HOGAN & HARTSON
L.L.P.

JANET L. McDAVID
PARTNER
DIRECT DIAL (202) 637-5780
INTERNET JM1@DC2.HHLAW.COM

COLUMBIA SQUARE
555 THIRTEENTH STREET, NW
WASHINGTON, DC 20004-1109
TEL (202) 637-5600
FAX (202) 637-5910

February 7, 1997

BY FEDERAL EXPRESS

The Honorable Joel I. Klein, Esquire
Acting Assistant Attorney General
Antitrust Division
United States Department of Justice
Room 3210
Washington, D.C. 20530

Re: First Priority Health System

Dear Joel:

On behalf of First Priority Health System ("FPHS" or the "Partnership"), we submit this request for a business review letter. Information concerning the formation and planned operations of FPHS are set forth below and in the attached volume of exhibits. We are, of course, available to provide any additional information you or the staff requests.

OVERVIEW

First Priority Health System is a joint venture between certain physicians and First Priority Health ("FPH"), the HMO subsidiary of Blue Cross of Northeastern Pennsylvania ("Blue Cross"). 1/ FPHS was created to form a risk-bearing service delivery organization ("SDO") to provide and manage medical

---

1/ The request for a business review letter sets forth the basic structure of FPHS and its partners in sufficient detail to understand its basic structure, organization, and purposes. More detailed information about the legal structure of FPHS and its partners is contained in Appendix A. This more detailed information is not relevant to an analysis of the efficiencies and possible antitrust issues raised by the formation and operation of the Partnership, but is provided as additional background.

services to FPH enrollees in a five-county area of Northeastern Pennsylvania consisting of Lackawanna, Monroe, Pike, Susquehanna, and Wayne Counties (the "SDO Geographic Area"). 2/ The other partner in FPHS is NEPPO Ltd. ("NEPPO"), a limited partnership composed of 156 primary care physicians ("PCPs") and specialists who practice in the SDO Geographic Area. 3/

The Partnership is an innovative joint venture between providers and a managed care payor to provide efficient medical services to the payor's enrollees. The joint ownership is designed to align the economic incentives of the payor and providers and to provide a mechanism to integrate providers in utilization management, and thereby create an incentive for physicians to provide excellent, cost-effective health care to enrollees.

This Overview provides general information concerning the organization, structure, and anticipated operations of FPHS. Additional information concerning the legal structure of FPHS, NEPPO, and their affiliates is attached for background as Appendix A. Following the Overview is a discussion of the potential antitrust issues raised by the formation and operation of FPHS and an explanation of why those issues should not concern the Antitrust Division and should be the subject of a favorable business review letter under the procedures established in the *1996 Statements of Antitrust Enforcement Policy in Health Care* (the "*1996 Policy Statements*").

FPHS will provide health care services and supplies to FPH enrollees in the SDO Geographic Area, including primary and specialist physician services, inpatient and outpatient hospital services, ancillary patient services, and

---

2/ FPH serves a broader geographic area than the SDO Geographic Area. FPH's service area consists of 13 counties in Northeastern Pennsylvania including the five-county area. Several other HMOs also operate in the SDO Geographic Area, including Geisinger (Lackawanna, Monroe, Susquehanna, and Wayne Counties), Qual-Med (Lackawanna County), and U.S. HealthCare/Aetna (Lackawanna, Pike, Susquehanna, and Wayne Counties).

3/ Two NEPPO physicians practice outside the SDO Geographic Area in adjacent counties.

rehabilitation services ("SDO Services").4/ In addition, FPHS will provide comprehensive, integrated medical management services, such as developing, maintaining, and expanding the provider network; credentialling; developing standards for quality assurance and clinical practice; and distributing payments to network providers.

FPH has agreed that FPHS will be the exclusive entity to provide SDO Services in the SDO Geographic Area. NEPPO has agreed that FPHS will be the only managed care plan with which its primary care physicians (except for pediatricians and OB-GYNs) will contract to provide "gatekeeper" services.5/ However, NEPPO primary care physicians are free to participate in other health plans, including POS or PPO plans, that do not involve a "gatekeeper" model. Thus, the FPHS primary care physicians are not truly exclusive. In addition, NEPPO specialists are free to contract with other all managed care plans, including other "gatekeeper" model managed care plans, and many do so.6/ Thus, there are no exclusivity obligations on NEPPO specialists.

FPHS recognizes that serving the enrollees of FPH will require more providers than those physicians who participate in NEPPO. To have sufficient providers to meet the needs of enrollees, FPHS will also contract with other providers in the SDO Geographic Area, including physicians who are not NEPPO members (referred to hereinafter as "Supplemental Physicians"), hospitals, and ancillary providers. As a result, the Partnership will contract with sufficient providers to meet the needs of FPH enrollees, although many of those providers will not be members of NEPPO. Such contract providers will not be subject to any exclusivity obligations and remain free to contract with all other payors, including

---

4/ The services to be provided at the inception of FPHS are listed in section 2.7 of the Operating Agreement. *See* Exhibit 3.

5/ For this purpose, a managed care plan is a product that is required to be provided through a licensed HMO in Pennsylvania or using gatekeeper physicians to access health care services. Thus, by the terms of the FPHS Operating Agreement, PPO or POS plans are not necessarily considered managed care plans. However, PPO or POS plans as well as indemnity plans may provide effective competition for managed care plans, including FPHS.

6/ As shown in the matrix attached as Exhibit 9, NEPPO specialists in fact contract with other managed care plans.

other managed care plans. Since the Supplemental Physicians will not be shareholders in NEPPO, they will not share the risk of ownership in NEPPO, and they will not participate in the management of the Partnership, but Supplemental PCPs will be paid capitated rates.

Participation in NEPPO is limited to physicians who have Provider Agreements; if a physician no longer has a Provider Agreement, her interest becomes non-voting. Similarly, if a physician ceases to practice medicine in the SDO Geographic Area, her interest in NEPPO either will be converted to non-voting or purchased by NEPPO. In addition, FPH and NEPPO have agreed that neither will separately acquire any provider in the SDO Geographic Area unless that opportunity has been first presented to FPHS.

NEPPO and its affiliates have raised substantial capital to fund part of the operations of the Partnership. The NEPPO physicians have contributed in excess of $1,250,000 in cash through their initial capital contributions and annual dues and an additional $750,000 through demand notes. Each NEPPO physician has been required to contribute $10,000; in addition, each NEPPO physician is committed to provide sufficient additional capital needed to operate FPHS. Any gains or losses from NEPPO are shared equally by NEPPO physicians. Thus, NEPPO physicians have invested substantial capital in the Partnership and share in its financial success.

FPHS will be compensated by FPH for providing SDO Services to FPH enrollees pursuant to a premium allocation formula based on FPH's rate filing. FPHS intends that its primary care NEPPO physicians will accept risk for the care of FPH enrollees. Primary care NEPPO physicians will be paid through capitated rates developed by FPHS's board of directors and FPH. NEPPO specialists will be paid on a discounted fee-for-service basis. NEPPO will be compensated for certain administrative services provided to FPHS pursuant to a premium allocation formula based upon the FPH rate filing.

FPHS will undertake all medical management services to insure that all care for FPH enrollees is timely, effective, and efficiently provided, including provider credentialling and recredentialling; network performance review and management; network development and maintenance; provider relations; provider staff training; development and implementation of clinical protocols; outcome management through prospective reviews, concurrent reviews, and retrospective reviews; discharge planning; and establishing methods for provider reimbursement. NEPPO members will participate fully in these processes so these management

techniques will be developed and implemented jointly by the payor and providers, rather than imposed unilaterally by the payor. FPHS believes that physicians will more willingly implement medical management techniques if they participate in developing those techniques.

Through their ownership of one of the FPHS partners, NEPPO physicians will share in the success (or failure) of the Partnership. Like all payors, FPH has an incentive to insure that medical care is provided to its enrollees in as cost-effective a manner as possible while maintaining or improving quality. Thus, as a result of the shared ownership and operation of FPHS by FPH and NEPPO physicians, there will be a shared incentive to provide high-quality services at the lowest possible cost.

Set forth below is a discussion of the reasons we believe that the formation and operation of FPHS is entirely consistent with the antitrust laws and should be the subject of a favorable business review letter from the Antitrust Division. First, we describe in detail the expected efficiencies that the parties believe can be achieved through FPHS, as well as their basis for those expectations. Second, we describe the arrangements among the NEPPO physicians to participate in the financial risks of the Partnership and explain why those risk sharing arrangements involve a "sharing of substantial financial risk" within the meaning of the *1996 Policy Statements*. Third, we discuss the limited exclusivity arrangements between FPHS and the NEPPO primary care physicians and explain why those arrangements are fully consistent with the antitrust laws, although they may modestly exceed the "safety zones" established by the *1996 Policy Statements*. Finally, we discuss the reasons that the arrangements between the Partnership and NEPPO specialists are consistent with the *1996 Policy Statements*.

I. THE LIKELY EFFICIENCIES PRODUCED BY THE PARTNERSHIP'S NEW PRODUCT OFFERING

As a fully integrated combination of NEPPO physicians and a managed care payor, the Partnership is designed to improve the cost and quality of care provided to FPH enrollees.

Medical care costs are fairly low in the FPHS area compared to other areas in the country. This is driven primarily by a low average cost per service. Utilization levels are acceptable when compared to areas with similar managed care penetration and market maturity, but are higher than in many areas,

especially mature managed care areas, which tend to have substantial risk transfers to physicians and, therefore, substantially lower utilization rates. By creating FPHS, physicians will share in the success of the organization, not only through the growth of the organization, but also through the elimination of any unnecessary or duplicative services. This creates a mutual, shared incentive to operate efficiently, which can be expected to increase overall efficiency levels and result in greater success in gaining managed care contracts.

Under historical trends, the cost of providing medical services tends to rise over time. There are many reasons for this upward trend, including increases in both the average cost of the services being provided and the number of services being provided. In order to project the possible savings developed by FPHS, we developed a baseline projection showing what would be expected in the absence of the Partnership. Based on national trends, we would expect to see a gradual increase in costs over time. For FPHS, there is actually an initial decline in costs is due to a one-time restructuring of some key hospital contracts. This drop is phased-in over two years, so that costs drop a total of 6.9% from 1995 to 1997. Costs are projected to start increasing in 1998, however, as the effect of the hospital contract restructuring phases out.

To project the effect that the incentives in the FPHS joint venture might have on costs, we modeled a set of possible outcomes, using a scenario of moderate decreases in utilization and a more aggressive scenario. The number of in-patient bed days per thousand provides an indication of the improvements in utilization management we are projecting. In 1995, historical data shows that bed days were 323.2 per thousand members. Under historical trends, this would improve to 254.5 in 1998. Under FPHS, projected bed days range from 198.4 to 226.3 per thousand, depending on the scenario.

In total, projected costs under the revised scenarios are 5%-14% lower than we would expect if past trends continue. This decrease can be summarized as:

	Historical Trends in Utilization (1998)	Predicted Improved Utilization Trends Under FPHS (1998)
Bed Days/1,000 Members Per Year	254.5	198.4-226.3
Per Member Per Month Medical Cost	$76.15	$65.32-$72.28
Total Annual Medical Cost	$56,700,000	$48,600,000 to $53,800,000
Change in Cost		-5% to -14%

The table shows that sizable decreases in the cost of providing medical care are possible if utilization levels can be improved. The overall projected cost savings ranges from $2.9 to $8.1 million. Given that levels of utilization achieved under risk contracts in other areas are well below those projected here, it seems the level of reduction projected for FPHS are achievable.

The Partnership further contemplates the creation of new medical management processes capable of producing additional substantial efficiencies. For example, one of the fundamental components of the management service to be provided to FPH under the Operating Agreement is the performance of on-line utilization management. This will be accompanied by NEPPO monitoring elective and emergency care on a twenty-four (24) hour basis. The utilization review and case management process are expected to produce significant efficiencies. The expected procompetitive effects include improved cost controls, reduced administrative and transaction costs, spreading of financial risk, better case management and quality assurance, inducing interdependent loyalties, and reducing utilization.

Moreover, the active participation in the Partnership, as a fifty percent (50%) partner, of FPH, a payor-affiliated entity, with contractual rights relating to pricing of physician services, guarantees that the physician compensation methodology employed will reflect a strong incentive to reduce prices for physician and other services provided to FPHS under the Provider Agreements and Provider Management Agreement.

II. ELEMENTS OF RISK-SHARING

NEPPO physicians will share substantial financial risk in two significant ways. First, all NEPPO physicians have made substantial investments in NEPPO . Second, NEPPO PCPs will share risk through their compensation arrangements.

A. Risk of Investment Required to Participate

Physician partners in NEPPO have raised approximately $750,000 in order to capitalize the joint venture. In addition, physician shareholders of NEPPO have invested in excess of $1,000,000. A portion of such capital will be used to purchase software and computer systems necessary to perform the utilization and medical management services and will also be used to gather aggregate and individual data on the cost, quantity, and nature of services provided or ordered by the Partnership's physicians, as required under its contract with the Partnership. That information will also be used to measure performance of the group and the individual doctors against cost and quality benchmarks, and to monitor patient satisfaction. 7/ The Partnership will provide detailed reports on the cost and quantity of services provided and on the joint venture's success in meeting its goals.

The concept of medical management requires that all services be closely monitored and that physicians be available on an on-line basis for immediate decision-making. This is also expected to produce cost savings.

The physicians have provided substantial risk capital to assure that the network is fully operational and achieves the desired efficiencies to assure that appropriate services are timely and efficiently delivered.

In order to assure that the appropriate network of physicians is available, the NEPPO Board has set up an elaborate screening process and has adopted the guidelines established by Blue Cross and FPH for physicians to participate in the network.

7/ FPHS also expects that these processes will improve the quality of care.

B. Physicians In the FPHS Provider Network Will Share Risk for Over-Utilization of Services

1. NEPPO Physicians

The Operating Agreement with FPH provides that FPH will allocate a portion of the premiums it collects to the Partnership for all medical services covered by FPHS. *See* Exhibit 3, Operating Agreement, Section II and Exhibit C thereto. NEPPO and other providers of SDO Covered Services will then contract with the Partnership to provide medical and physician services on a fixed fee basis. NEPPO will pay its specialist physicians on a discounted fee-for-service basis and will pay primary care physicians on a capitated basis. 8/ At such time as NEPPO has evolved its medical management and reimbursement methodology to the satisfaction of FPHS and FPH that NEPPO can develop and administer a global capitation system for its physicians, FPHS may implement a Global Capitated Contract with NEPPO for the provision of such agreed services to its members in the SDO Geographic Area. To create incentives for physicians to monitor utilization of services, NEPPO will set up such pools to reward physicians for reductions in utilization for physician services. The Partnership, therefore, contemplates the kind of capitated network that distributes income among the physician participants using payments on a per member per month basis, with pools established to reward efficient operations, and, for specialists only, discounted fee-for-service payments.

2. NEPPO Specialists

NEPPO Specialists will share risk because of their ownership interest in NEPPO, the 50% partner in the FPHS joint venture. As a result, NEPPO specialists will share in any gains realized by FPHS as a result of efficient management or losses from over-utilization. FPHS will compensate specialists for care provided to FPH enrollees on a discounted fee-for-service basis, but this is not significant for antitrust purposes because overall, FPH will pay FPHS on a capitated basis. *See 1996 Policy Statements* at 110, n. 51. In the future, NEPPO specialists may also share risk through the implementation of a global capitated system, which FPHS expects to develop and administer after it has gained sufficient experience with medical management and reimbursement. The development of a

---

8/ *See* Exhibit 4, Provider Management and Services Agreement between NEPPO, P.C. and FPHS at ¶ 2.4.

global capitated system would qualify as further evidence of substantial risk sharing by NEPPO specialists. *See 1996 Policy Statements* at 109.

3. Supplemental Physicians

As noted above, to provide sufficient provider coverage for FPH enrollees, FPHS will enter independent provider contracts with Supplemental Physicians. Although Supplemental Physicians will not risk venture capital like NEPPO member physicians, Supplemental Physicians who are PCPs will provide services on a capitated basis to FPHS, and thus, will share the risk of the over-utilization of services. 9/

C. Absence of Non-Risk-Sharing Arrangements

The arrangement between FPH and the Partnership is fully at risk for SDO Services. 10/ Related and reserved services will be provided by non-NEPPO providers. FPH will pay FPHS an agreed annual fee for each enrollee. 11/ The Partnership will either make or lose money depending on its management of care and services. The Partnership will initially enter into both risk-sharing and non-risk-sharing arrangements with its providers and will carefully monitor utilization. Accordingly, we do not believe a separate treatment of initial non-risk-sharing elements for specialists is required.

III. THE NATURE OF THE EXCLUSIVE ARRANGEMENTS

The parties' arrangements have two exclusivity features. First, they have agreed that FPHS will be the only entity to provide SDO Services to FPH enrollees. Second, NEPPO primary care physicians have agreed not to contract with other gatekeeper model managed care plans.

9/ Supplemental Physicians who are specialists will provide services to FPHS on a discounted fee-for-service basis.

10/ Upon commencement of operations, FPH will assume reinsurance liability for claims for covered services in accordance with the limits as established by FPH and FPHS. It is contemplated that FPHS may elect to secure reinsurance coverage for its obligations to provide covered services pursuant to the Partnership.

11/ *See 1996 Policy Statements* at 109.

A. The Partnership As Exclusive Provider of SDO Services

The parties have agreed that the Partnership will be the exclusive entity for providing SDO Services in the SDO Geographic Area to FPH plan subscribers. Since "SDO Services", for this purpose, are limited to designated covered physician, hospital and medical services purchased for subscribers of FPH, the scope of this exclusive arrangement will not include any services provided to any non-HMO type health plan. The geographic scope of this exclusive arrangement is limited to the SDO Geographic Area, i.e. five (5) Pennsylvania counties of Lackawanna, Monroe, Pike, Susquehanna and Wayne. 12/

B. The Partnership As Exclusive Entity Through Which Certain of its Primary Care Physicians Will Provide "Gatekeeper" Services in the SDO Geographic Area

NEPPO and its members have agreed that the Partnership will be the exclusive entity through which its primary care physicians will provide "gatekeeper" managed care services in the SDO Geographic Area. This exclusive arrangement does not apply to all NEPPO member physicians. 13/ It is limited to certain primary care physicians, who account for less than 1/3 of all members of NEPPO and only 19.6% of the primary care physicians in the SDO Geographic Area. NEPPO members who are not primary care physicians are not within the scope of this limited exclusivity provision. 14/

IV. THE NON-EXCLUSIVE FEATURES OF THE JOINT VENTURE

Only NEPPO primary care physician members will be subject to a narrow, limited exclusivity provision requiring them not to participate in managed care products with other health plans. The remaining FPHS primary care physicians who are not NEPPO members and NEPPO specialist physicians are free to participate in all managed care products with all other health plans. In this regard, the Partnership will be "non-exclusive in fact" not just in name.

12/ *See* Exhibit 2, Partnership Agreement at Article 10, Section 10.01(a).

13/ A list of the shareholders of NEPPO, P.C., and their medical service specialties is set forth in Exhibit 8.

14/ *See* Exhibit 2, Partnership Agreement Article 10, Section 10.01(b).

A. There are Competing Networks and Managed Care Plans with Substantial Physician Participation

Other managed care plans and networks are active in the SDO Geographic Area. For example, Aetna/U.S. Healthcare, Geisinger Health Plan, and Qual-Med/Greater Atlantic Health Service offer competitive managed care plans to subscribers in the SDO Geographic Area. The plans have experienced recent growth in numbers of subscribers.

Managed Care Plans
Operating in the Five-County SDO Geographic Area

1. Geisinger Health Plan
   100 North Academy Avenue
   Danville, PA 18722-3020

2. Health-America Pennsylvania, Inc.-Centre
   Central Medical Services Building
   1850 East Park Avenue
   State College, PA 16803

3. Aetna Health Plans of Central And Eastern Pennsylvania, Inc.
   955 Chesterbrook Boulevard, Suite 200
   Wayne, PA 19087
   United States Health Care Systems of Pennsylvania, Inc. d/b/a The Health Maintenance Organization of Pennsylvania and also U.S. Healthcare
   980 Jolly Road
   P.O. Box 1109
   Blue Bell, PA 19422

4. Greater Atlantic Health Service, Inc. (Qual-Med)
   3550 Market Street
   Philadelphia, PA 19101

In addition, physicians in the SDO Geographic Area belong to other networks. The following IPAs and networks operate in the SDO Geographic Area:

Other Physician Networks
in the SDO Geographic Area

1. Heritage Physician Organization
525 East Drinker Street
Dunmore, PA 18512
Peter Cognetti, M.D., President
Rose Mary Broderick, Ex-Director
70 PCPs in Lackawanna, Luzerne and Wyoming Counties. They are reportedly pursuing risk arrangements with other payors, including U.S. Healthcare.

2. Lackawanna County Physician Organization
Address unknown
Ken Rudolph, M.D., President
187 members. Organized over a year ago and have a consulting contract with the Pennsylvania Medical Society Management Company. This group includes both PCPs and specialists and was started by the Lackawanna County Medical Society. It will be contracting with insurers on the basis of risk.

3. Upper Delaware Area Physicians Hospital Organization
John Sternberg, M.D., President
41 Physicians in Wayne County.

4. Pocono Regional Physician Organization
175 East Brown Street
East Stroudsburg, PA 18301
Peter Yaswinski, M.D., President
99 members in Monroe County (both PCPs and specialists). Currently in contract negotiations with FPH for a risk arrangement.

5. Horizon (specialist organization)
Address unknown
H. Brereton, President or Ex-Director
6 members. Reportedly aligned with Mercy Scranton and acts as the preferred specialist network for Heritage Physicians Organization.

V. PERCENTAGE OF PARTICIPATING PHYSICIANS IN POTENTIAL RELEVANT GEOGRAPHIC MARKETS

Attached as Exhibit 6 is a table and two charts showing the numbers of NEPPO PCPs and specialists in Lackawanna County in absolute terms, and as a percentage of the total number of PCPs and specialists in Lackawanna County. 15/ Attached as Exhibit 7 is a table and two charts showing the numbers of NEPPO PCPs and specialist physicians in the SDO Geographic Area in absolute terms, and a percentage of the total number of PCPs and specialists in the SDO Geographic Area.

A. Lackawanna County

Most of the NEPPO physicians are from Lackawanna County (39 of 49 PCPs and 95 of 107 specialists). It is intended that the PCPs will be exclusive to NEPPO and that the specialists will be non-exclusive. In Lackawanna County, 25.0% of the PCPs will belong to NEPPO. This somewhat exceeds the *1996 Policy Statements* safe harbor of 20% for exclusive networks. As a whole, the percentage of NEPPO specialists in Lackawanna County is 27.3%, below the safe harbor of 30% for non-exclusive networks. In certain specialties, the number of NEPPO physicians exceeds the safe harbor for non-exclusive networks, but this is not problematic, as demonstrated below.

B. Five-County Area

There are only 10 PCPs and 12 specialists from the four counties outside of Lackawanna County who are NEPPO members. For the entire SDO Geographic Area served by FPHS, NEPPO physicians constitute only 19.6% of the PCPs and only 21.7% of the specialists.

C. Analysis of Limited PCP Exclusivity

As noted above, NEPPO's share of PCPs in the SDO Geographic Area is only 19.6% below the safe harbor for exclusive networks, and its share of PCPs in Lackawanna County is 25.0%, somewhat above the safe harbor. This does not raise antitrust concerns for several reasons.

15/ PCPs are defined as family practice, general practice and internal medicine physicians. Specialists are defined as physicians who are not PCPs.

First, it should be noted that the NEPPO network is not truly "exclusive" as that term is most often used in connection with provider networks. FPHS only precludes NEPPO primary care physicians from contracting with other managed care products, which are defined in the Operating Agreement as HMOs licensed in Pennsylvania or other plans that require PCPs to serve as "gatekeepers." That is, NEPPO PCPs are still available to participate in other physician networks established by, or contracting with other health plans, including indemnity plans, PPOs, or POS plans.

Second, while NEPPO has 25.0% of the PCPs in Lackawanna County; it has only 19.6% of the PCPs in the SDO Geographic Area. The large supply of PCPs not affiliated with NEPPO in the SDO Geographic Area serves as a check on any conceivable effort by NEPPO PCPs to exercise market power.

Third, even assuming that NEPPO PCPs are truly exclusive and that the relevant geographic market is narrowly defined as Lackawanna County, 75.0% of the PCPs in that county remain available to provide "gatekeeper" services to other managed care health plans. This would allow for the development of three other exclusive networks of equal size to FPHS, and an even greater number of nonexclusive networks.

Fourth, the NEPPO PCPs share financial risk with FPH, a payor. 16/ Thus, the incentives of the PCPs and all NEPPO physicians are aligned with those of FPH, which are to provide the highest quality care for the lowest possible cost. FPH has no incentive to pay NEPPO physicians rates that exceed competitive levels, and the financial success of the NEPPO physicians and the venture is linked to the continued competitiveness of FPH as a payor. This feature is a critical innovation of the FPHS. Accordingly, NEPPO's share of PCPs in Lackawanna County does not pose any conceivable threat to competition.

D. Analysis of NEPPO Specialists

Overall, NEPPO specialists constitute only 27.3% of the specialists in Lackawanna County and only 21.7% of the specialists in the SDO Geographic Area.

16/ FPHS is not provider-controlled. (See FTC Statement Regarding Physician Agreements to Control Medical Prepayment Plans, October 5, 1981.) Half of the Partnership's Board of Directors, consisting of ten (10) members are required to be selected by UMC, an FPH affiliate.

But in certain specialties, NEPPO's share of the physicians is nominally higher. In many instances, these shares are misleading because the product market for the relevant physician services is broader than the defined specialty.

For example, NEPPO physicians constitute 35.7% of gastroenterologists in the five county area. However, this significantly overstates NEPPO's share of the relevant product market since internists and PCPs are effective substitutes for gastroenterologists for many procedures and conditions. Similarly, NEPPO physicians account for 17.6% of the pediatricians in Lackawanna County and 32.4% of pediatricians in the SDO Geographic Area. Again, PCPs, especially those engaged in family or general practice, can and do provide pediatric care so these shares overstate their percentage of the relevant product market. NEPPO physicians account for five of the six physiatrists in the five county area, but physical therapists, PCPs, and orthopedic surgeons also provide the relevant services in competition with physiatrists. NEPPO's share of dermatologists is 36.4% in the five county area, but internists and other PCPs also provide dermatology services. NEPPO's share of vascular surgeons is 41.7% in the five county area, but cardiovascular and general surgeons provide similar services. Indeed, all five of the NEPPO's cardiovascular surgeons also hold themselves out as general surgeons, and are listed as such in the NEPPO physician directory. Under these circumstances, the fact that in some specialties NEPPO physicians modestly exceed the safety zones should not be problematic.

In other instances NEPPO qualifies for the exception for markets in which there are fewer than four physicians in a particular specialty. *See 1996 Policy Statements* § 8(A)(2). Thus, NEPPO is permitted to have and does have 1 of the 3 cardiovascular surgeons (33.3%); the sole pediatric neurologist (100%); and 1 of 2 specialists in neonatal-perinatal medicine (50%). Notably, these specialists are not exclusive to NEPPO.

VI. FPHS WILL CONTRACT WITH SUPPLEMENTAL PHYSICIANS

It is anticipated that the number and geographic distribution of the NEPPO physicians will be insufficient to adequately meet the needs of FPH members in the SDO Geographic Area. As of this date and when the Partnership becomes operational, FPH has and will have existing provider agreements with non-NEPPO physicians in the SDO Geographic Area. 17/ To facilitate FPH's ability

17/ A sample provider contract is attached as Exhibit 10

to provide adequate coverage in the SDO Geographic Area where the number and mix of NEPPO physicians is insufficient, FPH has agreed to assign to FPHS all of its physician provider contracts with non-NEPPO physicians for the SDO Geographic Area. These physicians will become Supplemental Physicians for FPHS, and their contracts are all non-exclusive: each Supplemental Physician is contractually free to enter into provider contracts with managed care plans and health insurance payors other than FPH (and FPHS).

It is also anticipated that after FPHS becomes operational, it will be necessary, in order for FPHS to provide adequate coverage to fulfill FPHS's obligations under the Operating Agreement between FPH and FPHS, for FPHS from time to time to renegotiate and/or renew these Supplemental Physician provider agreements.

In the future, it may be necessary to contract with other Supplemental Physicians in the SDO Geographic Area to respond to shifting demographic distribution of Plan subscribers, to respond to increased demand for coverage in particular fields of practice, and to replace retiring or nonparticipating Supplemental Physicians or NEPPO physicians. Again, any Supplemental Physicians will not be exclusive to FPHS, and will not participate in FPHS management.

The pricing aspects of all contracts with existing and future Supplemental Physicians will be dealt with exclusively by the Reimbursement Committee of the FPHS, as described below.

Physician provider agreements with these existing and future Supplemental Physicians are reasonably necessary to the operation of the joint venture and the new product the Partnership will offer. The arrangements with the Supplemental Physicians are therefore ancillary to the principal joint venture agreement.

In addition, FPH has agreed, when FPHS becomes operational, to assign to FPHS the existing August 15, 1996, hospital services and hospital-based physician services contract with Community Medical Center, Scranton, Pennsylvania ("CMC"). 18/ CMC and the parties to the FHPS joint venture have

---

18/ *See* Exhibit 11, CMC Agreement.

agreed to develop a system for delivering cost effective, high quality health care services to the community. To that end, CMC has agreed to work toward the development of a capitated compensation system for hospital services. In the interim, CMC has agreed to provide FPH (and by assignment, FPHS) with special discounted rates for hospital services. 19/ FPH and CMC have agreed to limited, qualified, exclusivity provisions. FPH has designated CMC as the exclusive provider of certain hospital services for FPH enrollees who are referred by a physician to a hospital in the City of Scranton. 20/ CMC has agreed not to establish its own HMO or contract with any other health plan using gatekeeper physicians. 21/

VII. THE FPHS REIMBURSEMENT COMMITTEE

The Partnership intends to create a policymaking board Committee of its Board of Directors (the Reimbursement Committee) consisting exclusively of the SDO Directors appointed by FPH and its managed care affiliates to deal with issues relating to compensation for physician services (a) provided to FPHS by NEPPO, and (b) provided by the Supplemental Physicians. All decisions relating to such compensation issues will be made by the Reimbursement Committee, without consultation with the FPHS Board representatives appointed by NEPPO. The Reimbursement Committee will have the exclusive responsibility to collect and analyze fee data for physicians for use in developing the NEPPO physician network's fee schedule and for use in determining reimbursement of the Supplemental Physicians. The Reimbursement Committee will perform this function using the services of an outside agent that will preserve strict confidentiality of the data collected and analyzed.

19/ *Id.* at § 3, Schedule B.

20/ *Id.* at § 6. The exclusive provider provision does not apply if CMC does not provide a distinct hospital service, if the patient is referred by her physician to a hospital outside Scranton, or if the patient requires one of the nonexclusive services listed in Schedule C to the CMC Agreement. *Id.* at Schedule C.

21/ *Id.* at § 7. However, CMC can contract with other health plans that do not use gatekeeper physicians, and can contract with any health plan to provide distinct hospital services for which CMC is the sole provider in the region. Moreover, there are two other acute care hospitals in Scranton (Mercy Hospital- Scranton and Moses Taylor Hospital) that can contract with health plans using gatekeeper physicians.

In this manner, the Partnership will avoid sharing of sensitive pricing information between the NEPPO network physicians and the Supplemental Physicians. The Reimbursement Committee shall maintain the confidentiality of all pricing information relating to the details of reimbursement by NEPPO of the NEPPO physicians.

In addition, FPHS is structured to minimize the likelihood of spillover effects. NEPPO will employ the services of an outside agent to collect and analyze fee data from its physicians for use in developing the NEPPO network's fee schedule/capitated rates in order to avoid the sharing of sensitive information among the NEPPO network's own physician participants. In this manner, the operation of the Partnership will minimize the risk of spillover effects of coordination of pricing activities for services provided by NEPPO physicians outside the FPHS venture.

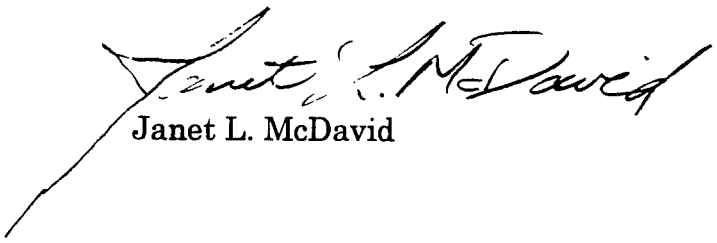
Precautions will also be taken to ensure that NEPPO network physicians will not share information about the prices they charge non-network patients and whether they plan (in the case of non-primary care physicians, who are not subject to any exclusive terms) to contract individually with non-network customers.

CONCLUSION

As described above, the proposed First Priority Health System represents an innovative response to the problems facing payors and providers in the changing healthcare industry. FPHS's partners believe that the venture will lower utilization in the SDO Geographic Area, and maintain and improve the quality of care provided to FPH members, by financially integrating physicians with a payor, and by involving physicians in the development and management of the systems that will monitor and affect utilization. The introduction of this new healthcare system promises to bring new and improved service at lower costs, and poses no threat to competition. First, in the market for healthcare financing, FPHS has, and will have, strong competitors including the Geisinger Health Plan, Aetna/U.S. HealthCare Systems and Greater Atlantic Heath Service (Qual-Med). The limited exclusivity features of the network means that these and other health plans have access to a sufficient numbers of PCPs to create viable, competing provider networks. Second, in the market for physician services, the nonexclusive nature of the specialist network, the financial integration of NEPPO physicians with FPH, a payor, and the partnership's price-setting process will protect competition for physician services inside and outside the venture. In sum, under

the principles of analysis set forth in the *1996 Policy Statements*, FPHS is procompetitive, and we request a favorable business review letter.

Very truly yours,



Janet L. McDavid

Enclosures

cc: Gail Kursh, Esquire
Harry Madonna, Esquire
William Roberts, Esquire
Robert Brittain, Esquire
Keith Saunders, Esquire
Dr. John Preston