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U.S. DEPARTMENT OF JUSTICE
Antitrust Division
Judiciary Center Building
555 Fourth Street, N.W.
Washington, D.C. 20001

Attention: Steven Brodsky

Re: ORLA

Dear Mr. Brodsky:

This letter is a follow up to our conference of last week. You had requested that I prepare a letter setting forth ORLA's intentions as an operating entity. In connection with such presentation, we are requesting a business review, since, as you know, your investigation occurred while ORLA was in its formative stages and prior to the time it had sufficient information to submit for a business review. Accordingly, I set forth the following:

1. Background Information. I cannot emphasize enough that at the time of the investigation ORLA was in its developmental stages and still is. No shares in the corporation have been issued. Only draft documents of the provider agreement and shareholders agreement had been prepared. These were not intended as final documents, since two key issues were still being discussed, namely the manner in which capitated fees would be distributed and the manner in which withholds would occur. In addition, since the date the subpoenas were issued, the "founders" of ORLA have spent a great deal of time discussing what ORLA would bring to the marketplace in terms of improved manpower, quality assurance, the ability to by-pass the middleman, economies of scale, and the like. I would like to emphasize that the investigation has not altered ORLA's plans, it has merely expedited its discussion and resolution of those issues. The purpose of this letter will be to further define those issues so you will have a better understanding of ORLA's future intentions.

2. Composition of ORLA. Its intended that ORLA be comprised of the shareholders who are anesthesiologists at the following hospitals:

<u>Hospital</u>	<u>Name of Medical Group</u>	<u>Number of Anesthesiologists</u>
St. Joseph's Hospital	Allied Anesthesia Medical Group	30
Hoag Hospital	Newport Harbor Anesthesia Consultants	27
South Coast Hospital	So. Orange County Anesthesia Medical Group, Inc.	5
Western Medical Center	Independent Anesthesiology Medical Association	13
Mission Community Hospital	Mission Anesthesia Medical Association	14
St. Jude's Hospital	Fullerton Anesthesia Medical Group, Inc.	15

3. Existing Contracts. Certain of the foregoing groups have exclusive contracts and certain of them have non-exclusive contracts with their respective hospitals and related outpatient surgery centers. It is anticipated that these contracts between each respective group and its related hospital will continue "as is" at the current time. If these contracts are later assigned to ORLA, then they will be governed under the provisions of paragraphs 4 and 5 below, which address capitated and discounted fee for service contracts.

4. Capitated Contracts. The prime purpose of ORLA is to provide a network of anesthesiologists which can negotiate for capitated contracts in the future. To date, the majority of the contracts with anesthesiologists have been discounted fee for service, but the definite trend is toward capitation. It is anticipated that in the near future, the majority, if not all contracts will be capitated. Most payors are anxious to contract with providers who can give regional coverage versus local coverage, so that (i) they can negotiate fewer contracts (which

obviously saves legal and administrative fees); (ii) exclude the middleman who acts as a broker for local groups; and (iii) acquire consistent quality assurance by dealing with a single group, which can provide centralized utilization review. Accordingly, ORLA believes it can bypass the middleman and "carve-out" anesthesia services which would be beneficial to the payor, ORLA and the patient. Any capitated fees paid ORLA would be distributed to the various anesthesiologists and/or groups according to their respective production. Obviously each provider would share the financial risk inherent with capitated contracts. In connection with ORLA's business review, we would provide evidence that ORLA's main thrust would be to obtain capitated contracts, and that in reality this is clearly the direction of current market forces.

5. Discounted Fee for Service Contracts. It is anticipated that during the transitional phase (of going to capitation), ORLA may have some discounted fee for service contracts (which eventually will be phased out as the market forces drive contracts towards capitation). These fees will be distributed to each provider on a productivity basis, after the appropriate withhold referred to below. The ORLA board is currently considering the option of adding all discounted fees (except MediCal and Medicare) to capitated payments, as part of a common pool. ORLA's expenses would be paid from the common pool and the balance of funds would then be distributed to each provider on a productivity basis. If this latter option is adopted (which decision should be made in the next 15 days), then there will be a substantial sharing of financial risk for all fees (except MediCal and Medicare).

6. Withholds. Any discounted fee for services paid ORLA would be subject to a withhold provision in which 20% of the total fee would be withheld by ORLA and distributed to its providers based upon the following types of cost containment measures:

(A) Pre-Op Lab Testing (see explanation in Exhibit 1 attached) and;

(B) Reduced Use of Community Resources (see explanation in Exhibit 1 attached).

If, however, the ORLA board elects to combine discounted fee for services into a common pool with capitated payments (as discussed above), then the withhold amount would be 10%, not 20%. In this latter case, discounted fees for service would be subject to a "double" sharing of risk, once when such fees are placed in the common pool with capitated payments and again when the withhold provision of 10% is enacted. All withhold provisions would be administered and governed by the utilization review

committee for ORLA.

7. Exclusive Contracts. It is the intent of ORLA that each of its medical providers continue its existing contracts "as is" with the possibility, but not the requirement, that these contracts will eventually be transferred to ORLA. Each provider will represent, however, that all new contracts (other than existing contracts or replacements of existing contracts) will be negotiated and signed by ORLA. Accordingly, this will be an exclusive network, except for the contracts currently in existence and any renewals thereof.

8. Pro-Competitive Effects. The formation of ORLA will have the following pro-competitive effects:

(A) Manpower. At the current time there are a number of manpower inefficiencies among the individual groups of ORLA. This is due to the fact, that in the anesthesia field, there are numerous fluctuations in manpower needs directly related to the variable use of operating rooms. At the low end of the cycle, the individual group is "over-staffed." At the high end of the cycle, the group must seek locum tenens to supplement its needs. Obviously, any reliance on locum tenens decreases quality assurance, frustrates physicians who want "known" anesthesiologists and dilutes the ability to control costs among the normal group providers. A larger group would allow a "leveling out" of the highs and lows, thus reducing manpower needs and assuring more consistent delivery of quality anesthesia.

(B) Centralized Scheduling. Related to manpower needs is the "crying" need for computerized scheduling on a centralized basis. The anesthesiologists at Hoag Hospital wanted to shift to computerized scheduling but were unable to convince the hospital to do so because of the costs. Attached as Exhibit 2 is a copy of a typical manual schedule completed by the physicians at Hoag Hospital. Such a schedule is time consuming and potentially error prone. No one group can convert to computerized scheduling due to the costs. The economies of scale would no doubt allow ORLA to do so. Such coordinated scheduling would govern the daily scheduling of cases and long term scheduling for regional manpower requirements. See Exhibit 3 for a further description of how such centralized scheduling would operate.

(C) "Carve Outs". Many contracts at the current time are with "middlemen" (i.e. IPAs, HMOs, or PPOs). ORLA strongly feels it would have the ability to contract directly with the original payors (i.e. employers or insurance companies) and thus reduce the costs of medicine to the patient. This would be a win-win situation, as ORLA would be able to command a higher price than was paid by the middleman while the payor would be

able to pay a lesser price than he paid the middleman. In essence, it would be like selling a home without using a real-estate broker. In the end, both the buyer and seller benefit. If the payor can reduce its costs, then such savings has the potential of being "passed through" in some part to the ultimate patient.

(D) Quality Assurance. ORLA will have a centralized utilization review committee which will have the effect of increasing quality medicine. For example, it will provide training programs on "cutting edge" topics that are simply not feasible in smaller groups. It will set standards for securing employees, reviewing data for case management control, and withholding funds if quality and cost containment standards are not being utilized; it will conduct patient surveys for data collection, provide programs for physician rehabilitation, train ancillary personnel, establish standards for common physician recruitment, and setting standards and implement mechanics on peer review, etc. In essence, ORLA's utilization review committee (to be known as the Risk and Quality Management Committee) would have sufficient manpower, resources and expertise to offer substantive controls and direction over the quality of patient care. See Exhibit 4 for a more detailed description of how the Risk and Quality Management Committee would operate.

(E) Economies of Scale.

(1) Billing. It is intended that ORLA would contract for billing on behalf of each of its providers. There is no question but that the billing companies will provide services at a lower rate in return for a higher gross volume. This, alone, could save approximately two percent (2%) of gross collections per year, a sizeable number when considering the billings of over 100 physicians.

(2) Data Collection. It is intended that ORLA pool its resources to provide data collection that could be helpful to it in marketing, obtaining better quality assurance, and developing new products such as the implementation of pain centers. A common data base will provide increased cost consciousness. At the current time, no such data is available.

(3) Insurance. ORLA has already determined that there could be a substantial savings in the purchase of malpractice insurance, health insurance, life insurance, D & O insurance and disability insurance based on the volume discount theory. These insurance costs, particularly malpractice insurance, are expensive and could result in considerable savings to the respective providers. See letter from the Doctors Insurance Agency, attached as Exhibit 5.

(4) Legal, Accounting, and Consulting Fees. Substantial fees could be saved in the payment of legal, accounting and consulting costs. This is particularly true in order to accommodate the fast paced changes in medicine.

9. Antitrust Issue. (Safety Zone) The first issue is whether or not ORLA comes within the antitrust "safety zone" guidelines. This is a two part test. The first part is a numbers test, namely, does ORLA comprise twenty percent (20%) or less of the anesthesiologists "with active hospital staff privileges who practice in the relevant geographic market." The second test is dependent upon whether or not ORLA's physicians "share substantial financial risk." ORLA believes it clearly and decisively satisfies both tests and thus falls within the safety zone guidelines, as evidenced by the following:

(A) Twenty Percent (20%) Test. The twenty percent (20%) test (required of groups which have exclusive contracts) is determined by calculating a ratio, the numerator being the number of anesthesiologists in ORLA, and the denominator being the number of anesthesiologists "whom health benefit plans and their subscribers consider to be good substitutes for physicians participating in the joint venture." (Emphasis added). We have a serious concern, however, that the Justice Department may be attempting to unilaterally change this standard from one of "good substitute" to "best substitute." Assuming the Justice Department does not change the standard in the guidelines, we believe the following will evidence that the ORLA physicians constitute less than twenty percent of the "good substitutes" in the relevant geographic market area:

(1) Size of Market Area. (Orange, Los Angeles, San Diego, Riverside, and San Bernardino Counties). It would be unrealistic to draw a ten mile radius around the various hospitals in Orange County and state this is the relevant geographic market area. We will be able to present evidence that ORLA physicians travel from Los Angeles County, Orange County, and San Diego County to their places of work. The entire Los Angeles, Orange County, and San Diego metropolitan areas have as a common occurrence, commuters who travel at least one hour per day each way. Our best estimate is that well in excess of 1,000 anesthesiologists (who are admitted at hospitals) reside within an hour commute of ORLA's central geographic point. Orange County alone has approximately 500 anesthesiologists who have active hospital staff privileges. Los Angeles County will have many more. Orange County is also bounded by San Diego County, Riverside County and San Bernardino County, which are the source of many more anesthesiologists within an hour commute. Currently we are obtaining more exact figures from the California Medical Association and will provide those for the business review.

(2) Over Supply of Anesthesiologists. We have spoken with numerous institutions as well as State and Federal agencies which will confirm that there is an over supply of anesthesiologists. Even anesthesiologists from premier medical schools such as Harvard are finding employment difficult. Obviously, this over supply (for which there is no immediate solution) will have a tremendous impact affecting the job security of existing anesthesiologists who are unwilling to negotiate "cost reductions." For some, it will be the choice of no job or lesser pay, and they will be happy with lesser pay. We will present statistical evidence substantiating this over supply.

(3) Fungibility of Anesthesiologists. One of the central issues is "how interchangeable are anesthesiologists" for contract replacement purposes. Obviously, an over supply of anesthesiologists has a tremendous bearing on this as referred to above. But there is more. Even if there were no over supply, there is a willingness of hospitals and payors to "switch" providers in order to achieve cost savings. There is no question that obstacles are encountered with any change, but California is so driven by managed care and cost controls that payors have and will continue to make changes where they can provide competent physicians willing to offer services at lessor rates. Attached as Exhibit 6 is a letter from Mark Ashlock, one of the leading accountants and consultants in the field of managed health care. It clearly sets forth the fungibility of anesthesiologists and the true nature of their contract risk. It is absolutely not true, as suggested by the Justice Department in its preliminary investigation, that hospitals and/or payors are unwilling to switch anesthesiologists. We will provide additional information on the fungibility of anesthesiologists and the tenuous nature of their hospital contracts at the time of the business review.

(4) Outside Group. In calculating the denominator, one ought to take into account Premier Anesthesia, a national group which actively competes for hospital contracts in the California area, Spring Anesthesia which is a large local competitor and ASMG, a San Diego Group comprised of approximately 150 anesthesiologists.

(5) Restricting Denominator to St. Joseph's, St. Jude's, Hoag and Mission Hospitals. The Justice Department, in its preliminary investigation, has suggested that the only anesthesiologists who may be calculated in the denominator are those anesthesiologists located at St. Jude, St. Joseph, Hoag, and Mission Hospitals (the "Premier Hospitals") on the basis that these are the premier hospitals in Orange County, and therefore a hospital administrator would only replace one of those groups with one of the other Premier Hospitals. Such reasoning is fallacious for the following reasons:

(a) Other Premier Hospitals. We will provide evidence that Orange County has more Premier Hospitals than four. Such a conclusion, as reached by the Justice Department, is simply untrue. As suggested by certain payors and reputable consultants in the field, it is "a ridiculous assertion."

(b) False Limitation on ORLA's Activities. The 20% numbers test was implemented to determine whether or not other physicians could be a good substitute for contracts which might be negotiated by ORLA. The Justice Department has falsely assumed that ORLA would only contract with its designated four Premier Hospitals. To the contrary, ORLA would contract with Western Medical Center and South Coast Hospital. Why aren't the competing physicians for these contracts in the denominator? Is the Justice Department contending there would be no competitors for these contracts? Or, what about the contracts of ORLA which have nothing to do with any of these six hospitals? For example, Allied Anesthesia has a contract with St. Mary's Hospital in Apple Valley, approximately 70 miles from Allied headquarters. Aren't there numerous good substitutes to compete against these contracts? Or, what about new contracts that ORLA would enter into in the Orange, Los Angeles, or San Diego Counties in the future? Won't it now be competing against physicians in each of those market areas? Yet, somehow, the Justice Department has omitted these competing physicians from the denominator.

(c) Twenty-Four Mile Radius. Assume for a moment that the Justice Department's argument is correct (with which we strongly disagree). In truth, the argument assists us. If the four Premier Hospitals (as designated by the Justice Department) are considered competitive threats to each other (but no one else is a good substitute) then one must consider that St. Jude's Hospital is approximately 24 miles from Mission Hospital; furthermore, St. Jude's is approximately 18 miles from Hoag Hospital. If Mission Hospital (at 24 miles away) is a competitive threat to St. Jude's, then why aren't all premiere hospitals within a 24 mile radius of St. Jude's also a competitive threat. What is so magical about county lines or only "going south." If one draws a radius 24 miles from St. Jude's Hospital then many of the hospitals in L.A. County will be included within the sweep, as well as certain hospitals within Riverside and San Bernardino Counties. Likewise, a 24 mile radius from Hoag Hospital will include a large portion of L.A. County. Suffice it to say, that once "premier" hospitals from L.A. County are brought into the picture, ORLA's numbers will fall well below twenty percent (20%). We will provide you with statistical information on premier hospitals in Los Angeles, San Bernardino, Riverside, and San Diego County which fall within such 24 mile sweep of each of the "Premier Hospitals" tabbed by the Justice Department. In addition, we will provide you with

evidence that approximately 90 hospitals are located within a 24 mile radius of the four "Premier Hospitals," the majority of which have anesthesiologists which could replace their counterparts at any other hospital.

(d) Other Competitive Threats. Furthermore, we are in complete disagreement that the anesthesiology groups at these four "Premier Hospitals" would be the only competitive threat for each other within the boundaries of Orange County. Certainly hospitals such as Saddleback, University of California at Irvine and others are very reputable hospitals with reputable anesthesiology departments that are "good" substitutes. We have already spoken with payors who have confirmed this. Until the guidelines are changed to read "best" substitutes it would be completely unrealistic to exclude any competent anesthesiologist within a one hour driving range of ORLA's central point.

(e) Competing Networks. There is nothing that would prevent any of the existing physicians from "breaking-off" from its existing medical group at one of those four "Premier Hospitals" and forming its own competing group. In addition, there is nothing that would prevent other competent anesthesiologists from Orange County, San Diego County, Los Angeles County, or neighboring counties from forming physician networks that could be highly competitive. The guidelines read "if in the relevant market there are any other physician network joint ventures or any physicians who would be available to perform competing network joint ventures or to contract directly with health benefit plans, it is unlikely that the joint venture would raise any competitive concerns." (Emphasis added.) The guidelines then go on to state that in order to determine if a competing physician network could be formed it is necessary to "analyze both the number of physicians in each relevant service market and the competitive significance of the exclusive or non-exclusive nature of the physician network joint venture." There are thousands of physicians who could form new networks in this multi-metropolitan area and are in fact doing so. San Diego already has one group known as ASMG, of approximately 150 anesthesiologists, which is a competitive threat. Premier, a national organization, has access to hundreds, perhaps thousands, of anesthesiologists and is a competitive threat at any hospital in the United States. We are personally aware of other anesthesiology groups which are forming in larger numbers which would be competitive threats. One group in San Gabriel Valley (with whom we are working) has the realistic potential of 70 anesthesiologists. Groups in North San Diego and at Cedars Sinai Hospital have seriously considered such "networks." To limit "good substitutes" to four "Premier Hospitals" in a metropolitan area such as L.A., where specialty IPAs are forming in almost frenzied fashion, is totally unrealistic. I represent about 300 physicians, numerous IPAs, MSOs, and the like, and am personally

aware of the daily networking of "new groups." To believe that four hospital groups have a super competitive hold on the L.A./Orange County market is to be out of touch with the explosive dynamics occurring here.

(f) Foundations - Staff Models. Currently, a number of hospitals are forming foundations after the "Kaiser" model. Adventist Hospital Systems has formed a foundation, Uni-Health has formed a foundation, Huntington Memorial Hospital has formed a foundation, and others are in the process. As foundations move towards the "Kaiser" model, more and more physicians will be "hired" by the foundation and not operate as independent groups. As a result, independent anesthesiology groups, as they now exist, will be even more at risk as to the nature of their contract. And who of all people will "move them out?," the very hospitals who claim they cannot replace them. The "take over" will be very subtle (as is already occurring); will be by hospitals forming foundations and purchasing primary care practices; and then, once they control the primary care field, they will pretty well dictate what anesthesiologists are hired and what prices they are paid. Accordingly, to give credence to the hospitals' version of "anesthesiology super power" is like asking Jesse James at which bank you should deposit your money. To say the least, there is a tremendous conflict of interest.

10. Antitrust Issue (Non-Safety Zone). If for some reason ORLA does not come within the safety zone, we believe that the pro competitive efficiencies generated by ORLA (as discussed above) outweigh any "super" market competitiveness it might otherwise possess and thus should not pose an antitrust concern.

The foregoing is a summary, and not an exhaustive presentation of the antitrust issues. As discussed, we will amend any existing Provider Agreements and Shareholder Agreements to be in conformance with the business operations of ORLA as set forth in this letter. In addition, any business plan or management guidelines for ORLA will be drafted in compliance with the issues discussed herein.

Our thanks to you for considering our request. We will wait to hear from you at this point.

Very truly yours,



TAD R. CALLISTER