensure that those physicians, when offered commercially reasonable terms, contract to provide services to all health plans seeking to contract for those physicians' services subject to bona fide capacity constraints.

15.2 Siena may petition the Attorney General in writing for an exception to Subparagraph 15.1 when market conditions justify its employing physicians in any of the enumerated specialties above the 30 percent limit. The Attorney General

will respond to the petition within 30 days from the receipt of all information from Siena reasonably necessary to analyze the petition.

16. "Most-Favored-Nation" Provisions in Contracts With Health Plans

Siena shall not enter into any provider contract with any health plan on terms that include a most-favored-nation clause. A most-favored-nation clause is any term in a provider contract that allows the buyer to receive the benefit of any better payment rate, term or condition that the seller gives another provider for the same service. In the case of any existing most-favored-nation clause in any current KHMC or SCH provider contracts, Siena shall not renew or extend such contracts without deleting that term. Siena shall inform the Attorney General of the presence of a most-favored-nation clause in any existing provider contracts by providing a list of such contracts to the Attorney General not more than 30 days after entry of this Final Judgment.

17. Ancillary Services

Siena shall not require any health care purchaser or patient to purchase ancillary services from it. If other firms cannot provide ancillary services in a manner that would permit Siena to contain costs in the context of risk-bearing contracts, Siena may require that these services be purchased from it. Siena shall not discriminate in the provision of information provided to patients regarding ancillary services provided by Siena and any other provider of ancillary services. If Siena provides such

services, it shall affirmatively inform patients and other purchasers of all alternative suppliers of those services when it provides information about its products or services to the purchaser if those suppliers provide the necessary information to Siena.

18. Applications

Siena shall not oppose applications filed by other hospitals or other health-care providers with the Wisconsin Department of Health & Social Services ("Department") unless it notifies the Attorney General in writing at least seven days prior to filing any opposition, and provides a copy of any opposition to the Attorney General at the time of its filing with the Department.

19. Future Sales and Acquisitions of Hospital Assets

Siena shall not, without the prior approval of the Attorney General, either (a) acquire any interest in (including entering into a management contract) any hospital or health-care system in Kenosha or surrounding counties, or (b) permit any hospital or health-care system in Kenosha and surrounding counties to acquire it or any portion thereof. In the future while this Final Judgment is in effect, Siena shall not enter into any joint venture with any health-care system in Kenosha or Racine Counties without the approval of the Attorney General, which approval shall not be unreasonably withheld. The Attorney General will notify Siena of its approval or disapproval within 30 days after the Attorney General has received from Siena information reasonably necessary for the Attorney General to analyze the

joint venture, provided that the Attorney General shall promptly notify Siena of its information requests. If the Attorney General withholds its consent, Siena may challenge that determination by filing a petition with this Court, and the Attorney General shall have the burden of persuasion to show that the joint venture would violate federal or state antitrust law. Siena shall not, without providing at least 60-days' notice to the Attorney General, (a) enter into any joint venture with any other hospital, health-care system or health plan relating to the provision of hospital services, (b) acquire or be acquired by any health plan, or (c) acquire any interest in any hospital or health-care system outside Kenosha and surrounding counties. Nothing in this Paragraph shall be construed to apply to any sale or acquisition in which KHMC and SCH are the only parties.

20. Binding on Successors and Assigns

The terms of this Final Judgment are binding on Siena and its directors, officers, managers and employees, successors and assigns, including but not limited to any person or entity to whom Siena may be sold, leased or otherwise transferred, and all persons who are in active concert or participation with them who have actual or constructive notice thereof. Siena shall not permit any substantial part of Siena to be acquired by any other person unless that person agrees in writing to be bound by the provisions of this Final Judgment. Neither Siena nor any member hospital shall undertake any action through any entity controlled by any of them that would violate this Final Judgment if

undertaken directly by Siena or a member hospital.

21. Reporting Mechanism

21.1 Within 150 days after the anniversary of this Final Judgment while it is in effect, Siena shall submit to the Attorney General an annual report accompanied by an officer's compliance certificate describing its compliance with this Final Judgment. This report shall include a review of capital and duplicative-service avoidance and indicate any monies spent to be added to the operational-savings target pursuant to Subparagraph 12.3. The report shall include an analysis of Revenue and Expense pursuant to Subparagraphs 12.6 (a), (b) and (c), indicating compliance with the required targets and documenting the amount and timing of any required rate reduction. The report shall also include a description of expenses incurred in providing low-cost or no-cost services to the community pursuant to Subparagraph 12.1(b). The Attorney General will provide notice to Siena of any concerns raised by the annual compliance report within 30 days after its receipt of the report. Siena will meet with the Attorney General to attempt to resolve any concerns that the Attorney General may raise from its review of the report.

21.2 Siena will reimburse the Attorney General for expenses, including the payment of any expert fees, incurred in analyzing and verifying this report, in an amount not to exceed $10,000 per year. Within 60 days from entry of this Final Judgment, Siena will pay the Attorney General $5,000 to establish

a mutually-agreed upon model to be used to analyze compliance. This amount shall be deducted from the first year's reimbursement requirement. Siena will cooperate with any expert hired by the Attorney General, including, but not limited to, providing any additional requested information within Siena's control reasonably necessary to complete the analysis and verification of the compliance report.

22. Publication

22.1 Efficiency Report

Within 30 days after entry of the Final Judgment, Siena shall prepare and submit to the Attorney General a condensed explanation of the anticipated efficiencies and service reconfigurations resulting from Siena's creation, which will be released to the general public in Kenosha and surrounding counties.

22.2 Terms and Conditions

Within 21 days after entry of the Final Judgment, Siena shall prepare and submit to the Attorney General a condensed version of the Final Judgment's terms, which will be released to the general public in Kenosha and surrounding counties.

23. Compliance

To determine or secure compliance with this Final Judgment, any duly authorized representative of the Attorney General shall be permitted:

23.1 Upon reasonable notice, access during normal business hours to all non-privileged records and documents in

Siena's possession or control relating to any matters contained in this Final Judgment; and

23.2 Upon reasonable notice, access during normal business hours to interview Siena officers, managers, or employees regarding any matters contained in this Final Judgment.

24. Complaint Procedure

Any person, including health-care providers, health plans, or consumers of medical services, who wishes to report a possible violation of this Final Judgment shall send a written description of the possible violation to the Assistant Attorney General in Charge of Antitrust Enforcement, Antitrust and Criminal Litigation Unit, Office of Attorney General, 4th Floor, 123 West Washington Avenue, Madison, Wisconsin 53707. Unless prohibited from doing so by law, the Attorney General shall send a copy of the complaint to Siena's President, 6308 Eighth Avenue, Kenosha, Wisconsin, 53143. At the request of the Attorney General, Siena shall respond in writing to the Attorney General within thirty 30 days after receiving the complaint. If the complaint is still unresolved, the Attorney General will attempt to negotiate a satisfactory resolution. If Siena believes any complaint is frivolous, it may so advise the Attorney General, and its obligations under this paragraph will be satisfied unless it is otherwise advised by the Attorney General to respond more fully to the Complaint.

25. Reimbursement of Expenses

Upon entry of this Final Judgment, KHMC and SCH shall

jointly pay $20,000 to reimburse the Attorney General's costs incurred to conduct its investigation, which payment shall be used for future antitrust enforcement purposes.

26. Enforcement

26.1 If the Attorney General believes that there has been a violation of this Final Judgment, it shall promptly notify Siena in writing and explain the possible violation. The Attorney General shall permit Siena a reasonable opportunity to cure any alleged violation without instituting legal action. If Siena does not cure the alleged violation within 60 days after notification, the Attorney General may take any remedial action it deems appropriate. This time period shall be extended in circumstances where the 60-day period is not sufficient in which to cure the alleged violation.

26.2 In any action or proceeding brought by the Attorney General to enforce this Final Judgment or otherwise arising out of or relating hereto, the Attorney General, if it is the prevailing party, shall recover its costs and expenses, including attorneys' fees.

27. Legal Exposure

No provision of this Final Judgment shall be interpreted or construed to require Siena to take any action, or to prohibit Siena from taking any action, if that requirement or prohibition would expose Siena to significant risk of liability, including, but not limited to, liability for any type of negligence (including negligent credentialing or negligence in making

referrals) or malpractice.

28. Notices

All notices required by this Final Judgment shall be sent by certified or registered mail, return receipt requested, postage prepaid, or by hand delivery, to:

If to the Attorney General:

Assistant Attorney General
in Charge of Antitrust Enforcement
Criminal Litigation and Antitrust Unit
Office of Attorney General
4th floor, 123 West Washington Avenue
Madison, WI 53707

If to Siena:

President, Siena Healthcare System, Inc.
6308 Eighth Avenue
Kenosha, WI 53143

29. Averment of Truth

Siena avers that the information it provided to the Attorney General in connection with this Final Judgment, to the best of its knowledge, is true and represents the most recent and comprehensive data available, and that no material information has been withheld.

30. Termination

This Final Judgment shall expire on the seventh anniversary of its date of entry if it has not terminated prior to that time as provided in Paragraph 31.

31. Early Expiration

Five years after entry of this Final Judgment, Siena may request the Attorney General in writing to concur in Siena's application to this Court for an order terminating this Final

Judgment. The Attorney General shall not unreasonably withhold its concurrence to the application if Siena has complied with the provisions of this Final Judgment. In addition, this Final Judgment shall terminate without further action by the Court or any of the parties at such time as any entity opens a health-care facility in Kenosha or Racine County which has a number of inpatient medical-surgical beds equal to 25 percent or more of the average number of inpatient staffed medical-surgical beds that Siena is operating at that time, except that Siena may not deem this Final Judgment to have terminated without first giving the Attorney General 30 days' advance written notice. In addition, if Siena believes that any entity has opened or expanded a health-care facility that will provide substantial competition to Siena, it may petition the Attorney General to join a petition to this Court to terminate this Final Judgment.

32. Modification

If either the Attorney General or Siena believes that modification of the Final Judgment would be in the public interest because of changed or unforeseen circumstances or for other reasons, that party shall notify the other, and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall petition the Court jointly to modify the Final Judgment. If they cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

33. Retention of Jurisdiction

Unless this Final Judgment is terminated early pursuant to Paragraph 31, this Court shall retain jurisdiction for seven years after entry to enable any party to apply for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Final Judgment.

DATED this 20th day of Dec., 1996.

JAMES E. DOYLE
Attorney General
State of Wisconsin

By: _____
Kevin J. O'Connor
Assistant Attorney General
Office of Attorney General
4th Floor
123 West Washington Avenue
Madison, WI 53707
(608) 266-8986

KENOSHA HOSPITAL AND
MEDICAL CENTER, INC.

By: _____
Richard O. Schmidt, Jr.
President and Chief
Executive Officer

Attest: _____

ST. CATHERINE'S HOSPITAL, INC.

By: _____
Ryland Davis
President and Chief
Executive Officer

Attest: _____

_____
John J. Miles
Bruce R. Stewart
Ober, Kaler, Grimes & Shriver
A Professional Corporation
1401 H Street, N.W.
Fifth Floor
Washington, DC 20005-3324
(202) 326-5000

Attorneys for KHMC and SCH

SO ORDERED.

_____
United States District Judge

Judgment entered this 31st day of December, 1996.

SOFRON B. NEDILSKY, Clerk

By _____, Deputy Clerk

Exhibit 1

Siena Healthcare System, Inc.
(000's Omitted)

		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.	Operating Savings Target	(457)	3,597	5,502	5,514	5,519	19,675
2.	Depreciation Expense Not Incurred	75	318	519	618	792	2,322
3.	Sub-Total	(382)	3,915	6,021	6,132	6,311	21,997
4.	Pass Through Rate	60%	80%	80%	80%	80%	
5.	Pass Through to Community	(229)	3,132	4,817	4,906	5,049	17,675
6.	Capital and Duplicative Service Avoidance	3,369	10,357	1,658	4,358	4,310	24,052

Total of Operating Savings and Capital-Avoidance Savings (Lines 1+6) $43,727

Exhibit 2

In determining the clinical privileges to grant applicants for medical-staff membership and clinical privileges, the Siena Board of Directors will grant each applicant Category I, II, or III privileges, depending on the characteristics of that physician's practice and patients.

Category I Privileges -- Those privileges requiring a physician to have his or her office and residence within 30-minutes driving time of Siena's northeast and southeast campuses because of the types of medical services he or she provides and the potential urgent or emergent nature of his or her patients' needs. For an applicant to be assigned Category I privileges, his or her patients must have the greatest acuity level and level of risk of complications resulting from the procedures performed by the physician at Siena.

Category II Privileges -- Those privileges requiring a physician to have his or her office and residence within 60 minutes of Siena's northeast and southeast campuses, and have written backup coverage for urgent and emergent patient-care needs with a physician whose clinical privileges are comparable and whose office and residence are within 30-minutes driving time of Siena's northeast and southeast campuses because of the types of medical services he or she provides and the potential urgent or emergent nature of his or her patients' needs.

Category III Privileges -- Those privileges requiring a physician to have his or her office and residence within 60 minutes of Siena's northeast and southeast campuses, but no physician backup coverage because the types of medical services rendered and type of patients seen result in little or no patient risk because of the non-urgent and non-emergent nature of patients seen or care rendered.

STATE OF WISCONSIN DANE COUNTY BRANCH

STATE OF WISCONSIN

v.

THE WISCONSIN CHIROPRACTIC ASSOCIATION, a corporation, RUSSELL A. LEONARD,

Case No. _____

FINAL JUDGMENT

WHEREAS, the Wisconsin Department of Justice ("WDOJ"), having initiated an investigation of certain acts and practices of the Wisconsin Chiropractor Association ("WCA"), and its Executive Director, and Russell A. Leonard, hereinafter sometimes referred to as "defendants;"

WHEREAS, the State of Wisconsin filed a Complaint in this matter on _____ pursuant to Secs. 133.16 and 133.17, Stats.;

WHEREAS, it now appearing that defendants and the State of Wisconsin are willing to enter into an agreement containing an order prohibiting those acts and practices, and providing for other relief, including civil forfeitures pursuant to Secs. 133.03(1), 133.03(3);

WHEREAS, the Office of the Attorney General of the State of Wisconsin ("Attorney General") is responsible for enforcement of the federal and state antitrust laws and is authorized to bring suit on behalf of the State and as parens patriae to protect its general economy;

WHEREAS, the defendants desire to assure the Attorney General and the community that they intend to operate in a manner that ensures that competition for health care services in Wisconsin will not be compromised now or in the future;

WHEREAS the defendants, desiring to resolve the Attorney General's concerns without trial or adjudication of any issue of fact or law, and before the taking of any testimony, have consented to entry of this Final Judgment;

WHEREAS the defendants, by signing this document containing the Final Judgment, represent that the full relief contemplated in the Final Judgment can be accomplished, that the defendants and their counsel have read the proposed Final Judgment and Order contemplated hereby, that the defendants understand that once the order has been issued they will be required to file one or more compliance reports showing that they have fully complied with the order, and that the defendants agree to comply with the proposed order from the date they sign this agreement; and

WHEREAS this Final Judgment is entered into for purposes of settlement only and is not an admission, or probative of liability by WCA or Leonard as to any issue of fact or law and may not be offered or received into evidence in any action, or otherwise be construed or interpreted, as an admission, or as being probative, of liability; it is hereby ordered:

I. JURISDICTION

This Court has jurisdiction over the subject matter of this action and each of the parties consenting to this Final Judgment. The complaint states claims upon which relief may be granted against the defendants under Section 133.03(1), Stats.

II.PARTIES

1. The "Wisconsin Chiropractic Association" ("WCA") is a corporation organized, existing, and doing business under and by virtue of the laws of the State of Wisconsin, with its principal office and place of business located at 521 E. Washington Avenue, Madison, Wisconsin 53703.

2. Defendant Russell A. Leonard is currently and has been the Executive Director of the WCA since 1990. His principal office or place of business is the same as that of respondent WCA.

III DEFINITIONS

As used in this Final Judgment, it is ordered that the following definitions shall apply:

A. "Wisconsin Chiropractic Association" or "WCA" means Wisconsin Chiropractic Association, its directors, officers, employees, agents and representatives, predecessors, successors, and assigns; its subsidiaries, divisions, groups, and affiliates, controlled by WCA, and the respective directors, officers, employees, agents and representatives, successors, and assigns of each.

B. The individual defendant identified in Section II, above, means Russell Leonard, individually, and his representatives, agents, and employees.

C. "Person" means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, partnerships, and governments.

D. "Payer" means any person that purchases, reimburses for, or otherwise pays for all or part of any health care services, including, but not limited to, chiropractic

services, for itself or for any other person. Payer includes, but is not limited to, any health insurance company; preferred provider organization; prepaid hospital, medical, or other health service plan; health maintenance organization; government health benefits program; employer or other person providing or administering self-insured health benefits programs; and patients who purchase health care for themselves.

E. "Provider" means any person that supplies health care services to any other person, including, but not limited to, chiropractors, physicians, and clinics.

F. "Reimbursement" means any payment, whether cash or non-cash, or other benefit received for the provision of chiropractic goods and services.

G. "Chiropractor" means a person licensed to engage in the practice of chiropractic.

H. "Participation agreement" means any agreement between a payer and a provider in which the payer agrees to pay the provider for the provision of health care services, and in which the provider agrees to accept payment from the payer for the provision of health care services.

IV.

IT IS HEREBY ORDERED that the defendants, directly or indirectly, or through any corporation or other device or agent, are enjoined from and shall forthwith cease and desist from:

A. Requesting, proposing, urging, advising, recommending, advocating, or attempting to persuade in any way any person to fix, establish, raise, stabilize, maintain, adjust, or tamper with any fee, fee schedule, price, pricing formula, discount, conversion factor, or other aspect or term or condition of the fees charged or to be charged for any chiropractic goods or services.

B. Creating, presenting, discussing, formulating, suggesting, encouraging adherence to, endorsing, or authorizing any fee or any list or schedule of fees for any health care goods or services, including, but not limited to, suggested fees, proposed fees, average fees, fee guidelines, discounts, discounted fees, reimbursement rate, capitation amounts, standard fees, recommended fees, or conversion factors.

C. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding:

1. To negotiate on behalf of any chiropractor or group of chiropractors regarding any term, condition, or requirement of dealing with any payer or provider; or

2. To deal or refuse to deal with, boycott or threaten to boycott, any payer or provider; or

3. To limit, discourage or prevent educational seminars for chiropractors.

D. Requesting, proposing, urging, advising, recommending, advocating, or attempting to persuade in any way any chiropractor to accept or not accept any aspect, term, or condition of any existing or proposed participation agreement, including, but not limited to, the price to be paid for chiropractic goods or services.

E. Soliciting from, or communicating to, any chiropractor any information concerning any other chiropractor's intention or decision with respect to entering into, refusing to enter into, threatening to refuse to enter into, participating in, threatening to withdraw from, or withdrawing from any existing or proposed participation agreement.

F. 1. Organizing, sponsoring, facilitating or participating in any meeting or discussion that WCA or Leonard expects or reasonably should expect will facilitate communications concerning one or more chiropractors' intentions or decisions with respect to entering into, refusing to enter into, threatening to refuse to enter into, participating

in, threatening to withdraw from, or withdrawing from any existing or proposed participation agreement; or

2. Organizing, sponsoring, facilitating or participating in any meeting or discussion any fee or list or schedule of fees for any health care goods or services, including, but not limited to, suggested fees, proposed fees, average fees, fee guidelines, discounts, discounted fees, standard fees, recommended fees, or conversion factors, are presented, suggested, endorsed, discussed or offered as a goal, benchmark or reference point for the pricing of any chiropractic service; or

3 Continuing a meeting or discussion where WCA or Leonard knows or reasonably should know that a person makes communications concerning one or more chiropractors' intentions or decisions with respect to entering into, refusing to enter into, threatening to refuse to enter into, participating in, threatening to withdraw from, or withdrawing from any existing or proposed participation agreement, and WCA or Leonard fails to eject such person from the meeting or discussion; or

4 Continuing a meeting or discussion where WCA or Leonard knows or reasonably should know that two or more persons make communications concerning one or more chiropractors' intentions or decisions with respect to entering into, refusing to enter into,

threatening to refuse to enter into, participating in, threatening to withdraw from, or withdrawing from any existing or proposed participation agreement; or

5. Continuing a meeting or discussion where WCA or Leonard knows or reasonably should know that any fee or any list or schedule of fees as described in subsection 2, herein above, has been or will be presented, suggested, endorsed, discussed or offered as a goal, benchmark or reference point for the pricing of any chiropractic service, by anyone participating in the meeting or discussion.

G. For a period of one (1) year after the date that this order becomes final, or until June 30, 2002, whichever is earlier, initiating, originating, developing, publishing, or circulating the whole or any part of any proposed or existing fee survey for any health care goods or services.

H. For a period of four (4) years beginning at the expiration of the period in Paragraph IV G of this order, initiating, originating, developing, publishing, or circulating the whole or any part of any proposed or existing fee survey for any health care goods or services unless (1) the data collection and analysis are managed by a third party; (2) the raw fee survey data is retained by the third party and not made available to WCA or Leonard; (3) any information that is shared among or is available to providers must be more than three months old; and (4) there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's

data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow respondents or any other recipients to identify the prices charged or compensation paid by any particular provider.

I. Requesting, proposing, urging, advising, recommending, advocating, or suggesting in any way that any chiropractor or non-chiropractor third-party, including without limitation chiropractors who are members of the Board of Directors of the WCA, district officers of the WCA, or schools of chiropractic medicine, not participate, sponsor or attend any educational seminar dealing in whole or in part with any aspect of chiropractic medicine.

J. Inducing, suggesting, urging, encouraging, or assisting any person to take any action that, if taken by any defendant, would violate this order.

K. Adopting, enforcing, or interpreting any by-law of the WCA or other policy of the WCA that conflicts any provision of this order in any respect.

Provided, however, that nothing contained in this order shall be construed to prohibit defendant WCA or Leonard from petitioning any federal or state government executive agency or legislative body concerning legislation, rule, or procedures, or to participate in any federal or state administrative or judicial proceeding, in so far as such activity is protected by the Noerr-Pennington doctrine.

Provided, however, that nothing in this Order shall be construed to prohibit the WCA or Leonard from referring to or explaining fees or contract terms so long as such references or descriptions

do not include any comments upon the appropriateness or desirability of any fee, fee schedule or contract term.

V.

IT IS FURTHER ORDERED that WCA, for a period of four years from the date of this Order shall:

A. Maintain a copy of each document distributed at each meeting of the WCA's board of directors, WCA district meeting, or seminar or training session sponsored in whole or in part by the WCA for a period of four (4) years from the date of distribution, along with records showing the date of the meeting or seminar at which the document was distributed.

B. Maintain a copy of each fee survey, or part thereof, distributed to any WCA member or members for a period of four (4) years from the last date of its distribution, along with records showing the date(s) of distribution and each person to whom the fee survey, or part thereof, was distributed.

C. Maintain a copy of each document relating to any subject that is covered by any provision of this order and which is distributed to any WCA member or members for a period of four (4) years from the last date of its distribution,

along with records showing the date(s) of distribution and each person to whom the document was distributed.

D. 1. Create detailed minutes of each meeting of the WCA board of directors, or any committee of the board, maintain such minutes in clearly identifiable form for a period of three years from the date of the meeting; and

2. Audiotape each seminar or training session dealing in whole or in part with business topics sponsored in whole or in part by the WCA, and maintain su

VI.

IT IS FURTHER ORDERED that the WCA shall pay forthwith the amount of Sixty-two Thousand Five Hundred Dollars to the WDOJ pursuant to Sec. 133.03(3), Stats. within seven days of the entry of this order.

VII.

IT IS FURTHER ORDERED that WCA shall:

A. Within thirty (30) days after the date that this order becomes final distribute a dated and signed notification letter in the form set forth in Appendix A of this order along with a copy of the complaint and order in this matter: (1) to each of its current officers and directors, and to each other agent, representative, or employee of the WCA whose activities are affected by this order, or who have responsibilities with respect to the subject matter of this

order; (2) to each of its current members; and (3) to the designated registered agent on file with the Wisconsin Office of the Commissioner of Insurance for each payer set forth in Appendix B of this order. The notification letter, complaint and order shall be delivered in a format that does not include any additional communication from respondent WCA or any other person.

B. For a period of four (4) years after the date of this Order, and within thirty (30) days of the date that the person assumes such position, distribute a dated and signed notification letter in the form set forth in Appendix A of this order along with a copy of the complaint and order in this matter to each new officer and director of the WCA, and to each other new agent, representative, or employee of the WCA whose activities are affected by this order, or who have responsibilities with respect to the subject matter of this order. The notification letter, complaint and order shall be delivered in a format that does not include any additional communication from respondent WCA or any other person.

C. For a period of four (4) years after the date that this order becomes final, provide each new member with a dated and signed notification letter in the form set forth in Appendix A of this order along with a copy of the complaint and order in this matter within thirty (30) days of the new member's admission to the WCA. The notification letter, complaint and order shall be

delivered in a format that does not include any additional communication from respondent WCA or any other person.

D. Publish a notification letter in the form set forth in Appendix A of this order along with a copy of this order and the complaint in an issue of *The Wisconsin Chiropractor* published no later than 60 days after the date that this order becomes final, and annually each year thereafter for a period of four (4) years. The notification letter, order and the complaint shall be published with such prominence as is given to regularly featured articles in *The Wisconsin Chiropractor.*

E. WCA shall publish and disseminate to its members via the WCA newsletter or a website accessible to WCA members informative minutes of all meetings of the board of directors of the WCA meetings within one month of any such meeting and such minutes shall include, without limitation, the contents of any motions made and detailed results of voting on said motions if a vote was taken and stating that detailed minutes are available upon request from the WCA on a timely basis; provided, however, the portion of the minutes dealing with confidential attorney-client communications, personnel issues, legislative strategies, communications with legislators, communications with government employees, political contribution strategies and specific complaints or information about individual practitioners need not be published or disseminated.

VIII.

IT IS FURTHER ORDERED that respondent WCA shall notify the Wisconsin Department of Justice at least thirty (30) days prior to any proposed change in the respondent, such as dissolution, assignment, sale resulting in the emergence of a successor corporation, or the creation or dissolution of subsidiaries or any other change in the respondent that may affect compliance obligations arising under this order.

IX.

IT IS FURTHER ORDERED that respondent Leonard shall, for a period of four (4) years after the date that this order becomes final:

A. Notify the WDOJ within thirty (30) days of the discontinuance of his present business or employment and of each affiliation with a new business or employment where the duties and responsibilities of such employment are subject to the provisions of this order. Each such notice of affiliation with any new business or employment shall include his new business address and telephone number, current home address, and a statement describing the nature of the business or employment and the duties and responsibilities.

B. Provide a copy of the complaint and order in this matter to each new employer within seven (7) days of his employment where the duties and responsibilities of such employment are subject to the provisions of this order.

C. Provided, further, however, that nothing contained in Paragraph IV(C)(3) of this order shall prohibit defendant Leonard, if and when he has terminated his employment with the WCA, from acting as an agent, employee or representative exclusively for a single provider or payer, from providing comments or advice on any matter to such single provider or payer, or determining or negotiating any terms, conditions, or requirements, including the price to be paid for any health care goods or services, upon which such single provider or payer will deal with any person.

X.

IT IS FURTHER ORDERED that:

A. Within sixty (60) days after the date that this order becomes final, each respondent shall submit to the WDOJ a verified written report setting forth in detail the manner and form in which the respondent intends to comply, is complying, and has complied with Paragraphs II through VII of this order.

B. One (1) year from the date that this order becomes final, annually for the next four (4) years on the anniversary of the date that this order becomes final, and at other times as the WDOJ may require, each respondent shall file a verified written report with the WDOJ setting forth in detail the manner and form in which the respondent has complied and is complying with Paragraphs IV through IX of this order.

XI.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this order, upon five business days written notice, each defendant shall permit any duly authorized representative of the WDOJ:

A. To obtain access, during normal office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in the possession or under the control of defendant relating to any matter contained in this order; and

B. To interview that defendant or any employee or representative of that defendant in the presence of counsel and without restraint or interference from that respondent.

XII.

IT IS FURTHER ORDERED that the order shall become final upon service. Delivery by the U.S. Postal Service of the complaint and decision containing the agreed-to order to defendant's business address as stated in this order shall constitute service. Named defendants waive any right they may have to any other manner of service.

XIII.

IT IS FURTHER ORDERED that this order shall terminate ten (10) years from the date that this order becomes final.

JAMES E. DOYLE
Attorney General
State of Wisconsin

_____
Kevin J. O'Connor

_____
Donald L. Latorroca
Assistant Attorneys General
Office of Attorney General
123 W. Washington Ave.
Madison, Wisconsin 53707
(608) 266-8986
(608) 267-2797

_____
Russell A. Leonard

_____
Stephen P. Hurley
Hurley, Burish & Milliken, S.C.
301 North Broom Street
Madison, Wisconsin 53703
(608) 257-0945
Counsel for Russell A. Leonard

WISCONSIN CHIROPRACTIC ASSOCIATION

_____
Sherry Walker, DC, President

_____
Roxane C. Busey
Gardner, Carton & Douglas
321 N. Clark Street, Ste. 3400
Chicago, Illinois 60610
(312) 245-8852
Counsel for WCA

SO ORDERED:

Dated this _____ day of _____, _____.

_____
Circuit Judge, Dane County

Appendix A

[Wisconsin Chiropractic Association Letterhead]

Dear Officer, Director, Agent, Representative, Employee, Member or Third Party Payer:

The Wisconsin Chiropractic Association ("WCA"), and its executive director, Russell A. Leonard, have entered into an agreement with the Wisconsin Department of Justice to settle charges that the WCA, acting through its executive director, violated the antitrust laws by, among other things, conspiring with at least some of the WCA's members and others to fix or to increase prices paid for chiropractic manipulation services and to boycott third-party payers to raise reimbursement rates for chiropractic manipulation services. As part of the settlement agreement, the WCA is required to send this notification letter and a copy of the complaint and order to each of its officer and directors, its agents, representatives, and employees who have responsibilities with respect to the subject matter of the order, its members, and third-party payers.

Under the terms of the order, the WCA and Leonard named are prohibited from:

- Fixing prices or encouraging others to fix prices for any chiropractic good or service (or, in the case of the individuals named, any health care goods or services);

- Creating, suggesting, or endorsing any list or schedule of fees to be charged for any health care good or service;

- Organizing, participating in, or enforcing any agreement (1) to negotiate on behalf of any chiropractor or group of chiropractors (or, in the case of Leonard, health care provider or group of health care providers) regarding any term, condition, or requirement of dealing with any payer or provider; or (2) to deal or refuse to deal with, boycott or threaten to boycott, any payer or provider;

- Advising, recommending, advocating, or attempting to persuade in any way any chiropractor (or, in the case of Leonard, any health care provider) to accept or not accept any aspect, term or condition of any existing or proposed participation agreement;

- Soliciting or communicating any chiropractor's (or, in the case of Leonard, any health care provider's) views, decisions or intentions concerning any participation agreement;

- Organizing, sponsoring, facilitating or participating in any meeting or discussion that the WCA or Leonard expects or reasonably should expect will facilitate communications concerning any chiropractor's intentions pertaining to any participation agreement;

- Conducting or distributing any fee survey for any health care good or service for a period of one year after the date the order becomes final, or before June 30, 2002, whichever is earlier. For an additional four (4) year period thereafter, the WCA and Leonard are permitted to conduct and distribute fee surveys, provided that (a) the data collection and analysis are managed by a third party; (b) the raw fee survey data is retained by the third party and not made available to the WCA or Leonard; (c) any information that is shared among or is available to providers is more than three months old; and (d) there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated that it would not allow respondents or any other recipients to identify the prices charged or compensation paid by any particular provider; and

- Discouraging anyone including chiropractors or schools of chiropractic medicine from sponsoring, participating in or attending seminars dealing with issues of chiropractic medicine.

- Encouraging or assisting any person to take any action that, if taken by the WCA or Leonard, would violate the order.

In addition, the WCA is required, under the terms of the order, to maintain better records, including, but not limited to, retaining copies of all materials distributed at WCA meetings and seminars. The WCA must also maintain audiotapes of its seminars. The WCA must also maintain a copy of each fee survey distributed to any WCA member, along with a record of its distribution. Finally, the WCA is required to maintain a copy of each other document relating to any subject that is covered by any provision of the order, along with a record of its distribution.

Nothing in the order prohibits either the WCA or Mr. Leonard from petitioning any

federal or state government executive agency or legislative body concerning legislation, rules, or procedures, or from participating in any federal or state administrative or judicial proceeding, in so far as such activity is protected by the Noerr-Pennington doctrine.

Copies of the complaint and order are enclosed.

/s/
Sherry Walker, D.C.
President
Wisconsin Chiropractic Association

NEWS RELEASE

DOYLE ANNOUNCES AGREEMENT ON CLINIC MERGER

For Immediate Release
June 18, 1997

For More Information Contact:
Jim Haney 608/266-1221

MADISON - Attorney General James Doyle announced an agreement today on the proposed merger of two large central Wisconsin health care facilities. Under the agreement, Doyle said that his office will not challenge the merger of Marshfield Clinic and the Wausau Medical Center provided that the clinics refrain from additional acquisitions and agreements which might limit competition in north central Wisconsin.

Marshfield Clinic and Wausau Medical Center, S.C., entered into an agreement on December 30, 1996, by which Marshfield agreed to purchase the medical practice and assets of the Wausau Medical Center. The proposed merger included operating the Wausau Medical Center as part of the Marshfield Clinic system.

Today's agreement between the Attorney General's Office and the two physician clinics, which was filed in federal court in Madison, prohibits Marshfield Clinic from acquiring any additional primary care medical practices in Marathon County for five years. Marshfield also is prohibited from acquiring any non-primary care services in all or part of seven counties in north central Wisconsin for three years. The area includes Marathon, Lincoln, Langlade, Portage and Wood

Counties, the southern half of Oneida County (including Rhinelander) and the western half of Shawano County (including Wittenberg). In addition, the agreement prevents Marshfield from entering into related agreements which would limit competition for health care services in north central Wisconsin.

According to Doyle, the investigation of the proposed merger was conducted over several months and involved interviews of numerous employers, consumers and health care providers familiar with health care markets. The Attorney General said the investigation was complicated by rapid changes occurring in health care markets.

(more)

"The development of integrated health care systems in north central Wisconsin, which involves services ranging from primary and specialty physician services to high-cost, in-patient hospital beds, has accelerated in recent months," Doyle said.

According to the Attorney General, "This agreement will allow Marshfield Clinic to establish a presence in the Wausau area while preventing any further acquisitions which might suppress competition. It should maintain consumers' access to quality services while allowing for health care choices and competition among providers."

The settlement agreement and related complaint were filed in the U.S. District Court for the Western District of Wisconsin in Madison. The court must give its approval before the settlement agreement becomes final.

###

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

STATE OF WISCONSIN,

Plaintiff,

v. Civil Action No. _____

MARSHFIELD CLINIC AND
WAUSAU MEDICAL CENTER, S.C.,

Defendants.

COMPLAINT

The State of Wisconsin, through its Office of Attorney General, brings this action under the federal antitrust laws to block the proposed combination of two multispecialty physician clinics in the relevant geographic market.

Unless prevented, this combination is likely to substantially lessen competition in the provision of certain health care services including those services typically provided by primary and non-primary care physicians employed by the defendant multi-specialty clinics.

I. JURISDICTION AND VENUE

1. This Court has jurisdiction over this action pursuant to 15 U.S.C.A. §§ 4 and 26 (1973), and 28 U.S.C.A. § 1331 (1993) and 28 U.S.C.A. § 1337 (West 1993 & Supp. 1996).

2. Defendants are found, and transact business, within this district, and the claims in substantial part arise in this district. Venue is proper in the Western District of Wisconsin

under sections 12 and 16 of the Clayton Act, 15 U.S.C.A. §§ 22 and 26 (1973), and under 28 U.S.C.A. § 1391(b) and (c) (1993).

II. PARTIES

3. The State of Wisconsin brings this action as parens patriae to protect its general economy and as a direct purchaser of health care services from defendants through its Medicaid and employe benefits programs.

4. "Marshfield Clinic" ("MC") means: the corporation organized under the laws of the State of Wisconsin that operates a multispecialty clinic with the same name located in Marshfield, Wisconsin, including, without limitation, the clinic that will be operated by MC in Wausau, Wisconsin, and that, following consummation of the transaction provided for in the agreement of December 30, 1996, will operate a regional clinic in Wausau, Wisconsin; any entities owned, operated, controlled or managed, directly or indirectly, by MC; and any partnerships, joint ventures, and affiliates owned, operated, controlled or managed, directly or indirectly, by MC.

5. "Wausau Medical Center" ("WMC") means: the service corporation organized under the laws of the State of Wisconsin that operates a multispecialty clinic with the same name at 2727 Plaza Drive, Wausau, Wisconsin 54401; any entities owned, operated, controlled or managed, directly or indirectly, by WMC and any partnerships, joint ventures, and affiliates owned, operated, controlled, or managed, directly or indirectly, by WMC.

III. DEFINITIONS

7. "Multispecialty Clinic" means a health care entity employing, directly or indirectly, physicians in various specialties relating to both primary and non-primary health care services.

8. "Health-care Provider" means any physician, hospital, clinic, laboratory or physician network.

9. "Managed-care Plan" means a health maintenance organization ("HMO"), preferred provider organization ("PPO"), or other health-service purchasing program which uses financial or other incentives to prevent unnecessary services and includes some form of utilization review.

10. "HHI" means the Herfindahl-Hirschman Index, a measure of market concentration calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20 and 20%, the HHI is 2,600 ($30^2 + 30^2 + 20^2 + 20^2 = 2,600$). The HHI takes into account the relative size and distribution of the firms in a market. It approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 when a market is controlled by a single firm. The HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases.

IV. TRADE AND COMMERCE

11. Each defendant corporation is engaged in interstate commerce, and their activities are in the flow of, and substantially affect, interstate commerce.

12. The provision of various types of primary and non-primary health care occurs, at least in part, through various channels of interstate commerce and transportation.

V. RELEVANT GEOGRAPHIC MARKET

13. MC is a multispecialty clinic located primarily in the city of Marshfield, Wood County, Wisconsin but also having satellite clinics throughout north central Wisconsin.

14. WMC is a multispecialty clinic located primarily in the City of Wausau, Marathon County, Wisconsin but also having a presence in and drawing patients from the areas adjacent to the City of Wausau.

15. MC and WMC seek to consolidate.

16. MC and WMC are competitors and potential competitors in the provision of primary and non-primary health care services.

17. The relevant geographic market for non-primary care services in which to assess the effects of the proposed merger is north central Wisconsin including all or parts of the following counties: Lincoln, Langlade, Marathon, Oneida, Portage, Shawano, and Wood.

18. The relevant geographic market for primary care services in which to assess the effects of the proposed merger include the City of Wausau and a substantial portion of Marathon County adjacent to the City of Wausau.

VI. RELEVANT PRODUCT MARKET

19. MC and WMC each sell primary and non-primary health care services to a variety of purchasers, including managed-care plans such as HMOs and PPOs. Managed-care plans reduce health-care costs by encouraging health care providers to compete vigorously on price and quality. These plans contract with a select number of health care providers and employ financial incentives to encourage plan enrollees to use the contracted facilities.

20. Through competition for the provision of health care services to their managed-care plans, these price-sensitive health-care purchasers could secure primary and non-primary health care services at competitive rates, which substantially contains overall costs of such health care. This, in turn, permits managed-care plans to offer health insurance to consumers at lower prices. Managed-care plans will constitute a significant, and growing, percentage of revenues from patient care in north central Wisconsin.

21. The provision of primary and certain non-primary physician services each constitutes separate lines of commerce, or relevant product markets, within the meaning of section 7 of the Clayton Act.

VII. MARKET CONCENTRATION

22. These markets tend to be highly concentrated by any measure of capacity or output and market concentration in several relevant product markets as measured by HHIs would increase substantially as a result of the proposed combination of MC and WMC. The combined clinics would employ a large share of the physicians practicing in certain specialities in the relevant geographic markets.

23. There are few substitutes for the physician-based services provided by these clinics.

24. In the foreseeable future, no new multispecialty clinic is likely to enter the relevant geographic market.

VIII. VIOLATION

25. As a direct result of the merger, competition for primary and non-primary health care services in the relevant geographic markets may be substantially lessened in the following ways, among others:

a. Existing competition and the potential for increased competition between MC and WMC for the provision of primary and non-primary health care services in the relevant geographic markets will be eliminated;

b. Concentration in the relevant product market in the geographic markets referenced will be substantially increased; and

c. The likelihood of collusion in the relevant product markets in the relevant geographic markets may be substantially increased.

27. The proposed acquisition violates section 7 of the Clayton Act, 15 U.S.C.A. § 18 (1973).

IX. INJURY

28. Unless the violations described above are enjoined, the State of Wisconsin will suffer direct, immediate and irreparable damage to its general economy and as a direct purchaser of physician-based health care services. There is no adequate remedy at law.

X. RELIEF REQUESTED

WHEREFORE, plaintiff prays:

(a) That the proposed consolidation of MC and WMC be adjudged to be in violation of section 7 of the Clayton Act;

(b) That defendants, their parents, subsidiaries, affiliates, directors, officers, agents, successors, and assigns, and all others acting on their behalf, be preliminarily and permanently enjoined from taking any action directly or indirectly to consummate the proposed consolidation of MC and WMC;

(c) That defendants be ordered to pay plaintiff's costs and attorneys' fees; and

(d) That the Court grant such other relief as it deems appropriate.

Dated this 18th day of June, 1997.

JAMES E. DOYLE
Attorney General

KEVIN J. O'CONNOR
Assistant Attorney General
State Bar No. 1016693

Attorneys for the State of Wisconsin

Wisconsin Department of Justice
Post Office Box 7857
Madison, Wisconsin 53707-7857
(608) 266-8986

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

STATE OF WISCONSIN,

Plaintiff,

v. Civil Action No. _____

MARSHFIELD CLINIC AND
WAUSAU MEDICAL CENTER, S.C.,

Defendants.

FINAL JUDGMENT

WHEREAS the State of Wisconsin filed a Complaint in this matter on _____, as a direct purchaser of health care services in the Wausau, Wisconsin area and as parens patriae to protect its general economy, pursuant to section 7 of the Clayton Act, 15 U.S.C. § 18;

WHEREAS Marshfield Clinic ("MC") and Wausau Medical Center, S.C. ("WMC"), entered into an agreement of December 30, 1996, by which MC agreed to purchase the medical practice and assets of WMC;

WHEREAS MC intends to operate a regional clinic in Wausau, Wisconsin, to be known as Wausau Medical Center, a part of the Marshfield Clinic system;

WHEREAS the Office of Attorney General of the State of Wisconsin ("Attorney General") is responsible for enforcement of the federal and state antitrust laws and is authorized to bring suit on behalf of the State as a direct purchaser of health care services and as parens patriae to protect its general economy;

WHEREAS MC and WMC have cooperated fully with the Attorney General's investigation of the proposed consolidation;

WHEREAS the Attorney General has concluded its investigation of the proposed consolidation of the two clinics and believes that, without this Final Judgment, the consolidation could raise competitive concern under federal and state antitrust laws;

WHEREAS MC and WMC desire to assure the Attorney General and the community that they intend to operate in a manner that ensures that competition for health care services in Wausau and surrounding areas will not be compromised now or in the future;

WHEREAS MC and WMC, desiring to resolve the Attorney General's concerns without trial or adjudication of any issue of fact or law, and before the taking of any testimony, have consented to entry of this Final Judgment; and

WHEREAS this Final Judgment is not an admission, or probative, of liability by MC or WMC as to any issue of fact or law and may not be offered or received into evidence in any action, or otherwise be construed or interpreted, as an admission, or as being probative, of liability; it is hereby ordered:

I. JURISDICTION

1. This Court has jurisdiction over the subject matter of this action and each of the parties consenting to this Final Judgment. The complaint states a claim upon which relief may be granted against the defendants under section 7 of the Clayton Act, 15 U.S.C. § 18.

II. DEFINITIONS

As used in this Final Judgment:

2. "Marshfield Clinic" ("MC") means: the corporation organized under the laws of the State of Wisconsin that operates a multispecialty clinic with the same name located in Marshfield, Wisconsin, including, without limitation, the clinic that will be operated by MC in Wausau, Wisconsin, and that, following consummation of the transaction provided for in the agreement of December 30, 1996, will operate a regional clinic in Wausau, Wisconsin; any entities owned, operated, controlled or managed, directly or indirectly, by MC; and any partnerships, joint ventures, and affiliates owned, operated, controlled or managed, directly or indirectly, by MC.

3. "Wausau Medical Center" ("WMC") means: the service corporation organized under the laws of the State of Wisconsin that operates a multispecialty clinic with the same name at 2727 Plaza Drive, Wausau, Wisconsin 54401; any entities owned, operated, controlled or managed, directly or indirectly, by WMC; and any partnerships, joint ventures, and affiliates owned, operated, controlled, or managed, directly or indirectly, by WMC.

4. "Control," "Controlled," or "Controlled by" means (1) either (i) holding more than fifty percent of the outstanding stock volume of an entity or (ii) having the right to more than fifty percent of the profits of the entity or having the right in the event of dissolution to more than fifty percent of the assets of the entity; or (2) having the present contractual power to designate more than fifty percent of the directors of a corporation, or, in the case of unincorporated entities, of individuals performing similar functions.

5. "Own" means to have ownership, directly or indirectly, of more than fifty percent of the equity or voting rights of an entity or the legal right to appoint a majority of the Board of Directors or a Management Committee where no Board exists.

6. "Acquire" means to purchase the whole or the majority of the assets, stock, equity, capital, or other interest in a corporation or other business entity, or to obtain the right or ability to designate the majority of directors or trustees or otherwise control the management of a corporation or other business entity.

7. "Wausau area" means, in the case of primary care physicians, Marathon County, and, in the case of non-primary care physicians, Marathon, Lincoln, Langlade, Portage, and Wood Counties, the southern half of Oneida County (including Rhinelander), and the western half of Shawano County (including Wittenberg).

8. "Medical practice" means all or part of the assets or business owned or controlled in whole or in part by a physician(s) or an entity employing physician(s), including, without

limitation, the goodwill, patient lists, records, fixtures, inventory, supplies, accounts receivable, prepaid expenses or any other miscellaneous tangible and intangible property, used to deliver primary care and/or specialty health care services.

9. "Primary Care Physician" means family practice, general pediatrics, and general internal medicine physicians who devote the majority of their time to the delivery of primary care services.

III. ORDER

10. IT IS HEREBY ORDERED that MC shall not, without the written prior approval of the Attorney General, which shall be granted or denied within a period not to exceed sixty (60) days following receipt of a detailed written description of the proposed transaction:

a. acquire any medical practice relating to primary care services in the Wausau area for a period of five (5) years from the date this order becomes final; or

b. acquire any medical practice relating to non-primary care services in the Wausau area for a period of three (3) years from the date this order becomes final;

c. employ, contract for services of, or affiliate on an exclusive basis with any physician(s), or entities employing physician(s), practicing in the Wausau area when at the time of the employment or affiliation the physician(s) is already practicing in the Wausau area, whether or not the medical practice of the physician(s) is acquired; or

d. enter into any exclusive contract with any

physician(s) in the Wausau area or with any entity owning a medical practice in whole or in part, by which, with respect to physicians in the Wausau area not employed by MC, MC requires that the physician(s) render services only, or primarily to, or in conjunction with MC;

e. enter into a covenant not to compete in connection with the employment of any physician(s) by MC in the Wausau area for a period in excess of eighteen (18) months.

f. Nothing in this paragraph shall prevent MC from entering into agreements concerning cross-coverage or locum tenens arrangements with any physicians in the Wausau area, limit the recruitment of physicians by MC into the Wausau area, nor prevent Security Health Plan, an affiliate of MC, in the ordinary course of its business of providing health insurance from contracting for the services of or affiliating on a nonexclusive basis with any physicians in the Wausau area.

11. The terms of this Final Judgment are binding on MC and its directors, officers, managers and employees, successors and assigns, including but not limited to any person or entity to whom MC may be sold, leased or otherwise transferred, and all persons who are in active concert or participation with it who have actual or constructive notice thereof. MC shall not permit any substantial part of MC to be acquired by any other person unless that person agrees in writing to be bound by the provisions of this Final Judgment. MC shall not undertake any action through any other entity, whether or not controlled or owned by MC, that would violate this Final Judgment if undertaken directly by MC.

12. Any person, including health-care providers, health plans, or consumers of medical services, who wishes to report a possible violation of this Final Judgment shall send a written description of the possible violation to the Assistant Attorney General in Charge of Antitrust Enforcement, Antitrust and Criminal Litigation Unit, Office of Attorney General, 4th Floor, 123 West Washington Avenue, Madison, Wisconsin 53707. At the request of the Attorney General, MC shall respond in writing to the Assistant Attorney General in charge of Antitrust enforcement within thirty (30) days after receiving the complaint. If the request is still unresolved, the Assistant Attorney General may attempt to negotiate a satisfactory resolution, may pursue appropriate enforcement alternatives available to the Attorney General.

13. Upon entry of this Final Judgment, MC shall pay $25,000 to reimburse the Attorney General's costs incurred to conduct its investigation, which payment shall be used for future antitrust enforcement purposes.

14. Enforcement

14.1 If the Attorney General believes that there has been a violation of this Final Judgment, it shall promptly notify the parties in writing and explain the possible violation. The Attorney General shall permit the parties a reasonable opportunity to cure any alleged violation without instituting legal action. If in the judgment of the Attorney General the parties do not cure the alleged violation within sixty (60) days after notification, the Attorney General may take any remedial action it deems appropriate. This time period may be extended, in the sole discretion of the Attorney General, in circumstances where the 60-

day period is not sufficient in which to cure the alleged violation.

14.2 In any action or proceeding brought by the Attorney General to enforce this Final Judgment or otherwise arising out of or relating hereto, the Attorney General, if it is the prevailing party, shall recover its costs and expenses, including attorneys' fees.

15. Notices

All notices required by this Final Judgment shall be sent by certified or registered mail, return receipt requested, postage prepaid, or by hand delivery, to:

If to the Attorney General:

Assistant Attorney General
in Charge of Antitrust Enforcement
Criminal Litigation and Antitrust Unit
Office of Attorney General
4th floor, 123 West Washington Avenue
Madison, WI 53707

If to MC:

General Counsel
Marshfield Clinic
1000 North Oak Avenue
Marshfield, WI 54449-5777

16. Averment of Truth

MC and WMC aver that the information they provided to the Attorney General in connection with this Final Judgment, to the best of their knowledge, is true and represents the most recent and comprehensive data available, and that no material information has been withheld.

17. Termination

This Final Judgment shall expire on the fifth anniversary of its date of entry.

18. Retention of Jurisdiction

This Court shall retain jurisdiction for five (5) years after the date of entry to enable any party to apply for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Final Judgment.

Dated this _____ day of _____, 1997.

MARSHFIELD CLINIC

By:

_____

President

Attest:

_____

_____

Phillip A. Proger
Kathryn M. Fenton
Jones, Day, Reavis & Pogue
1450 G Street, N.W.
Washington, DC 20005-2001
(202) 879-4668

STATE OF WISCONSIN

JAMES E. DOYLE
Attorney General

_____

Kevin J. O'Connor
Assistant Attorney General
Office of Attorney General

4th Floor
123 West Washington Avenue
Madison, WI 53707
(608) 266-8986

WAUSAU MEDICAL CENTER, S.C.

By: _____

President

Attest: _____

_____

Michael S. Weiden
Quarles & Brady
One South Pinckney Street
Suite 600
Madison, WI 53703
(608) 251-5000

SO ORDERED: _____

_____

United States District Judge

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