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UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of **THE MAINE HEALTH ALLIANCE,** **a corporation,** **and** **WILLIAM R. DIGGINS,** **individually.**	**Docket No.**

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41 *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the Maine Health Alliance (the "Alliance") and William R. Diggins (the "Respondents") have violated and are violating Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint stating its charges in that respect as follows:

The Nature of the Case

1. Acting through the Alliance, the vast majority of hospitals and physicians located in a five-county area of northeastern Maine have agreed to limit competition among themselves by collectively negotiating contracts – including price terms – with employers, health insurers, and others seeking to provide health-care coverage to the people of northeastern Maine ("payors"). Further, these eleven hospitals and more than 325 physicians have refused to contract individually with those unwilling to meet the Alliance's collective terms. These price-fixing agreements and concerted refusals to deal among otherwise competing hospitals and among otherwise competing physicians, in turn, have kept the price of health care in northeastern Maine above the level that would have prevailed absent the Alliance's illegal conduct. The Alliance has not undertaken any efficiency-enhancing integration sufficient to justify its challenged conduct.

The Respondents

2. The Alliance is a taxable, nonprofit corporation, organized, existing, and doing business under and by virtue of the laws of the State of Maine, and its principal address is 12 Stillwater Avenue,

Suite C, Bangor, Maine 04401. The Alliance was formed in 1995, and its membership currently consists of over 325 physicians and eleven hospitals located throughout a five-county area in northeastern Maine.

3. William R. Diggins is the Alliance's Executive Director, and he has served in this capacity since its inception. As Executive Director, Mr. Diggins manages the Alliance's day-to-day operations, and he is one of the organization's principal contract negotiators with payors. Mr. Diggins' principal address is 12 Stillwater Avenue, Suite C, Bangor, Maine 04401.

Jurisdiction and Interstate Commerce

4. The Alliance's eleven hospital members are: Calais Regional Hospital, Cary Medical Center, Down East Community Hospital, Houlton Regional Hospital, Maine Coast Memorial Hospital, Mayo Regional Hospital, Millinocket Regional Hospital, Mount Desert Island Hospital, Northern Maine Medical Center, Penobscot Valley Hospital, and St. Joseph Hospital. Each of these hospitals is a tax-exempt organization. The Alliance is not a tax-exempt entity.

5. The Alliance's approximately 325 physician members include both primary care and specialist physicians. A substantial majority of these physicians practice in independent solo or small group practices on a for-profit basis. Some physician members are salaried employees of an Alliance hospital.

6. At all times relevant to this complaint, a substantial majority of the Alliance's physician members have been engaged in the business of providing medical services for a fee. Except to the extent that competition has been restrained as alleged herein, Alliance physicians have been, and are now, in competition with other Alliance physicians for the provision of physician services.

7. At all times relevant to this complaint, the Alliance's hospitals have been engaged in the business of providing hospital services for a fee. Except to the extent that competition has been restrained as alleged herein, Alliance hospitals have been, and are now, in competition with other Alliance hospitals for the provision of hospital services.

8. The Alliance's bylaws provide that physician members hold 11 of the 22 seats on the Alliance's Board of Directors ("Board"). The physician members at each of the 11 Alliance hospitals elect a representative to the Board. In addition, each Alliance hospital appoints a hospital representative to serve on the Alliance Board. The Board is the Alliance's chief policy-making body.

9. The Alliance is organized in substantial part, and is engaged in substantial activities, for the pecuniary benefit of its members, and is therefore a "corporation" within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

10. The Respondents' general business practices and conduct, including the acts and practices alleged herein, are in or affecting "commerce" as defined in the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

11. According to the Alliance's records, as of 2002, the contracts that the Respondents and others have negotiated with payors and entered into on behalf of the Alliance's physicians and hospital members represent "in excess of 100 million dollars in commercial revenue."

Overview of the Market and Competition

12. The Alliance and its physician and hospital members do business in Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties in northeastern Maine (the "Northeastern Maine Counties").

13. Physicians often contract with payors to establish the terms and conditions, including price and other competitively significant terms, under which they will provide services to subscribers of health plans.

14. Hospitals, likewise, often enter into contracts with payors to establish the terms and conditions, including price and other competitively significant terms, under which they will provide services to subscribers of health plans.

15. Physicians and hospitals entering into payor contracts often agree to discount or lower their prices in exchange for access to additional patients made available by the payors' relationship with their subscribers. These contracts may reduce payors' costs and enable payors to lower the price of health insurance, and reduce out-of-pocket medical care expenditures by subscribers to the payors' health insurance plans.

16. Absent agreements among physicians or hospitals on prices and other contract terms on which they will provide services to subscribers of health plans, competing physicians and competing hospitals decide individually whether to enter into contracts with payors, and at what prices they will accept payment for services rendered pursuant to such contracts.

17. The Medicare Resource Based Relative Value Scale ("RBRVS") is a system used by the Centers for Medicare and Medicaid Services ("CMS") to determine the amount to pay physicians for the services they render to Medicare patients. Under RBRVS, the price for physician services is determined by multiplying a dollar conversion factor, set by CMS, by the Relative Value Unit ("RVU") assigned by CMS to each physician service (*e.g.*, under RBRVS, a Medicare conversion factor of $35 x 2.34 RVU for a physician service = an $82 fee). Payors in many areas of the country make contract offers to individual physicians or groups at a price level specified as some percentage of the RBRVS fee for a particular year (*e.g.*, "110% of 2003 RBRVS"). In the Northeastern Maine Counties, payors

negotiate the conversion factor, rather than a percentage of the RBRVS fee, with physicians. For example, if a Maine payor offers a conversion factor of $42, rather than the Medicare conversion factor of $35, and the RVU that CMS assigns for a particular physician service is 2.34, then the physician's price for that service to the payor would be $42 x 2.34, or $98.28.

18. The Maine Bureau of Insurance has promulgated access to care regulations requiring health maintenance organizations ("HMOs") to make physician and hospital services available within certain travel times and distances from the residences of the HMO's subscribers. To comply with these regulations, an HMO doing business in the Northeastern Maine Counties must include in its provider network a large number of primary care and specialist physicians and hospitals that provide services in the Northeastern Maine Counties.

19. To be competitively marketable in the Northeastern Maine Counties, a payor's health plan must include in its provider network a large number of primary care and specialist physicians and hospitals in the Northeastern Maine Counties.

20. The substantial majority of the primary care and specialist physicians who practice in the Northeastern Maine Counties are members of the Alliance, and more than 85% of the physicians on staff at the Alliance's hospitals are members of the Alliance. Eleven of the sixteen hospitals in the Northeastern Maine Counties are members of the Alliance.

The Alliance Is a Joint Contracting Organization, and Acts as an Exclusive Contracting Agent, for Its Members

21. According to its business records, the Alliance was formed primarily to serve as a "joint contracting organization" for its physician and hospital members, and to negotiate payor contracts that contain "higher compensation" and other more "advantageous" contract terms than its physician and hospital members could obtain by dealing individually with payors. Moreover, as set forth in the Alliance's 1998 Strategic Plan, its "mission" is to provide Alliance members with "increased market strength through joint contracting."

22. The Alliance Board, in conjunction with its Contracts Committee, has compiled written "Contracting Guidelines and Parameters" setting forth price-related and other competitively significant terms that the Alliance requires when contracting with payors on its members' behalf.

23. As part of the process of joining the Alliance, physicians and hospitals sign an agreement designating the Alliance as their negotiating agent to contract with payors, and authorizing the Alliance to enter into, on their behalf, payor contracts that meet the organization's "Contracting Guidelines and Parameters."

24. The Board has authorized Mr. Diggins to serve as one of the Alliance's principal negotiating agents with payors. Mr. Diggins reports the details of Alliance negotiations with payors, including the status of price negotiations and the specific price levels that are discussed, to the Alliance's Contracts Committee and the Board.

25. The Board relies on Mr. Diggins's recommendations in deciding whether to accept or reject a payor contract on behalf of the Alliance's physician and hospital members.

26. In correspondence with Alliance physicians, Mr. Diggins has touted "the favorable compensation which the Alliance has obtained for its physician members." Alliance representatives, including Mr. Diggins, demanded and received payor contracts containing higher conversion factors used to determine prices for physician services than physicians were able to obtain through direct, unilateral negotiations with payors. As a result of the higher conversion factors that the Alliance demanded, the Alliance physicians received higher compensation for their services.

27. Alliance hospitals determine their own respective price lists. The Alliance, representing the hospitals collectively, fixes the maximum percentage discount allowable from member hospital price lists. In correspondence with Alliance hospitals, Mr. Diggins asserted that "Alliance contracting has frequently afforded its members better compensation than its individual hospitals could have obtained unilaterally," by demanding and receiving smaller discounts off the hospital's charges and refusing payor requests to negotiate the hospital list prices underlying the discounts.

28. The Alliance and Mr. Diggins, on the Alliance members' collective behalf, also have negotiated competitively significant contract terms in addition to price, resulting in higher compensation than the physicians and hospitals could have obtained without the Alliance's collective bargaining power (*e.g.*, large monetary penalties for failure to pay in a timely manner, and restrictions on how payors utilize software programs to review physicians' claims for payment).

29. Although the Alliance's rules and bylaws state that its physician and hospital members are permitted to participate in other provider networks and to negotiate with payors individually, the Alliance and Mr. Diggins have repeatedly convinced Alliance members to contract exclusively through the organization. They have done so by, among other things:

a. urging Alliance physicians, when contacted individually by payors, to "refer them to the Alliance" to enhance the group's collective power;

b. facilitating efforts by Alliance physicians to "roll their [pre-existing individual payor] contracts through the Alliance" when they came up for renewal, to benefit from the more lucrative terms that the Alliance demands from payors;

c. discouraging Alliance physicians from contracting with other provider networks, and encouraging those who already are members of other networks to "reconsider [their] participation" in those networks, to maintain the Alliance's collective power; and

d. warning Alliance hospitals that contracting outside the Alliance will "'gut' the organization"and "diminish" its purpose and effectiveness.

30. By agreeing with each other to negotiate concertedly through the Alliance, the Alliance's physician members and hospital members have obtained higher compensation and other more favorable contract terms from payors than they would have by negotiating with payors individually.

Aetna, Inc.

31. In September 1996, the Alliance entered into a contract with NYLCare Health Plans of Maine, Inc. ("NYLCare"), a payor doing business in the Northeastern Maine Counties. In 1998, Aetna, Inc. ("Aetna"), acquired NYLCare, and assumed all of NYLCare's contracts with physicians and hospitals in the Northeastern Maine Counties, including NYLCare's contract with the Alliance.

32. Through contract negotiations with NYLCare in 1996, the Alliance, on behalf of its physician members, demanded and received a $65 conversion factor, which is equivalent to approximately 175% of 1996 RBRVS, for services performed for non-HMO subscribers. For NYLCare's HMO subscribers, the Alliance successfully negotiated a $52 conversion factor, which is equivalent to approximately 140% of 1996 RBRVS. At that time, NYLCare contracted with non-Alliance physicians for services rendered to all NYLCare subscribers (HMO and non-HMO) in Maine at conversion factors ranging from $48 to $50, which is equivalent to approximately 130% to 135% of 1996 RBRVS. The prices obtained by the Alliance for its physician members were substantially higher than the physicians could have obtained by negotiating individually with NYLCare.

33. Since Aetna's acquisition of NYLCare in 1998, Aetna and non-Alliance physicians have renegotiated their contracts, resulting in savings for Aetna subscribers. Aetna currently utilizes conversion factors ranging from $44 to $48, which is approximately equivalent to 120% to 130% of 2003 RBRVS, for services rendered by non-Alliance physicians to its subscribers in Maine. Aetna has made repeated attempts to renegotiate the rates that it pays to the Alliance's physician members, but the Alliance, on the collective behalf of its physician members, has refused to reduce the $65 and $52 conversion factors for physician services agreed to in 1996. As a result, Aetna pays Alliance physicians prices that are approximately 40% to 50% higher for non-HMO subscribers, and 10% to 20% higher for HMO subscribers, than Aetna pays to non-Alliance physicians for comparable services.

34. The Alliance's contract with Aetna was set to expire August 31, 1999. In a letter dated March 8, 1999, Aetna approached Alliance physicians directly to negotiate new contracts with individual physicians, to ensure that there would be no interruption of service to its subscribers if Aetna and the Alliance failed to reach an agreement for renewal prior to the termination of the contract.

35. In response to Aetna's attempt to negotiate with Alliance physicians unilaterally, Mr. Diggins told Alliance physicians in a March 18, 1999 memorandum that "[t]he Alliance has strenuously objected" to Aetna about its "bold effort at recruiting physicians around the Alliance." In addition, Mr. Diggins warned the physicians that Aetna's contract offer to the physicians would reduce physician compensation to a conversion factor of $44, which Mr. Diggins characterized as a "significant reduction in compensation" and one to which Aetna realized "the Alliance is unlikely to agree." The $44 conversion factor, which is equivalent to approximately 127% of 1999 RBRVS, was Aetna's arrangement with non-Alliance physicians in 1999.

36. On March 17, 1999, the Alliance's lawyer and business agent sent a letter to Aetna, demanding that Aetna: (a) retract its offers for direct contracts with Alliance physicians; (b) notify the physicians that the Alliance's contract with Aetna governs the relationship between the physicians and Aetna; and (3) "return, marked void, to the physician any contract executed by the physician" in response to Aetna's offer.

37. The Alliance physicians collectively refused to deal with Aetna, other than as a group through the Alliance, and forced Aetna to renew its contract with the Alliance at the $65 and $52 conversion factor rates. Without Alliance physician members in its network, Aetna would have been unable to maintain a competitively marketable health plan in the Northeastern Maine Counties and comply with the Maine Bureau of Insurance access to care regulations.

38. The Alliance's hospital members also negotiated collectively through the Alliance with NYLCare/Aetna for a contract. In 1996, the Alliance, on behalf of its hospital members, negotiated a 5.5% discount from billed charges for services rendered to NYLCare non-HMO subscribers, and an 11% discount from billed charges for services rendered to NYLCare HMO subscribers. Both of these discounts were approximately 33% smaller than the discounts that NYLCare contracted for, on average, with non-Alliance hospitals for the same health plan products. Since it acquired NYLCare, Aetna has attempted to negotiate with the Alliance for new hospital prices. The Alliance refused to accept lower prices and has continuously demanded higher prices.

39. In 1999, the Alliance demanded that Aetna agree to a 6% discount from billed charges for all services provided by Alliance hospitals to Aetna's HMO and non-HMO subscribers. In response, Aetna proposed different rates for different Alliance hospitals, which provide varying services and levels of care. The Alliance refused to agree to anything other than a single discount rate for all of its member hospitals. Aetna counter-offered a 15% discount, which equaled Aetna's statewide average discount for Maine hospitals. The Alliance also rejected this offer, continuing to insist upon a

6% discount. Due to a stalemate over compensation, the Alliance continues to provide services to Aetna subscribers under the terms of the 1996 Alliance-NYLCare contract, which pays Alliance hospitals substantially higher prices than Aetna pays to non-Alliance hospitals. Without the Alliance hospitals in its network, Aetna would have been unable to maintain a competitively marketable health plan in the Northeastern Maine Counties and comply with Maine Bureau of Insurance access to care regulations

Cigna HealthCare of Maine, Inc.

40. Cigna HealthCare of Maine, Inc. ("Cigna"), is a payor doing business in the Northeastern Maine Counties that contracts with the Alliance for physician and hospital services. In May, 1998, on the collective behalf of Alliance hospital members, the Alliance told Cigna that it must reduce the discount off hospital charges that Cigna received under its existing agreement with the Alliance. In December, 1998, having no reasonable alternative but to meet the Alliance's demand, Cigna reduced, by almost 50 percent, the discount that it received off Alliance hospital charges. This resulted in substantially higher prices paid to those hospitals.

41. In August, 2001, four months prior to the expiration date of its contract with the Alliance, Cigna directly approached the Alliance's physician and hospital members to negotiate individual contracts containing price terms to which the physicians and hospitals would agree unilaterally, not collectively through the Alliance.

42. Upon reviewing the terms of the contract Cigna was offering Alliance members individually, Mr. Diggins advised Alliance members that the contract's prices and price-related terms were unacceptable, and that they should not to accept Cigna's offer.

43. Mr. Diggins also provided the Alliance's physician and hospital members with a model letter for them to use to notify Cigna that they refused to negotiate individually, and that the Alliance would negotiate on their behalf. Shortly thereafter, the physician and hospital members sent almost identical letters to Cigna, stating that they would not enter into direct contracts with Cigna and that Cigna should negotiate with the Alliance. As the termination date for the Alliance's Cigna contract approached, Alliance physician members started to notify Cigna that they would no longer provide services to Cigna health plan enrollees.

44. The Alliance and Mr. Diggins demanded, on behalf of Alliance physician and hospital members collectively, that Cigna continue contracting through the Alliance, and that Cigna agree to the Alliance's demands concerning a number of competitively significant price terms. These demands included continuing the limits on discounts off hospital charges, rejecting Cigna's request to negotiate the hospital list prices underlying the discounts, and rejecting Cigna's request to renegotiate physician prices.

45. Cigna was forced to continue contracting with the Alliance on the Alliance's collectively demanded terms because, without a majority of Alliance physician and hospital members in its network, Cigna would have been unable to maintain a competitively marketable health plan in the Northeastern Maine Counties and comply with the Maine Bureau of Insurance access to care regulations.

Anthem Health Plans of Maine, Inc.

46. The Alliance and Blue Cross and Blue Shield of Maine ("Blue Cross"), a payor then doing business in the Northeastern Maine Counties, entered into a contract in September, 1997, for the provision of services by the Alliance's hospital members. The agreement provided that Alliance hospital members be paid their billed charges, minus a 6% discount, during the remaining months of 1997, and billed charges minus a 7% discount, for the calendar years 1998 and 1999. Blue Cross had sought lower prices through deeper discounts, but the Alliance hospitals collectively refused to alter their terms. The Alliance's business records show that, by fixing the discount rate, the eleven Alliance hospitals increased their combined annual revenues by approximately $700,000.

47. On June 5, 2000, Anthem Health Plans of Maine, Inc. ("Anthem"), purchased Blue Cross and assumed the Alliance contract. Over the course of negotiations lasting nearly two years, the Alliance insisted that Anthem replace its individual physician contracts with an Alliance contract, and that Anthem not reduce its compensation to Alliance member physicians under the existing individual contracts.

48. In mid-2002, Mr. Diggins told Anthem that the Alliance's physicians would terminate their individual contracts with Anthem, unless Anthem agreed to contract through the Alliance for the physicians' services, at prices agreeable to them collectively. Concerned about losing the Alliance providers from its network, Anthem agreed to include the physicians in its contract with the Alliance, and engaged in several more months of price negotiations. In the midst of the investigation of the Alliance by the Federal Trade Commission and the State of Maine's Office of Attorney General, the Alliance notified Anthem that it could not go forward with the new contract, which would have included all Alliance physician and hospital members, and agreed to an additional one year extension of the 1997 hospital-only contract.

Harvard Pilgrim Health Care, Inc.

49. In early 1999, Harvard Pilgrim Health Care, Inc. ("Harvard Pilgrim"), approached the Alliance about contracting for physician and hospital services, which would allow Harvard Pilgrim to offer an HMO product in the Northeastern Maine Counties.

50. During contract negotiations with Harvard Pilgrim, the Alliance demanded high compensation for its members. The Alliance told Harvard Pilgrim that its hospital members "have been willing to accept discounts on charges ranging up to 7%," and "[p]hysician compensation agreed to has

ranged from $47 [conversion factor] to $51 [conversion factor]." The Alliance's rates were substantially higher than Harvard Pilgrim's standard compensation terms. Nevertheless, Harvard Pilgrim offered the Alliance a 7% discount for its hospital members and a $47 conversion factor for its physicians, which is equivalent to approximately 135% of 1999 RBRVS. The Alliance rejected the offer and countered with a 4% discount off of charges for hospital services and a conversion factor of $49.95 for physician services, which is equivalent to approximately 144% of 1999 RBRVS.

51. The Alliance's repeated demands for higher compensation resulted in Harvard Pilgrim abandoning its contracting efforts with the Alliance. Harvard Pilgrim approached individual Alliance physicians and hospitals for contracts directly with Harvard Pilgrim, but was unable to sign enough physicians and hospitals to create a network. As a result, Harvard Pilgrim does not offer an HMO product in the Northeastern Maine Counties.

Fraser Paper, Inc.

52. Fraser Paper, Inc. ("Fraser Paper"), a large employer in the Northeastern Maine Counties, covers approximately 2,300 individuals under a self-insured health plan. In 1997, Fraser Paper attempted to create its own provider network by entering into individual contracts with the Alliance physician and hospital members located near Fraser Paper employees. The physicians and hospitals refused to deal directly with Fraser Paper, and told Fraser Paper that the Alliance would negotiate collectively on their behalf. Confronted with the physicians' and hospitals' refusals to deal individually, Fraser Paper entered into a contract with the Alliance in 1998.

53. Fraser Paper sought to include only two Alliance hospitals in its network, but, because of the Alliance's restrictive policy, was compelled to include all Alliance hospitals as a condition of dealing with the Alliance. This prevented Fraser Paper from selecting particular hospitals with which to negotiate for inclusion in its network. Absent the Alliance's demand, Fraser Paper could have offered select hospitals access to Fraser Paper's employees in exchange for a significant reduction in the hospitals' prices.

54. Since 1998, Alliance hospitals have raised their charges for hospital services by as much as 15%. Fraser Paper made several attempts to negotiate larger discounts off the hospitals' charges to offset these increases, but the Alliance refused. The Alliance also rejected Fraser Paper's offers to negotiate the hospitals' charges underlying the discounts.

55. Fraser Paper attempted to contract directly with Alliance physician and hospital members on several occasions from 1998 to 2001, and to address its concerns over high health care costs. In each instance, the Alliance physician and hospital members refused to negotiate individual contracts, and directed Fraser Paper to contract with the Alliance.

Other Payors

56. Respondents have informed other payors that the Alliance represented the collective interest of its physician and hospital members, and that the Alliance would negotiate and sign contracts on behalf of all its physician and hospital members. Respondents also informed these payors of the specific price and price related terms that the Alliance demanded as a condition for signing a contract. To exert pressure on and coerce these payors to agree to the Alliance terms, Alliance physician and hospital members informed such payors that they would not negotiate individually, and told the payors to contract for the Alliance members' services only through the Alliance. As a result of the collective conduct, the Alliance has successfully obtained contracts on behalf of its physicians and hospitals with these payors on terms demanded by the Alliance.

The Alliance's Conduct Has Restrained Trade

57. The Alliance, acting as a combination of its members, combining or conspiring with its members, and acting through Mr. Diggins and others, has restrained competition by, among other things:

a. facilitating, negotiating, entering into, and implementing agreements among Alliance physicians on price and other competitively significant terms;

b. refusing to deal with payors except on collectively agreed-upon terms; and

c. negotiating uniform prices and other competitively significant terms in payor contracts for Alliance physicians.

58. The Alliance, acting as a combination of its members, combining or conspiring with its members, and acting through Mr. Diggins and others, has restrained competition by, among other things:

a. facilitating, negotiating, entering into, and implementing agreements among Alliance hospitals on price and other competitively significant terms;

b. refusing to deal with payors except on collectively agreed-upon terms; and

c. negotiating uniform discounts from hospital charges and other competitively significant terms in payor contracts for Alliance hospitals.

The Alliance Has Not Created Significant Efficiencies Justifying Its Conduct

59. In collectively negotiating and entering into contracts with payors, the Alliance and its physician and hospital members have failed to engage in any significant form of financial risk sharing or clinical integration. Respondents' negotiation of prices and other competitively significant contract terms on behalf of Alliance members has not been, and is not, reasonably related to any efficiency-enhancing integration among the Alliance's physician and hospital members.

The Alliance's Conduct Has Had Anticompetitive Effects

60. Respondents' actions described in Paragraphs 11 through 58 of this Complaint have had, or tend to have, the effect of restraining trade unreasonably and hindering competition in the provision of physician and hospital services in the Northeastern Maine Counties in the following ways, among others:

a. price and other forms of competition among Alliance physicians were unreasonably restrained;

b. price and other forms of competition among Alliance hospitals were unreasonably restrained;

c. prices for physician services were increased;

d. prices for hospital services were increased;

e. health plans, employers, and individual consumers were deprived of the benefits of competition among physicians; and

f. health plans, employers, and individual consumers were deprived of the benefits of competition among hospitals.

61. The combination, conspiracy, acts and practices described above constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45. Such combination, conspiracy, acts and practices, or the effects thereof, are continuing and will continue or recur in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this _____ day of _____, 2003, issues its Complaint against the Maine Health Alliance and William R. Diggins.

By the Commission.

Donald S. Clark
Secretary

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