UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA, and
STATE OF CONNECTICUT, ex rel., RICHARD BLUMENTHAL, ATTORNEY GENERAL,

Plaintiffs,

vs.

HEALTHCARE PARTNERS, INC., DANBURY AREA IPA, INC., and DANBURY HEALTH SYSTEMS, INC.,

Defendants.

Civil Action No:
3 95 C V 0 1 9 4 6 RNC

Entered: February 15, 1996

FINAL JUDGMENT

Plaintiffs, the United States of America and the State of Connecticut, having filed their Complaint on September 13, 1995, and plaintiffs and defendants, by their respective attorneys, having consented to the entry of this Final Judgment without trial or adjudication of any issue of fact or law, and without this Final Judgment constituting any evidence against or an admission by any party with respect to any issue

of fact or law;

AND WHEREAS defendants have agreed to be bound by the provisions of this Final Judgment pending its approval by the Court;

NOW, THEREFORE, before the taking of any testimony, and without trial or adjudication of any issue of fact or law, and upon consent of the parties, it is hereby ORDERED, ADJUDGED, AND DECREED:

I.

JURISDICTION

This Court has jurisdiction over the subject matter of and each of the parties to this action. The Complaint states claims upon which relief may be granted against the defendants under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2.

II.

DEFINITIONS

As used in this Final Judgment:

(A) "Competing physicians" means physicians in separate medical practices in the same relevant physician market;

(B) "Control" means either:

(1) holding 50 percent or more of the outstanding voting securities of an issuer;

(2) in the case of an entity that has no outstanding voting securities, having the right to 50 percent or more of the profits of an entity, or having the right in the event of dissolution to 50 percent or more of the assets of the entity; or

(3) having the contractual power to designate 50 percent or more of the directors of a corporation, or in the case of unincorporated entities, of individuals exercising similar functions.

(C) "DAIPA" means Danbury Area IPA, Inc., each of its directors, officers, agents, representatives, and employees (in such capacity only), its successors and assigns, and each entity over which it has control.

(D) "DHS" means Danbury Health Systems, Inc., each of its directors, officers, agents, representatives, and employees (in such capacity only), its successors and assigns, and each entity over which it has control.

(E) "DHS Affiliated Physician" means any physician

employed, or whose practice is owned, by DHS or DOPS at the time of the filing of the Complaint in this action.

(F) "DOPS" means Danbury Office of Physician Services, P.C., each of its directors, officers, agents, representatives, and employees (in such capacity only), its successors and assigns, and each entity over which it has control.

(G) "HealthCare Partners" means HealthCare Partners, Inc., each of its directors, officers, agents, representatives, and employees (in such capacity only), its successors and assigns, and each entity over which it has control.

(H) "Messenger model" means the use of an agent or third party to convey to payers any information obtained from individual providers about the prices or other competitive terms and conditions each provider is willing to accept from payers, and to convey to providers any contract offer made by a payer, where each provider makes a separate, independent, and unilateral decision to accept or reject a payer's offer; the information on prices or other competitive

terms and conditions conveyed to payers is obtained separately from each individual provider; and the agent or third party does not negotiate collectively for the providers, disseminate to any provider the agent's or third party's or any other provider's views or intentions as to the proposal, or otherwise serve to facilitate any agreement among providers on prices or other competitive terms and conditions.

The agent or third party, so long as it acts consistently with the foregoing, may:

(1) convey to a provider objective information about proposed contract terms, including comparisons with terms offered by other payers;

(2) solicit clarifications from a payer of proposed contract terms, or engage in discussions with a payer regarding contract terms other than prices and other competitive terms and conditions, except that the agent or third party (a) must tell the payer that the payer may refuse to respond or may terminate discussions at any time and (b) may not communicate to the providers regarding, or comment on, the payer's

refusal to offer a clarification or decision not to enter into or to terminate discussions except to providers who requested the clarification;

(3) convey to a provider any response made by a payer to information conveyed or clarifications sought;

(4) convey to a payer the acceptance or rejection by a provider of any contract offer made by the payer;

(5) at the request of a payer, provide the individual response, information, or views of each provider concerning any contract offer made by such payer; and

(6) charge a reasonable fee to convey contract offers, by applying preexisting objective criteria, not involving prices or other competitive terms and conditions, in a nondiscriminatory manner.

Additionally, the agent or third party must communicate each contract offer made by a payer unless the payer refuses to pay the fee for delivery of that offer; the offer is the payer's first offer and lacks

material terms such that it could not be considered a bona fide offer, or the agent or third party applies preexisting objective criteria, not involving prices or other competitive terms and conditions, in a nondiscriminatory manner (for example, refusing to convey offers of payers whose plans do not cover a certain minimum number of people, or offers made after the agent or messenger has conveyed a stated maximum number of offers for a given time period).

(I) "Pre-existing practice group" means a physician practice group existing as of the date of the filing of the Complaint in this action. All DHS affiliated physicians at the time of the filing of the Complaint in this action constitute a single pre-existing practice group. DAIPA does not constitute a pre-existing physician practice group. A pre-existing practice group may add any physician to the group after the filing of the Complaint, without losing the status of "pre-existing" under this definition for any relevant physician market, so long as each additional physician is not currently offering services in the

relevant physician market and would not have entered that market but for the group's efforts to recruit the physician into the market.

(J) "Prices or other competitive terms and conditions" means all material terms of the contract, including information relating to fees or other aspects of reimbursement, outcomes data, practice parameters, utilization patterns, credentials, and qualifications.

(K) "Provider panel" means those health care providers with whom an organization contracts to provide care to its enrollees.

(L) "Qualified managed care plan" means an organization:

(1) whose members or owners share substantial financial risk and either directly or through membership or ownership in another organization, comprise, (a) where membership or ownership is non-exclusive, no more than 30% of the physicians in any relevant physician market, except that it may include any single physician or pre-existing practice group, or (b) where membership or ownership is exclusive, no more

than 20% of the physicians in any relevant physician market; and

(2) whose provider panel, does not have more than where non-exclusive 30% or where exclusive 20% of the physicians in any relevant physician market, unless, for those subcontracting physicians whose participation increases the panel beyond the 20% or 30% limitations, the organization bears significant financial risk for payments to and the utilization practices of the subcontracting physicians and does not compensate those subcontracting physicians in a manner that substantially replicates membership or ownership in the organization.

The organization may not facilitate an agreement between any subcontracting physician and any other physician on their charges to payers not contracting with the organization. The organization may at any given time exceed the 20% or 30% limitations as a result of (a) any physician exiting any relevant physician market or (b) the addition of any physician not previously offering services in a relevant

physician market who would not have entered that market but for the organization's efforts to recruit the physician into the market; however, the organization may not exceed the 20% or 30% limitation by any greater degree than is directly caused by such exit or entry.

(M) "Relevant physician market" means, unless defendants obtain plaintiffs' prior written approval of a different definition, each of the following groups of physicians with active staff privileges other than courtesy privileges at Danbury Hospital:

(1) physicians who are: (a) board-certified only in general internal medicine or family practice; (b) listed only under family practice or internal medicine on the attached medical staff lists of Danbury Hospital; or (c) generally-recognized, and in fact practicing more than a third of the time as a family practitioner or general internist (for purposes of determining the percentage of physicians applicable to a qualified managed care plan, each physician included in a relevant physician market pursuant to this clause (c) of Paragraph (II)(M)(1) of this Final Judgment

shall count as only one-third of a physician);

(2) physicians who are board-certified in, or board-eligible and actually practicing in, obstetrics or gynecology;

(3) physicians who are board-certified in, or board-eligible and actually practicing in, pediatrics; and

(4) any other group of physicians who offer services in a relevant product market as defined applying federal antitrust principles.

(N) "Subcontracting physician" means any physician who provides services to an organization or to persons receiving healthcare services from that physician pursuant to an agreement by that organization to provide such services, but who does not hold, directly or indirectly, any ownership interest in that organization.

(O) "Substantial financial risk" means financial risk achieved through capitation or the creation of significant financial incentives for the group to achieve specified cost-containment goals, such as

withholding from all members or owners of a qualified managed care plan a substantial amount of the compensation due to them, with distribution of that amount to the members or owners only if the cost-containment goals are met.

III.

APPLICABILITY

This Final Judgment applies to DHS, DAIPA, and HealthCare Partners, and to all other persons who receive actual notice of this Final Judgment by personal service or otherwise and then act or participate in active concert with any or all of the defendants.

IV.

INJUNCTIVE RELIEF

(A) DAIPA and HealthCare Partners are enjoined from, directly or through any agent or other third party, setting, or expressing views on, the prices or other competitive terms and conditions or negotiating for competing physicians, regardless of whether those physicians are subcontracting physicians or owners or

members of DAIPA or HealthCare Partners, unless done as part of the operation of a qualified managed care plan; provided that, nothing in this Final Judgment shall prohibit DAIPA or HealthCare Partners from acting as or using a messenger model.

(B) DAIPA, HealthCare Partners, and DHS are enjoined from:

(1) Precluding or discouraging any physician from contracting with any payer, providing incentives for any physician to deal exclusively with DAIPA, HealthCare Partners, or any payer, or agreeing to any priority among themselves as to which will have the right to first negotiate with any payer, provided that, nothing in this Paragraph shall prohibit a physician from agreeing to exclusivity in connection with an ownership interest or membership in a qualified managed care plan, or prohibit DHS from participating in contracting decisions of DHS-affiliated physicians;

(2) Disclosing to any physician any financial or other competitively sensitive business information about any competing physician, except as is reasonably

necessary for the operation of any qualified managed care plan, or requiring any physician to disclose any financial or other competitively sensitive business information about any payer or other competitor of DAIPA or HealthCare Partners; provided that, nothing in this Final Judgment shall prohibit the disclosure of information already generally available to the medical community or the public or the provision of information pursuant to the Antitrust Safety Zones delineated in the attached Statements 5 and 6 of the 1994 Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust;

(3) Owning an interest in any organization (including DAIPA and HealthCare Partners) that, directly or through any agent or other third party, sets, or expresses views on, prices or other competitive terms and conditions or negotiates for competing physicians, regardless of whether those physicians are subcontracting physicians or owners or members of that organization, unless that organization is a qualified managed care plan and complies with

Paragraphs IV (B)(1) and (B)(2) of the Final Judgment as if those Paragraphs applied to that organization; provided that, nothing in this Final Judgment shall prohibit owning an interest in an organization that acts as or uses a messenger model.

(C) DHS is enjoined from:

(1) Exercising its control over staff privileges with the purpose of reducing competition with DHS in any line of business, including managed care, outpatient surgery or radiology, and physician services; provided that nothing in this Final Judgment shall limit DHS's authority to make staff decisions for the purpose of assuring quality of care;

(2) Conditioning the provision of inpatient hospital services to individuals covered by any payer on:

(a) The purchase or use of DHS's utilization review program, any DHS qualified managed care plan, DHS's ancillary or outpatient services, or any physician's services unless such services are intrinsically related to the provision of acute

inpatient care (as, for example, are radiology, anesthesiology, emergency room, and pathology services deemed to be for purposes of this Final Judgment where these services are performed in connection with an inpatient admission), or

(b) A contract or other agreement to deal through HealthCare Partners or any other organization; provided that, nothing in this Paragraph IV(C)(2) shall limit the terms and conditions on which DHS may contract with any payer pursuant to which DHS bears substantial financial risk for the delivery of the services or products identified in Subparagraphs (1) and (2); and

(3) Conditioning rates to any payer for inpatient hospital services on the exclusive use of DHS outpatient services; provided that nothing in this Paragraph IV(C)(3) shall (a) limit the terms and conditions on which DHS may contract with any payer pursuant to which DHS bears substantial financial risk for the delivery of outpatient services; or (b) prohibit DHS from entering into exclusive contracts

that require payers to use DHS's outpatient services where rates for those services are not tied to discounts on inpatient rates.

V.

ADDITIONAL PROVISIONS

(A) DAIPA and HealthCare Partners shall:

(1) Inform each participating physician annually in writing that the physician is free to contract separately with any payer on any terms, except with regard to physicians who have agreed to exclusivity in connection with an ownership interest or membership in a qualified managed care plan; and

(2) Notify in writing each payer with which HealthCare Partners currently has or is negotiating a contract, or which subsequently inquires about contracting with HealthCare Partners, that each provider on HealthCare Partners' provider panel is free to contract separately with such payer on any terms, without consultation with DAIPA or HealthCare Partners.

(B) DHS shall file with plaintiffs each year on the anniversary of the filing of the Complaint in this

action a written report disclosing the rates for inpatient hospital services to any payer, including any plan affiliated with DHS, or in lieu of such a report, documents sufficient to disclose those rates for each payer (other than Medicare and Medicaid). Plaintiffs agree not to disclose this information unless in connection with a proceeding to enforce this Final Judgment or pursuant to a court or congressional order.

VI.

COMPLIANCE PROGRAM

Each defendant shall maintain an antitrust compliance program (unless the defendant dissolves without any successors or assigns), which shall include:

(A) Distributing within 60 days from the entry of this Final Judgment, a copy of the Final Judgment and Competitive Impact Statement to all officers and directors;

(B) Distributing in a timely manner a copy of the Final Judgment and Competitive Impact Statement to any

person who succeeds to a position described in Paragraph VI(A);

(C) Briefing annually in writing or orally those persons designated in Paragraphs VI (A) and (B) on the meaning and requirements of this Final Judgment and the antitrust laws, including penalties for violation thereof;

(D) Obtaining from those persons designated in Paragraphs VI (A) and (B) annual written certifications that they (1) have read, understand, and agree to abide by this Final Judgment, (2) understand that their noncompliance with this Final Judgment may result in conviction for criminal contempt of court and imprisonment and/or fine, and (3) have reported violations, if any, of this Final Judgment of which they are aware to counsel for the respective defendant; and

(E) Maintaining for inspection by plaintiffs a record of recipients to whom this Final Judgment and Competitive Impact Statement have been distributed and from whom annual written certifications regarding this

Final Judgment have been received.

VII.

CERTIFICATIONS

(A) Within 75 days after entry of this Final Judgment, each defendant shall certify to plaintiffs that it has made the distribution of the Final Judgment and Competitive Impact Statement as required by Paragraph VI(A); and

(B) For 10 years, unless the defendant dissolves without any successors or assigns, after the entry of this Final Judgment, on or before its anniversary date, each defendant shall certify annually to plaintiffs whether it has complied with the provisions of Section VI applicable to it.

VIII.

PLAINTIFFS' ACCESS

For the sole purpose of determining or securing compliance with this Final Judgment, and subject to any recognized privilege, authorized representatives of the United States Department of Justice or the Office of the Attorney General of the State of Connecticut, upon

written request of the Assistant Attorney General in charge of the Antitrust Division or the Connecticut Attorney General, respectively, shall on reasonable notice be permitted:

(A) Access during regular business hours of any defendant to inspect and copy all records and documents in the possession or under the control of that defendant relating to any matters contained in this Final Judgment;

(B) To interview officers, directors, employees, and agents of any defendant, who may have counsel present, concerning such matters; and

(C) To obtain written reports from any defendant, under oath if requested, relating to any matters contained in this Final Judgment.

IX.

NOTIFICATIONS

Each defendant shall notify the plaintiffs at least 30 days prior to any proposed (1) dissolution of that defendant, (2) sale or assignment of claims or assets of that defendant resulting in the emergence of a

successor corporation, or (3) change in corporate structure of that defendant that may affect compliance obligations arising out of Section IV of this Final Judgment.

X.

JURISDICTION RETAINED

This Court retains jurisdiction to enable any of the parties to this Final Judgment, but no other person, to apply to this Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify or terminate any of its provisions, to enforce compliance, and to punish violations of its provisions.

XI.

EXPIRATION OF FINAL JUDGMENT

This Final Judgment shall expire ten (10) years from the date of entry.

XII.

PUBLIC INTEREST DETERMINATION

Entry of this Final Judgment is in the public interest.

Dated: February 15, 1996

United States District Judge