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September 3, 1992

WRITER'S DIRECT DIAL NO.

312/704-3120

FILE NO.

John W. Clark, Esq.
Acting Assistant Attorney General
Antitrust Division
United States Department of Justice
Washington, DC 20530

RE: Preferred Provider Agreements

Dear Mr. Clark:

Pursuant to our discussions with you and Mr. Martin during late March 1992, we have revised our request for a Business Review Letter for Saint Anthony Medical Center of Rockford, Illinois (hereafter, "Saint Anthony" or "Hospital"). This letter will amend and supersede our original request of October 31, 1991.

Saint Anthony Medical Center is a short-term acute care hospital that is owned and operated by OSF Healthcare System, an Illinois not-for-profit corporation sponsored by a religious order. Saint Anthony provides tertiary care to patients living in Winnebago County, Illinois and surrounding communities. (The Division obtained further information about Saint Anthony through discovery during its investigation and trial of the *United States v. Rockford Memorial Corp.* case; Saint Anthony was the hospital which was *not* part of the proposed merger.)

Saint Anthony wishes to offer multi-provider hospital and physician services through "preferred provider" proposals to employers and other third party payors covering groups of beneficiaries.

"Preferred provider"[1] proposals offering volume services at discounted rates are not

[1] A plan sponsor contracts only with certain hospitals as "preferred providers." Plan beneficiaries are given financial incentives to use preferred providers. Usually, any services provided to beneficiaries at non-preferred provider hospitals would subject the patient to a greater co-payment obligation than if the same services were performed by the preferred

new. What would be new--and for which this letter is submitted--is the Hospital's intent to make "preferred provider" proposals which would cover the services of more than one institutional provider, including a second hospital that serves the same geographic market as Saint Anthony. As an example of the kind of proposal which Saint Anthony would make to third-party payors:

A. Saint Anthony would offer to provide all hospital services required by plan beneficiaries through an exclusive[2] preferred provider contract. Anticipating that the requirements for hospital services by employees of a given employer under the exclusive preferred provider contract may exceed the capacity of Saint Anthony at any given time, Saint Anthony would enter into a secondary contract with another hospital, or hospitals. Under that secondary contract the second hospital would render services to patients covered by the Saint Anthony preferred provider contract. But the number of patients to be served at the second hospital would be limited, as would the circumstances when they would be referred by Saint Anthony to the second hospital.

This secondary contract would enable Saint Anthony to fulfill demand for managed care contracts with large employers, yet continue to serve patients covered by public insurance (which reimburses at much lower rates than private insurance) without disrupting service patterns to any segment of the population. To the extent that Saint Anthony is successful in obtaining a contract or contracts that could require more beds/services than Saint Anthony, itself, might be capable of providing at any given time, the secondary contract would enable Saint Anthony to secure sufficient services/beds to cover Saint Anthony's contract obligations at preferred rates from a competing institution.

B. A Saint Anthony preferred provider contract could also combine a range of hospital *and* professional services at discounted rates. The foregoing

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provider.

[2] "Exclusive" means that the plan sponsor would only have one preferred provider contract--that with Saint Anthony. In practice, most employers of the size of companies in the Rockford area only enter into one "preferred provider" agreement, if it offers coverage at two hospitals. That is because no single employer has such a large number of beneficiaries as to require more than one or two hospitals. The plan would not be "exclusive" from the point of view of the beneficiary; while financial disincentives to the beneficiary discourage use of other than the "exclusive" hospital provider, the beneficiary still enjoys substantial coverage for services by a non-preferred provider.

proposal--paragraph A, above--could also include a physician services component.

For any preferred provider contract which includes physician services, physician providers' reimbursement would be at rates set by Saint Anthony, or on any other basis requested by the payor. Saint Anthony would contract with individual physicians or physician groups to provide physician services as part of the same hospital preferred provider agreement. Saint Anthony's relation with physician providers shall be determined by arms length negotiations with physicians, and physician groups, and physicians shall not control any preferred provider agreement offered by Saint Anthony.

Preferred provider agreements by Saint Anthony which include physician services would be competitive with existing HMO's, with managed care plans sponsored by non-provider entities, and with IPA's sponsored by existing physician groups.

Competitive concerns would be safeguarded in any preferred provider arrangement involving another institution. If another hospital were providing services as part of a preferred provider agreement between Saint Anthony and an employer, each hospital (i.e., Saint Anthony and the other hospital) would commit explicitly that the secondary contract between Saint Anthony and the other hospital is not exclusive. That is, Saint Anthony would not require that the other hospital decline to provide quotes or participate in preferred provider agreements sponsored by other hospitals, or by non-hospital PPO intermediaries. Each hospital would, if asked, submit a separate preferred provider proposal to any employer that would cover services by that one hospital. Each hospital would also be willing to offer a proposal involving services by that hospital and by any other specific hospital (under a secondary contract), if invited to do so by an employer/insurer, or by another hospital. Saint Anthony would not refuse to quote, nor to participate in preferred provider agreements organized by non-hospital PPO intermediaries. Any such multi-hospital preferred provider agreement would also include the express representation by each hospital to the employer that the discount granted by that hospital was determined independently by the hospital rendering services.

Saint Anthony would not attempt to restrict any physician providers who elect to participate in a preferred provider agreement of Saint Anthony, from also participating in other managed care arrangements involving other intermediaries or other hospitals.

Of course, the most effective protection of competition for managed care contracts is and will remain the employer/third party payors which wish to reduce their expenditures for health care, and have professional staffs of benefit coordinators who monitor utilization and costs under different managed care systems. Saint Anthony's preferred provider agreement proposed here would be a commercial failure--i.e., industry will not "buy" it--

unless Saint Anthony can, in fact, provide the same services at lower cost than industry could obtain through several two-party contracts with competing providers. Many Rockford industries compete in national markets (e.g., Sunstrand, Rockford Products, Woodward Governor, Barber Colman, Elco Industries). With health care costs at the present levels, it is improperly paternalistic and plain wrong to suppose that industry in Rockford does not seek to minimize costs through competition, just because some companies mistakenly supported the aborted Rockford-Swedish American merger.

Saint Anthony believes that by offering discounts on its services to employer groups it can attract additional patients it is not presently serving, thereby increasing utilization which, in turn, reduces the per patient-day fixed costs that go into determining Saint Anthony's rates. This is the fiscal rationale that drives all preferred provider agreements. However, Saint Anthony has heretofore only been able to offer its services alone, or offer them through third-party intermediaries whose involvement increases the total cost of services for which a payor pays, without increased benefits to either the consumer-beneficiary or to the employer-third-party payor.

Independent, non-provider intermediaries play a pivotal role in managed healthcare. Such intermediaries negotiate discounted prices for volume services with providers, then package those bundles of services and market them to third party payors. But their existence is justified by legal reasons rather than because they provide the most cost efficient way of providing health care services. Typically, such intermediaries are organized as for-profit corporations. They disclaim any responsibility for the quality of services provided, and attempt to structure their relationship with providers so that they have (a) no obligation for payment--leaving it for the provider to look to the contracting organization to provide all reimbursement, and (b) no obligation to the employer or beneficiary for the quality of care provided. Intermediaries whose principal or sole role is to package bundles of services from different providers must include in their price to group purchasers the costs of the intermediary's operations as well as its profit.

Because of informational and transaction efficiencies, Saint Anthony's preferred provider agreement should be more cost effective than competing proposals by independent intermediaries. First, there are inherent cost savings when one is "negotiating" with one's self. When Saint Anthony negotiates a contract with a payor, Saint Anthony's transaction costs for that negotiation may arguably be similar to those of an intermediary. But an independent intermediary must also negotiate for Saint Anthony's participation in such a contract. That intermediary--hospital negotiation is not replicated when Saint Anthony offers its own contract to a payor.

Second, because of better access to pertinent information (e.g., utilization costs, demand) and better understanding of the reliability of that information, Saint Anthony should also be in a superior position to negotiate the most favorable rates from a competing hospital, and to manage patient referrals when appropriate. Saint Anthony has more

employees who know and understand the details of different areas of cost and services than an independent intermediary can profitably employ. Because Saint Anthony employees are engaged in more aspects of the hospital industry, their knowledge is likely to be more current and more complete at any given time than is true for employees of independent intermediaries, who will not have the same range of experiences to stay current.

Third, because Saint Anthony employs more people and can use them in several ways, its transaction costs for managed care negotiations should be less than an independent intermediary. A strict cost accounting for the time invested by Saint Anthony employees in managed care contracts should show that Saint Anthony spends less of its employees' time on contract formulation and negotiations than would be true for an independent intermediary. That is because the independent intermediary which must spread all of its employees' salary expense over the contracts they successfully complete. Unlike Saint Anthony, the independent intermediary's employees do not have any other productive uses for their time. This indivisibility of labor input for the intermediary should mean that Saint Anthony can be more cost efficient in negotiating a managed care contract covering more than one institutional provider.

Saint Anthony, a provider, is also in a superior position vis a vis an independent, non-provider intermediary to act as "gatekeeper" in rendering patient service. Saint Anthony succeeds with payors only to the extent it controls or reduces costs, and with patients only to the extent it renders high quality care, and Saint Anthony more efficiently controls both elements of satisfaction than can any intermediary, which can only negotiate with hospitals in response to consumer complaints.

Some employers and insurers are unwilling to enter into a preferred provider agreement which restricts the services to beneficiaries to only one hospital. Saint Anthony believes, based upon conversations with employer payors, that it would be more successful in obtaining preferred provider contracts if it can offer exclusive contracts to provide all hospital services to the employer's beneficiaries, but that would also include an element of patient choice. Patient choice would be achieved by allowing a part of such services to be provided by another, competing institution. Saint Anthony believes that the importance of patient choice may be more significant than the demand for services at another hospital. Even among some patients that historically received services at the other hospital, if they are covered by a contract in which Saint Anthony is the primary provider and their historical hospital is a secondary provider, some will choose Saint Anthony.

Saint Anthony's original proposal would not limit the number or percent of covered patients who could receive services at a secondary, competing hospital. That is because Saint Anthony would serve all of the covered patients it could accommodate, and would not refer patients to another institution--even one which is a secondary preferred provider--except when compelled by competitive conditions to do so. Such competitive conditions include the obvious: (a) when Saint Anthony does not offer the service or, due to temporary

circumstances, cannot serve the patient; and (b) when by servicing the patient, Saint Anthony cannot serve another patient who might be adversely affected by having to go to another hospital (e.g., charity cases, beneficiaries of other managed care contracts).

A further competitive condition is (c) when the payor desires a "patient choice" feature. When the payor or its beneficiaries wish to be served by a secondary preferred provider, Saint Anthony needs and wants the ability to respond to that demand by including a secondary preferred provider as a feature of its contract. The written agreement between the primary provider and a secondary provider differs significantly from a proposal by two providers in several ways. With a secondary preferred provider, Saint Anthony assumes the risk of paying for services rendered by the secondary provider. That risk would be controlled by terms in the preferred provider contract such as limits on aggregate patient days, or other parameters. Those limitations enable Saint Anthony to price all hospital services under its preferred provider contract more efficiently to the payor, while maximizing whatever patient choice is desired by the payor. The terms of the contract between the primary provider and the secondary provider would result from arms length negotiations between the primary and the secondary providers. Those negotiations may take place before or after the payor had accepted a preferred provider agreement with a primary provider. Saint Anthony's preferred provider agreements would thereby give the payor, and the individual beneficiaries what each wants--the greatest discount for the largest guaranteed volume of services, along with an element of patient choice.

Saint Anthony must assure its ability to perform such exclusive contracts by being able to direct some patients to another hospital, when necessary based on conditions at Saint Anthony. Moreover, to enable Saint Anthony to offer the lowest price to the employer and to be able to compete with PPO intermediaries that negotiate discounts with multiple providers, Saint Anthony must also be able to negotiate discounted rates from the other hospital that would treat Saint Anthony overflow. Negotiating competitive discounts is possible only insofar as Saint Anthony can quantify the patients that would be referred to the other hospital from which Saint Anthony is seeking a discount. Unless a hospital can quantify the number of patients it will attract (or, not lose) by granting a discount, that hospital would be unwilling to grant a favorable, discounted price. That is because only by defining a number of patients, or patient days that the secondary provider would continue to serve, can the secondary hospital determine its utilization and patient mix, and therefore calculate the effect of the secondary contract upon its fixed and variable costs, as part of its pricing analysis.

**Overview of the Market**

As determined in the *Rockford Memorial Corp.* case, the geographic market for hospital services consists of Winnebago and Boone Counties, Illinois, and parts of four contiguous counties, having a combined population of nearly 300,000. It is served by three

tertiary level hospitals. Two smaller, primary care hospitals are located about 15 miles away in Belvidere (Highland Hospital--70 beds/ 42% occupancy--and Saint Joseph Hospital--57 beds/35.5% occupancy), are affiliated with Swedish American Hospital and Saint Anthony Medical Center, respectively. The two primary care hospitals play a minimal role in serving the health care needs of the market in which Saint Anthony competes. For the most recent period for which data is publicly available (1989), the data on the three tertiary hospitals is as follows:

| | Staffed beds | Occupancy | Patient Days |
|---|---|---|---|
| Rockford Memorial Hosp. | 393 beds | 76.5% | 109,761 |
| Swedish American Hosp. | 331 beds | 66.7% | 80,596 |
| Saint Anthony Med. Center | 246 beds | 61.3% | 55,013 |

Some specialized services are only provided by one hospital, including neurological ICU and lithotripsy (Saint Anthony), neonatal ICU, renal dialysis, rehabilitation, (Rockford Mem.), and weight management programs (SwedishAmerican). Rockford Memorial and Saint Anthony are certified as Level I Trauma Centers by the state of Illinois.

There are approximately 450 physicians practicing in or near Rockford. Essentially all have clinical privileges at two or more Rockford hospitals, although most concentrate their practice at one institution. Approximately one-third of all physicians are members of Rockford Clinic, a large multispecialty clinic that is located adjacent to the campus of Rockford Memorial Hospital. Together, Rockford Memorial Hospital and the Rockford Clinic sponsor a closed-panel physician HMO, "Clinicare." Patient subscribers of Clinicare can receive services at any of the Rockford-area hospitals after a pre-admission authorization.

Approximately two-thirds of the Rockford physicians are members of the Blackhawk Area Independent Physicians Association ("BAIPA"), an IPA that has contracts to provide health services on a capitation basis. The Blue Cross-sponsored HMO contracts with BAIPA for the physician services provided through that HMO.

In addition, Swedish American Hospital markets its physicians as the "Staff Core," which competes for managed care contracts with third party payors. "Staff Core" is part of the "Concerned Consumer Network" ("CCN"), which is a PPO that competes for contracts with businesses. Swedish American is the only hospital provider under preferred provider contracts of CCN.

A number of independent PPO's regularly solicit proposals from the Rockford area hospitals, which the PPO's package and attempt to sell to local companies/third party payors. This competition is expected to continue.

The purpose of Saint Anthony's proposal is to offer a lower cost alternative to existing managed care services now available only through an independent PPO, or the Rockford Clinic HMO.

There are several companies in the greater Rockford area which would be interested in managed care as Saint Anthony would propose, particularly with a physician component. These include Sunstrand Corp., Rockford Products, Woodward Governor, Clarcor, Barber Colman, Rockford Powertrain, Elco Industries, and Atwood. No single company represents more than about 12% of the insured employees in the Rockford area. Each competing hospital is, itself, a major employer in this market; each hospital is the primary provider of hospital services to its own employees under their health insurance plans.

Saint Anthony contract proposals to employers would define health care rates for a two or three year term. The contacts, once accepted, could not be cancelled for the term of the contract without a retroactive financial adjustment to the payor. Moreover, the contracts would proscribe an employer from steering beneficiaries to any hospital except to Saint Anthony or any other hospital(s) participating in the successful contract (up to a defined annual limit), during the period of the contract.

It is very speculative to project possible cost savings to any particular employer/third party payor. However, Saint Anthony believes its proposals would likely be priced in the range of a 20 percent discount off published charges. A physician component would likely provide physician services at a discount off charges by the particular physician, averaging about 10 percent. Both of these estimates would vary substantially according to the number of insured patients employed by the contracting employer.

During a meeting with Ms. DeBusschere, Ms. Allen and Mr. Martin on March 19, 1992, we discussed the Division's concern for appropriate limits on the referral of patients by Saint Anthony to a secondary, preferred provider competing hospital. The concern, as we understand, is that absent some limitation on patient referrals between Saint Anthony and another hospital, the preferred provider agreement could become a mechanism for division of a patient submarket.3

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[3] This analysis treats the insured patients of a given employer as a submarket. As applied to employers the size of those in the Rockford area. Each employer's employees probably are not a submarket. Unless they are so numerous or unique as to be a submarket, there is no competitive significance to an agreement such as Saint Anthony

We argued that express limits on the patients going to the second hospital are unnecessary. Saint Anthony, like any other hospital, would not refer privately insured patients to any other institution unless competitive circumstances compelled the referral. Only when Saint Anthony could not provide the service needed by the patient, or when Saint Anthony had assured a certain number of patient referrals to a second hospital (in order to obtain a discounted rate through a secondary contract), would Saint Anthony give up the opportunity to serve every privately insured patient.

We discussed circumstances when Saint Anthony would not be able to serve patients, including the temporary inability to render needed services that Saint Anthony does provide. For example on a given day, intensive care unit (ICU) beds may not be available. Similarly, a male patient suffering an infectious disease would not be admitted when the only available bed is in a semi-private room occupied by a female patient (although, statistically, Saint Anthony is not operating at full capacity on that day). If diagnostic equipment such as MRI scanner is needed, a patient may be redirected by her physician to another institution if the MRI equipment cannot be conveniently scheduled. As small a consideration as the operating room schedule at Saint Anthony can result in a patient receiving elective surgery at another hospital, when more convenient to the same surgeon's schedule. Saint Anthony, like other hospitals, experiences seasonal fluctuations in utilization, and even fluctuations in utilization depending on the day of the week.

Because of the diversity of circumstances when patients are diverted from Saint Anthony, Saint Anthony could only locate incomplete historical data on patient transfers. During 1991, Saint Anthony's emergency room transferred one or two patients each month to another hospital. In addition, the ambulance and helicopter services operated by Saint Anthony directed 27 patients to other hospitals during the same year. Most diversions of the kind Saint Anthony would need to make if it secures an exclusive preferred provider agreement with a large employer would not be reflected in these data because the decision to divert to another hospital would be made by the attending physician before the patient

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proposes. There would be nothing anticompetitive about a contract between a single provider and a single payor to render (a) all hospital services required, or (b) a fixed percentage of the payor's requirement for services, say 70 percent. If it is not anticompetitive to enter into a "requirements" contract, which allows for minimal competitor participation in serving the payor's employees, it cannot be "anticompetitive" if the provider that is contractually responsible to provide all services, subcontracts with a competitor to participate in providing patient care. If this were not true, each employer that contracts with one insurer or one intermediary would be creating the same kind of "competitive" problem.

was ever admitted, based on information given by telephone about the availability of different hospital facilities.

Based on anecdotal information from Mr. Kevin Schoeplein (former administrator of Saint Anthony), in the early 1980's, when hospital utilization was higher the problem of transfers due to unavailable facilities at Saint Anthony was greater than shown by this 1991 data. If Saint Anthony is successful in obtaining an exclusive contract as the preferred hospital provider for an employer, utilization--and the problem of patient transfers--is expected to increase.

Saint Anthony must be able to utilize other competing institutions in performing an exclusive preferred provider contract for a large employer. This is obvious where another hospital is the only provider of a particular service. It may be less obvious but equally necessary where Saint Anthony encounters circumstances where it is not possible or not practical to provide a particular service at a given time to a certain patient, even though Saint Anthony provides that service.

To compete with proposals by independent PPO intermediaries, Saint Anthony must be able to negotiate discounted rates from other hospitals that would serve "overflow" patients that Saint Anthony could not serve. For larger employers, the number of covered employees may make it possible to predict accurately the incidence of patients that would be referred by Saint Anthony to another hospital. However, it may be impossible to accurately predict the incidence of referrals to another hospital where the number of covered employees is smaller (e.g., under 200).

In order to meet the Division's concerns, as an alternative to no limitations on the referrals to a second hospital we suggested at our March 1992 meeting that the permissible referrals by capped at 20 percent of the hospital admissions covered under any contract. The 20 percent limitation would include all patient transfers except (a) those necessitated because Saint Anthony does not offer the service needed by the patient being admitted, and (b) those involving emergency care where the hospital was selected by the emergency personnel attending the patient. This 20 percent of admissions standard would include circumstances where Saint Anthony would be unable to admit a patient because of a temporary lack of capacity and when it is advantageous in meeting a commitment of volume that was necessary to obtain a preferred rates from the competing hospital. This referral cap on "overflow" referrals would not compel Saint Anthony to actually divert or refer each and every patient to the secondary provider. Saint Anthony could set guidelines for limited access to the secondary provider and publish those guidelines to beneficiaries who could directly seek the services of the second hospital without first presenting at Saint Anthony.

A simple percentage standard achieves two procompetitive objectives. First, it saves costs to Saint Anthony by not requiring that Saint Anthony factually document why each patient was not treated at Saint Anthony, but was referred to another hospital. Of course,

no independent PPO intermediary has to create such a paper trail on why each potential patient was not served by a given hospital. Second, it gives Saint Anthony the ability to negotiate preferred rates from the second hospital that would serve such "overflow" patients. Only by quantifying, or guaranteeing a certain number of referrals could Saint Anthony secure favorable discounts from another hospital. Otherwise, no competing hospital would have any incentive to discount its charges and thereby reduce Saint Anthony's cost to perform its requirements contract.

In sum, Saint Anthony wishes to offer preferred provider contracts to employers and insurance companies which are competitive with similar products presently offered only by non-hospital intermediaries. Such contracts provide for hospital services by Saint Anthony and, to a limited, predefined extent, by another institution from which Saint Anthony could attempt to negotiate discounted rates. Saint Anthony would be responsible for paying those rates to the other hospital in fulfilling Saint Anthony's preferred provider contract with the employer. Saint Anthony would thereby provide a package of health care services at a lower cost, but with a similar range of choices to the consumer as are now available only through contracts offered by independent PPO's or HMO's. Competition would not be restricted because neither Saint Anthony, nor any other provider that might participate in Saint Anthony's PPA would decline to discount to intermediaries, or would be restricted from offering a similar preferred provider agreement. Competition would be enhanced because Saint Anthony, and any other hospital or non-hospital provider, could develop its own contract package offering payors and their beneficiaries the services of the exclusive preferred provider hospital as well as the services of one or more alternative providers.

I will be pleased to provide further information and documents on the proposed activity for which we seek a statement of the Division's enforcement intentions. Saint Anthony Medical Center has not undertaken this activity, and does not intend to do so prior to an expression of the Division's intentions.

Very truly yours,

Robert E. Nord

REN/bak
cc Molly DeBusschere, Esq.