Business Reviews (Since 1993 Issuance of DOJ/FTC Health Care Antitrust Statement of Enforcement Policy)

1. Monoclonal Antibody Manufacturers
July 23, 2020

Facts: Eli Lilly and Company, AbCellera Biologics, Amgen, AstraZeneca, Genentech, and GlaxoSmithKline are pharmaceutical companies developing monoclonal antibody treatments for COVID-19. The companies proposed sharing information about their manufacturing facilities and capacity, raw materials, and supplies in order to expedite production of approved treatments beyond what one firm could do alone. The companies will not exchange price information or costs of inputs or production.

Response: The proposed information exchange will likely expedite and increase output of critically important treatments for COVID-19 and, as such, is unlikely to lessen competition. This conduct is also unlikely to result in collusion because the information in question is very technical and closely related to the companies' procompetitive goal of ramping up efficient production of treatments. In addition, the companies have agreed to implement safeguards against collusion, such as not exchanging price information and only exchanging information relevant to COVID-19 treatments.

Read the full Business Review Letter

2. PPE: McKesson Corporation, et al.
April 4, 2020

Facts: McKesson Corporation, Owens & Minor, Cardinal Health, Medline Industries, and Henry Schein, Inc. ("the Requesting Parties") are U.S. healthcare distributors of medical Personal Protective Equipment ("PPE") and medications. The Requesting Parties propose to collaborate with and at the direction of FEMA, HHS, and other government entities in order to expedite and increase manufacturing, sourcing, and distribution of PPE and COVID-19 treatment-related medication essential to protect public health and safety.

Response: Collaboration between private parties with federal agencies is immune from antitrust enforcement when the collaboration is compelled and supervised by an agency. The Requesting Parties' proposed collaborations would benefit consumers because they allow the parties to bring life-saving products to the market much more quickly. In addition to the involvement and oversight of federal agencies, the Requesting Parties agreed to implement a series of safeguards against anticompetitive behavior. For example, the Requesting Parties agreed not to exchange competitively sensitive information directly with each other, and also agreed not to use their collaboration to increase prices, reduce output, quality, or engage in COVID-19 profiteering. Furthermore, the Requesting Parties agreed to limit their collaboration to the time period of the pandemic and to formally dissolve their collaboration at the end of the

pandemic. Based on the information and representations provided by the Requesting Parties, the Department presently does not intend to challenge the Requesting Parties' proposed efforts to expedite and increase manufacturing, sourcing, and distribution of PPE and COVID-19 treatment-related medication essential to protect public health and safety.

Read the Business Review Letter

3. PPE: AmeriSource Bergen
April 20, 2020

Facts: AmeriSource Bergen Corporation ("AmeriSource Bergen"), a distributor of medications and healthcare products, was asked by U.S. government agencies to utilize its industry position to identify and facilitate opportunities for distribution of medications and healthcare products for treatment of COVID-19 patients. AmeriSource Bergen proposed collaboration with the Federal Emergency Management Agency ("FEMA"), the Department of Health and Human Services ("HHS"), and PPE distributors to get medications such as hydroxychloroquine as well as protective gear to areas in need.

Response: Collaboration between private parties with the federal agencies is immune from antitrust enforcement when the collaboration is required and supervised by an agency. AmeriSource Bergen's collaboration with other firms at the direction of federal agencies is not an antitrust concern because of the benefits it is likely to provide to the American public during the COVID-19 pandemic. In addition to the involvement and oversight of federal agencies, AmeriSource Bergen agreed to implement a series of safeguards against anticompetitive behavior, such as limiting what information is exchanged and how long it will be exchanged or kept, to minimize the risk that its conduct might harm competition.

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4. AOAExcel GPO
January 15, 2020

Facts: The American Optometric Association (the "Association") is a trade association representing optometrists, their employees, and optometry students. AOAExcel GPO, LLC (the "GPO") is the Association's group purchasing organization. The parties proposed broadening the GPO's purchasing activities to include optometric products, specifically corrective eyeglass lenses, eyeglass frames, and contact lenses. Prior to this expansion, the GPO's purchasing activities were limited to non-optometric products such as life insurance and office supplies.

Response: Statement 7 of the *Statements of Antitrust Enforcement Policy in Health Care* identifies three safeguards that protect against price fixing and other anticompetitive behavior in joint purchasing agreements. The expansion of the GPO's purchasing activities is unlikely to harm competition because the Association and the GPO will adhere to those three safeguards: (1)

members are not required to make any purchases through the GPO; (2) price negotiations with suppliers will take place through a third party; (3) price-related communication between individual members and the GPO will not be shared with other members. The parties' embrace of these safeguards indicates their intention to lower costs and promote competition. In addition, the expansion is unlikely to harm competition because the GPO's ability to raise prices will be limited by other optometric product GPOs and producers and sellers of optometric products.

Read the Business Review Letter

5. Greater New York Hospital Association
January 16, 2013

Facts: The association, consisting of 250 hospitals and continuing care facilities in New York and several nearby states, proposed a voluntary gainsharing program through which participating hospitals can measure physician performance against a benchmark – Best Practice Norms – and award bonuses to physicians for improvements in quality and efficiency. Each hospital would determine whether and to what extent to compensate the physicians. Best Practice Norms would be created based on publicly available, historical data.

Response: First, the gainsharing program did not constitute a horizontal agreement among competing hospitals about compensation levels for physicians. No provision involved any agreement or coordination concerning the prices that participating hospitals or physicians charged for their services. Hospitals could independently and unilaterally choose whether to participate and determine a hospital-specific incentive payment cap. The two provisions regarding cap regulation and fair market value analysis were narrowly tailored to achieve the program's purpose and were not intended to coordinate or standardize hospital payments. Second, the program did not constitute an information exchange among hospitals that would facilitate anticompetitive coordination to limit physician compensation. The only shared information among the hospitals would be Best Practice Norms, which would be built on publicly available data and would be sufficiently aggregated to prevent identification of any competitively sensitive information. Thus, the proposed sharing of Best Practice Norms with participating hospitals therefore complied with the antitrust safety-zone requirements of Statement 6 of the Department of Justice's and Federal Trade Commission's *Statements of Antitrust Enforcement Policy in Health Care* (1996).

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6. Pacific Business Group on Health
April 26, 2010

Facts: Three broad-based associations–the Pacific Business Group on Health ("PBGH"), the California Public Employees' Retirement System ("CalPERS"), and the California Health Care Coalition ("CHCC"), representing group purchasers of health care services for more than 7

million people–proposed a data exchange program for hospital services called the Hospital Value Initiative ("HVI"). The HVI proposed to (1) analyze the claims data that major third-party health plans (hereinafter "payors") receive from hospitals; (2) develop index scores from the data that will allow for comparison of the relative cost and resource utilization efficiency of hospitals in California; and (3) distribute these index scores to hospitals, payors, and group purchasers of health care services.

Response: HVI's proposal is not likely to produce anticompetitive effects because the exchange would involve data that is at least 10 months old and the program would not disclose disaggregated data or any hospitals' actual service fees. The HVI's data exchange program could potentially benefit consumers by increasing the transparency of the relative costs and resource efficiency of hundreds of hospitals in California. The proposed information exchange may reduce health care costs by improving competition among hundreds of hospitals in California and facilitating more informed purchasing decisions by group purchasers of health care services.

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7. Memorial Health, Inc. and St. Joseph's/Candler Health System
September 4, 2009

Facts: Memorial and St. Joseph's/Candler are 501(c)(3) non-profit organizations that own acute tertiary care hospitals in Savannah, Georgia, that serve Southeast Georgia and the low-country area of South Carolina. Memorial owns and operates the Memorial Health University Medical Center. St. Joseph's/Candler owns and operates St. Joseph's Hospital and Candler Hospital. Under the proposed agreement, Memorial and St. Joseph's/Candler would jointly evaluate medical and surgical products, designate suppliers, and negotiate prices and other terms with them.

Response: The proposed joint purchasing agreement may yield volume discounts and reduced transaction costs for the hospitals and ultimately could result in lower costs and increased hospital services for consumers. Furthermore, the proposal meets the requirements of the antitrust safety zone set forth in Statement 7 of the Department's and Federal Trade Commission's *Statements of Antitrust Enforcement Policy in Health Care*. The safety zone requires that the cost of all products purchased through the joint purchasing agreement account for less than 20 percent of the total revenue of all products and services sold by each participant in the agreement. It also requires that products purchased through the joint purchasing agreement from a given supplier account for less than 35 percent of that supplier's sale of those products in the relevant market. Memorial and St. Joseph's/Candler represented that they will abide by these limitations.

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8. CEO Roundtable on Cancer
September 17, 2008

Facts: The CEO Roundtable on Cancer ("CRC"), a non-profit organization whose goal is to make continuous progress toward eliminating cancer as a personal disease and public-health problem, and the National Cancer Institute ("NCI"), the federal government's principal agency for cancer research and training, proposed to develop and publicize model clauses for use in clinical-trial agreements. Clinical-trial agreements typically involve three parties: a pharmaceutical or medical-device company known as a sponsor; a hospital, clinic, or university where the research is performed, known as the research institution; and the physician in charge of the trial, known as the principal investigator. The CRC proposed to make the model language available to sponsors, research institutions, and principal investigators.

Response: The model language is not likely to be anticompetitive and can be used to help increase efficiency in contract negotiations, potentially reducing costs and shortening the time needed to begin clinical trials. The model language does not contain any provisions specifying prices or rates, and each party acting independently will determine whether to use the language or any of its provisions.

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9. Internationally Board-Certified Lactation Consultants
May 25, 2004

Facts: International Board-Certified Lactation Consultants ("IBCLCs") – self-employed or working for organized health care providers such as hospitals or physicians' offices – proposed to conduct an online fee survey. The survey would be conducted by an independent online survey company and would go only to independent IBCLCs with access to the Internet (believed to be a majority of IBCLCs). The survey data would be collected anonymously, sorted by region and other criteria (*e.g.,* rural vs. urban), and disseminated as a range of fees. The data provided would be more than three months old and would be made available in both electronic and printed format at no cost to any interested parties. At least 20 and potentially several thousand participants will provide data for this survey and no individual participant's data will represent more than 25 percent, on a weighted basis, of any given statistic. The information disseminated will be sufficiently aggregated that it will not allow recipients to identify the fees charged by any particular provider.

Response: The stated conditions meet the standards outlined in Statement 6 of the *Statements of Antitrust Enforcement Policy in Health Care*, jointly issued by the Department and the Federal Trade Commission in August 1996. Furthermore, the survey will determine the range of prices customarily charged by self-employed IBCLCs and will allow independent practitioners to set reasonable fees for their area, providing procompetitive benefits while raising little risk of anticompetitive effects. However, the consultants are cautioned against the use of the

data to coordinate pricing activity in any region or to artificially maintain higher-than-competitive pricing. The caution is given in response to past communications by IBCLCs on several Internet list serves where lactation consultants have episodically mentioned prices or sensitive fee information. IBCLCs may or may not be affiliated with the International Lactation Consultants Association, which does not sanction any of the list serves used by members of the profession.

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10. Washington State Medical Association
September 23, 2002

Facts: The Washington State Medical Association ("WSMA") proposed to survey its members for two categories of statistics: (1) physician charges for services; and (2) insurer reimbursement for services.

Response: With respect to the first category of physician charges, the WSMA proposal complies with guidelines previously announced by the Department of Justice and the Federal Trade Commission. In accordance with the DOJ/FTC Health Care Guidelines, the survey will be managed by the WSMA professional staff, will utilize underlying data that is at least three months old at the time that the survey results are disseminated, and will aggregate the underlying data in a manner designed to prevent the identification and misuse of individual provider information. The second portion of the survey involving insurer reimbursements raises the possibility of anticompetitive effects, in particular because the WSMA plans to identify average reimbursements paid by individual insurers and because the information could lead to boycotts or collusive pricing. In response to these concerns, the WSMA asserted that there are procompetitive justifications for the survey and that it intends to prevent use of the survey for anticompetitive conduct. Based on WSMA's factual representations and intentions regarding the survey, the anticompetitive concern is judged to be balanced against procompetitive benefits and safeguards.

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11. Michigan Hospital Group
April 3, 2002

Facts: A group of seven, small geographically dispersed community hospitals in Michigan proposed to form a network, Michigan Hospital Group Inc. ("MHG"), to negotiate contracts on its behalf with insurance companies, employers, and managed care plans. MHG will collect and analyze data from each participating hospital in order to negotiate managed care contracts on behalf of its members. All proprietary data collected from participating hospitals will be treated in strict confidence. No individual member will have access to any other member's costs or prices. MHG will be a non-exclusive network and its members will remain

free at all times to contract individually with health care plans and other payors or to join other provider networks.

Response: The operation of MHG will allow these seven community hospitals to contract with health plans and other third-party payors in an efficient and cost-effective manner. The network, as proposed, would pose no threat to competition in the areas served by the members of MHG. The hospitals represented, and the Department's own investigation confirmed, that these seven hospitals do not currently compete with one another in the geographic areas surrounding each hospital.

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12. Rio Grande Eye Associates, P.A.
August 29, 2001

Facts: The association proposed to establish a network of ophthalmologists in the El Paso, Texas, area to provide ophthalmologic services at reduced prices to managed care plans and other third-party purchasers of these services. The network will be non-exclusive, leaving its member ophthalmologists free to compete with the network, both individually and by joining other networks.

Response: The network will implement a 20% withhold arrangement, and the member ophthalmologists will share substantial financial risk. In addition, the network will be non-exclusive and will constitute less than 30% of the ophthalmologists in the El Paso, Texas, area. Thus, it appears the network's proposed operations fall within the Antitrust Safety Zone for non-exclusive physician joint ventures under the *Statements of Antitrust Enforcement Policy in Health Care*, and it does not appear that the network's operations are likely to lessen competition substantially.

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13. Endoscopy Accessory Products Sales Agency Agreement
August 29, 2001

Facts: Olympus America Inc. (“OAI”) and C.R. Bard Inc. (“Bard”) proposed a dealer and sales agency agreement for their sales of endoscopy accessory products (“EAPs”) in the United States. EAPs are medical instruments used with endoscopes and video systems to examine patients’ upper and lower digestive tracks and bronchial trees. OAI sells both a limited line of EAPs and other endoscopy equipment manufactured by its parent company. Bard manufactures and sells a full range of EAPs but does not sell other endoscopy equipment. Under the proposed agreement, Bard is designated as the exclusive dealer for the sales of Olympus-branded EAPs, and OAI will become a non-exclusive sales agent of Bard for both Olympus-branded and Bard-branded EAPs. Each party’s sales force will sell the full line of all Olympus-branded and Bard-

branded EAPs, and will be compensated under commission structures that provide equal financial incentives to sell both brands. OAI and Bard will each be entitled to a share of any incremental revenue that its sales force generates from sales of the other company's EAPs.

Response: The proposed collaboration economically integrates the sales forces of the companies in a manner that could produce procompetitive benefits that OAI and Bard could not produce separately and thus warrants a Rule-of-Reason analysis. The only EAPs sold by both OAI and Bard are biopsy forceps, which come in two varieties–disposable and reusable. Nearly all of the biopsy forceps sold by OAI are reusable, while virtually all the biopsy forceps sold by Bard are disposable. Whether the disposable and reusable biopsy forceps are in the same or separate markets, the proposed collaboration does not raise market power concerns. Even if reusable and disposable biopsy forceps are in a single market, the parties' combined shares of all reusable and disposable biopsy forceps do not appear to be significantly above the twenty percent "safety zone" for competitor collaborations established by the *Antitrust Guidelines for Collaborations Among Competitors*, issued by the Federal Trade Commission and the U.S. Department of Justice in April 2000. Based on this analysis, the proposed marketing and sales agreement is not likely to result in anticompetitive harm, and could generate procompetitive efficiencies benefitting consumers.

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14. Midwest Behavioral Health Care LLC ("MBH")
February 4, 2000

Facts: Providers of ten types of behavioral health care services (general psychiatrists, child and adolescent psychiatrists, psychologists, nurses, social workers, counselors, foster parents, therapists, technicians, and case managers) in six geographic areas of North Dakota and Northwestern Minnesota (Fargo, ND; Moorhead, MN; Grand Forks, ND; East Grand Forks, MN; Bismarck, ND; Minot, ND; Alexandria, MN; and Bemidji, MN) proposed to form MBH, a non-exclusive network of behavioral health care providers. Initially, the network will hire or employ a "messenger" who will convey contracting information between managed care and other third-party payors and MBH's individual member providers. Within approximately two years after beginning operations, the network plans to shift to a risk-sharing joint venture among its member providers that will negotiate with payors collectively on behalf of the entire network. MBH intends to limit the number of competing members of each of the ten types of behavioral health care services, in each of the six geographic areas, to either one pre-existing provider or one integrated group practice of providers. In the event additional providers are needed, MBH will include additional pre-existing providers, provided no more than 30% of the pre-existing providers of each type of service in each geographic area are included in the network.

Response: MBH appears to have properly structured its messenger arrangement to avoid agreements between competing member providers on prices or other competitively sensitive

matters. When MBH shifts to a joint venture arrangement, its members will share substantial risk and have incentives to achieve cost containment and utilization goals. Third-party payors have indicated that MBH's inclusion in its non-exclusive network of no more than 30% of each type of provider in each geographic area is not likely to produce any substantial anticompetitive effects. The Department has no present intention to challenge the proposal.

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15. Preferred Physicians Medical Group ("PPMG")
July 23, 1999

Facts: Multispecialty practice group consisting of 103 members, including 54 primary care physicians, proposed to contract on a shared risk basis with multiple payors in the Southside Hampton Roads, Virginia, area. PPMG represented fewer than 10 percent of the providers in any given specialty (including general practitioners and family practice physicians) in the coverage area, which is comprised of Virginia Beach, Chesapeake, Portsmouth, and Norfolk, Virginia, and the surrounding residential areas. Even with growth, PPMG did not plan to exceed 15 percent of the providers in any one specialty, or 10 percent of all physicians in the coverage area. PPMG would be a limited liability company owned entirely by its physician members. Members would contract exclusively through PPMG and would not contract individually with the payors. All revenues would be derived from risk contracts, with risk arrangements including all-inclusive case rates, capitated rates, percentage of premium rates, or use of a 15% risk pool, to be distributed upon attainment of quality and utilization targets by the group as a whole. PPMG would establish internal protocols to monitor its utilization and efficiency goals.

Response: Assuming that PPMG's membership continues to constitute 20 percent or fewer of the physicians in any given physician specialty with active hospital staff privileges who practice in the relevant geographic market, PPMG would appear to fall within the safety zone for exclusive physician network joint ventures described in Statement 8 of the *Statements of Antitrust Enforcement Policy in Health Care,* issued jointly by the Department and Federal Trade Commission. Thus the Department stated it had no intention to challenge the network if it operates as proposed.

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16. Heritage Alliance/Lackawanna Physicians' Organization
September 15, 1998

Facts: Two independent practice organizations in northeastern Pennsylvania (principally Lackawanna County) proposed to merge to form a nonexclusive risk-bearing multi-specialty physician network and associated management services organization (MSO) to contract with payors to provide physician services. The Heritage Alliance's members were 90 primary care physicians (PCPs) practicing in six counties, while the Lackawanna Physicians' Organization

consisted of 167 specialists and 23 PCPs, all located in Lackawanna County. Physician compensation would be either based on capitation or fee schedules from which 15% would be withheld pending accomplishment of efficiency goals. Contracts would be negotiated through the MSO, which would also market the network's services and provide medical management services and practice management support. An actuarial firm might eventually develop a fee schedule for various payors based on demographic and market conditions, but in no case would prices charged by individual physicians be solicited or communicated to other physicians, or used to set fees for the network. The network would limit its membership to no more than 30% of the non-employed pediatricians or any other specialists currently constituting less than 30% of the group in any relevant geographic market, and would add no members in any specialty where the group already represented more than 30% of physicians in the area.

Response: Members of the Network propose to share substantial financial risk, and it appears that establishing common prices is reasonably necessary to achieve anticipated efficiencies. Thus, a Rule of Reason analysis is appropriate. The network would account for approximately 39% of non-pediatrician PCPs in Lackawanna County, the primary geographic market, and 28% of pediatricians. These percentages are not likely to cause substantial adverse competitive effects in this market. However, a rise in the 39% figure might cause concern. As for specialists, in eight of 27 medical specialties represented, the network will account for more than 50% of Lackawanna County physicians. While these numbers might also be cause for concern, they represent the pre-merger composition of Lackawanna Physicians Organization, which does not appear to have caused competitive harm at those levels. In general, payors interviewed supported formation of the network and did not consider anticompetitive effects likely. In addition, the network could provide significant competition to another physician network operating in Lackawanna County. Thus, the Department does not intend to challenge the network if it operates as proposed.

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17. AHA Pharmaceutical Roundtable
March 20, 1998

Facts: The Pharmaceutical Roundtable ("PRT") of the American Heart Association ("AHA") proposed changes to PRT operations, which were the subject of a business review in 1989 when the PRT was formed. The PRT sponsors and funds basic biomedical research in the cardiovascular field by independent researchers. It proposed changes to: (1) increase the annual contribution of PRT members to $1,000,000; (2) decrease the terms of its members' agreements from five years to three years; and (3) use members' contributions to fund targeted research in specific areas of interest in the cardiovascular field.

Response: Legitimate research ventures are not usually on balance anticompetitive, particularly in the case of joint ventures to perform basic, non-appropriable research. The PRT,

which has been and will remain essentially a funding device, appears to constitute such a joint venture. Knowledge obtained from research funded by the PRT will continue to be made public. Moreover, the PRT's proposed operations appear to contain sufficient limitations to prevent significant anticompetitive spill-over effects in any market, including the market for biomedical research.

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18. First Priority Health System ("FPHS")
November 3, 1997

Facts: First Priority Health ("FPH"), an HMO subsidiary of Blue Cross of Northeastern Pennsylvania, and NEPPO Ltd, a limited partnership of 166 specialist and primary care physicians ("PCPs") practicing primarily in Lackawanna County, Pennsylvania (Scranton) proposed to form FPHS, a risk-bearing 50/50 joint venture, to provide and manage medical services for FPH's HMO enrollees in Scranton and surrounding counties. The PCPs in NEPPO would agree not to provide gatekeeper services for any other gatekeeper-type managed care plan. They would be free to contract with non-gatekeeper plans. Neither the specialists in NEPPO, nor any non-NEPPO specialists or PCPs hired by FPHS would be restricted from contracting with other plans, and some NEPPO PCPs would be excused from the exclusivity requirement because of shortages of PCPs in the towns where they practice. Fees for FPHS would be set by a Reimbursement Committee made up of only payor representatives on the FPHS Board of Directors; thus, no providers would be involved in setting provider fees. In addition, Community Medical Center, one of three hospitals in Scranton, would continue an agreement not to contract with any other gatekeeper-type HMO, and FPHS would agree to send all of its Lackawanna County area enrollees to Community Medical Center unless medical necessity dictated otherwise.

Response: While other area managed care plans and some area employers felt that the loss of 38 NEPPO PCPs (most of whom will have to withdraw from other plans) could cause competitive harm to rival plans, the Department concluded that roughly 70% of area PCPs would still be available to the rival plans, and that other area hospitals, IPAs, and PHOs would provide adequate competition to the FPHS system. Although FPH currently controls 60% of the managed care lives in Lackawanna County, three other active gatekeeper-type plans currently operate there, and a fourth is about to enter. At least two of these are strong national competitors that have formed relationships with the other two Scranton hospitals. NEPPO physicians will be at risk for any losses of FPHS through their ownership interest and capitation, and are thus motivated to effect cost-saving measures and other efficiencies. On balance, we are reluctant to discourage an innovative and potentially procompetitive venture but remain free to challenge FPHS should anticompetitive effects result.

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19. Vermont Physicians Clinic ("VPC")
July 30, 1997

Facts: Approximately 40 physicians from various medical specialties in Rutland, Vermont, proposed to have their jointly-owned corporation negotiate risk contracts collectively on their behalf with third-party payors. With three exceptions, VPC's participating physicians will not exceed 30 percent of the physicians in any specialty. The exceptions are: 1) specialties in which all of VPC's physicians are in a pre-existing integrated group practice not formed or expanded to avoid the 30 percent limitation; 2) internal medicine practitioners, who were properly considered part of a larger market that includes family practitioners; and 3) three specialties, each of which represents a small percentage of the total number of VPC's physicians. Safeguards will be established to ensure that VPC's competing physicians do not learn of their competitors' fees and prices through its operations. VPC will provide utilization review, quality improvement services, and some administrative services. VPC's individual physicians and practice groups have no current intention of terminating their existing contracts with third-party payors, or refusing to negotiate individually with them in the future.

Response: VPC's physicians will share substantial financial risk by providing services on either a capitated or substantial (at least 20%) withhold-of-compensation basis. In addition, with exceptions deemed unlikely to have any substantial adverse competitive effect, VPC will limit the number of its participating physicians to 30 percent of the physicians in each specialty. VPC's physicians will be free to contract with other managed care entities independently or through other provider networks. The proposed operations of VPC could produce significant efficiencies, and managed care plans and other third-party payors expressed no concern that VPC's proposed operations would likely cause any substantial anticompetitive effects. Many payors believed that VPC would bring much-needed competition to the managed care panel of physicians formed by the only hospital in the Rutland area.

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20. Allentown, Pennsylvania Gastroenterologists
July 7, 1997

Facts: Three practice groups each comprised of four gastroenterologists proposed to merge into a single 12-person firm in Allentown, Pennsylvania. The group would then represent 12 of 14 gastroenterologists in Allentown (85.7%) and 12 of 19 gastroenterologists in Allentown and nearby Bethlehem (63%). The group suggested that the geographic area within which to measure the potential market power of the merged firm would be the Greater Lehigh Valley, including Lehigh and Northampton counties and parts of Bucks, Berks, and Carbon counties, because some of the merging physicians regularly traveled to these areas to provide services at outlying hospitals. Within that area, the group would comprise 36% of all board-certified gastroenterologists.

Response: Managed care payors told the Department that they could not market a product that excluded gastroenterologists, and the Department concluded that the medical specialty of gastroenterology was the appropriate product or service market for analyzing the merger. The Department also found the relevant geographic market to be at most the cities of Allentown and Bethlehem, and possibly only Allentown. Managed care payors told the Department that they could not ask enrollees to travel to distant counties or, in many instances, even from Allentown to Bethlehem, to obtain gastroenterologic services in order to defeat a price increase by the merging firms. Based on its investigation, the Department concluded there was a substantial likelihood that the merging group would cause anticompetitive harm in the market for gastroenterologic services in the Allentown/Bethlehem area. It was not apparent that entry within two years of additional gastroenterologists would occur to defeat a price increase, particularly as it appeared there was already an oversupply of gastroenterologists in the area. The parties demonstrated no merger-specific efficiencies to counteract the potential anticompetitive harm posed by this merger. As a result, the Department could not state that it would not take enforcement action against the merger were it consummated as described.

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21. Southwest Orthopedic Specialists ("SOS")
June 10, 1997

Facts: Ten of approximately 62 orthopedic specialists in the Albuquerque metropolitan area proposed to form a non-exclusive risk-bearing joint venture to jointly market their services to third party insurers covering a statewide population. Risk would be shared either by accepting capitated rates, or by offering services under a discounted fee-for-service schedule with a 15% withhold that would be forfeited unless SOS as a whole met certain efficiency and quality parameters. While the network intends to expand in the future to meet insurers' coverage needs, at no time would it exceed 30% of the orthopedic specialists in any relevant geographic market.

Response: Absent extraordinary circumstances, the Department will not challenge a non-exclusive physician network joint venture whose participants share substantial financial risk and constitute 30% or fewer of the physicians in a practice specialty in a relevant market. SOS meets these criteria.

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22. CVT Surgical Center ("CVT") and Vascular Surgery Associates ("VSA") of Baton Rouge
April 16, 1997

Facts: A group of six cardiovascular-thoracic surgeons proposed to merge with group of four peripheral vascular surgeons. About 15% of the procedures performed by CVT were peripheral procedures also performed by VSA. The groups contended that the geographic area

for their services was at least an area within one and one-half hours' drive from Baton Rouge, including the cities of Hammond, New Orleans, Houma, Lafayette and Thibodaux. In that area the merged entity would represent significantly less than 20% of the surgeons available to perform the relevant procedures. The merging groups accounted for approximately 50% of the vascular surgeons listed in the Baton Rouge Yellow pages.

Response: While the Department doubted that the geographic market was as large as the parties proposed, the payors in the greater Baton Rouge area (a more probable geographic market) needed very few peripheral vascular surgeons to successfully market their plans to consumers. Competing surgeons from the New Orleans area seemed capable of quickly entering the Baton Rouge market, and had in fact begun to do so. Payors in the area were generally confident that the merged group was not likely to acquire market power. The Department concluded that the proposed merger was not likely to have any significant adverse competitive effects and might result in efficiencies benefitting consumers and payors.

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23. Orthopaedic Associates of Mobile, P.A., and the Bone and Joint Center of Mobile
April 16, 1997

Facts: Two groups of orthopedic specialists in the greater Mobile, Alabama area proposed to merge. The combined entity would be an integrated group practice comprised of 16 of the 50 providers of orthopedic services (32%) in the greater Mobile area.

Response: Such a combination could raise competitive concerns, but no managed care plan or other third-party payor expressed concern that the proposed merger would likely cause any substantial anticompetitive effects. Rather, payors were confident that if the merged group attempted to raise prices, they would have adequate substitutes to defeat such a strategy. Therefore, it does not appear likely that the proposed merger would lessen competition substantially in the greater Mobile area.

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24. Santa Fe Managed Care Organization (“SFMCO”)
February 12, 1997

Facts: Sole general acute care hospital and 70-75 physicians in Santa Fe proposed to form a non-profit managed care organization to negotiate primarily risk-based contracts with payors. By subcontracting, the organization's physician panel could include virtually all remaining Santa Fe physicians. All physicians would provide services on a non-exclusive basis. For contracts not involving substantial risk sharing among SFMCO's members, SFMCO will act as a “messenger” to facilitate contracting between third-party payors and SFMCO's individual member and non-member (subcontracting) physicians. While SFMCO members will be liable for a share of

SFMCO's deficits and eligible for a share of SFMCO's surplus, non-member physicians will not. SFMCO will also implement other requirements designed to create divergence of economic interest between member and non-member physicians, giving members incentives to bargain down the compensation paid to non-member physicians. With three exceptions, SFMCO's member physicians together with any physician employees of the hospital will not exceed 30 percent of the physicians with offices in the City of Santa Fe in any physician specialty. The exceptions are for (1) physician specialties in which all the SFMCO member physicians in the specialty are in a preexisting integrated practice group that has not been formed or expanded to avoid the 30 percent limitation, (2) family practitioners and internists who are represented to be good substitutes for each other in the Santa Fe area, and (3) pediatricians.

Response: Although SFMCO's proposal creates the potential for anticompetitive conduct that could cause harmful effects on consumers, it also has the potential for creating significant efficiencies by offering payors capitation, and global fee arrangements that are not now generally available in the Santa Fe area. Under these circumstances, the Division is unable to conclude that SFMCO's plan would likely cause anticompetitive harm if it is implemented as proposed.

Read full Business Review Letter

25. Marin General Hospital and Ross Hospital
February 11, 1997

Facts: Two Marin County, California hospitals proposed to consolidate their inpatient mental health services. While the two hospitals compete in providing inpatient and other psychiatric care to adults, Marin General does not provide the chemical dependency programs and the inpatient psychiatric services for children and adolescents that Ross provides. The hospitals will continue to compete in the sale of the consolidated services and will not jointly determine prices for the consolidated services, other than for Medicaid and indigent patients covered under a Marin county program for indigent patients. Joint pricing for Medicaid and county program patients will not eliminate competition, however, since the hospitals do not compete for that business.

Response: The proposed consolidation will not result in per se illegal conduct, and under a rule-of-reason analysis the Department is not prepared to say that the consolidation is likely to have a net anticompetitive effect. While these are the only hospitals in Marin County providing inpatient psychiatric care, the venture explicitly preserves the potential for price competition between the hospitals and protects against the unnecessary sharing of confidential business information. The venture may lower the cost of adult mental health services by eliminating duplicative costs and spreading fixed costs over a larger population. The consolidation may thus permit the hospitals to offer competitive rates for the care of Medicaid patients and indigent patients covered by a Marin County program. On the other hand, the venture may eliminate competition in quality of care or other nonprice areas, and joint pricing for Medicaid patients

could facilitate collusion on the pricing for other patients. On balance, and on the facts presented, the Department does not have a present intention to challenge the venture, but that view could change depending on how the venture actually operates.

Read full Business Review Letter

26. RWHC Network, Inc.
November 12, 1996

Facts: A group of 21 small, rural hospitals in Wisconsin proposed to form a network to contract with managed care plans and other third-party payors. Initially, network contracts would provide for services on a discounted fee-for-service basis, but the network's goal would be to provide services on a capitated basis. The network would employ the services of a third-party administrator, probably the Rural Wisconsin Health Cooperative, of which all 21 hospitals are members, to collect and analyze data from each member hospital, create databases, prepare statistical analyses and furnish recommendations to enable the network to contract with payors. No member would have access to any disaggregated information held by the administrator. Each member would be free to join other networks and to contract individually with payors. The network contended that each of its proposed members serves a different geographic area and that members do not compete with each other for patients.

Response: Based on the parties' representations regarding the absence of competition among the network's member hospitals, the network's proposed operations are not likely to cause anticompetitive effects. The network appears to be a bona fide joint venture designed to facilitate health care contracting between small, rural hospitals that are not actual or potential competitors and managed care organizations and other large third-party payors. No managed care plan or other third-party payor expressed concern that the network is likely to result in competitive harm.

Read full Business Review Letter

27. Anne Arundel Medical Center Anesthesiologists
October 17, 1996

Facts: The 16 independent practitioner anesthesiologists that currently provide anesthesia services at Anne Arundel Medical Center in Annapolis, Maryland, proposed to merge into a single, integrated group to contract with the Medical Center and third party payors. The Medical Center and payors indicated a preference for a single anesthesia group for a variety of reasons including ease of negotiating contracts, scheduling doctors' time, identifying and budgeting for costs, and establishing and monitoring consistent quality control standards. The proposal would enable the Medical Center to contract with the integrated group about pricing terms in order to offer payors global fee arrangements.

Response: Under any plausible geographic market definition and assumption about the number of market participants, the merger does not raise substantial competitive concern. This conclusion is bolstered by the lack of concern about possible anticompetitive effects by the Medical Center or any third-party payors who utilize the Medical Center. The merged group should face effective competitive constraints on its ability to exercise market power. In addition, the merger may produce substantial efficiencies to the benefit of consumers.

Read full Business Review Letter

28. Cincinnati Regional Orthopaedic and Sports Medicine Associates ("CROSMA")
October 4, 1996

Facts: Fifty-six of the approximately 158 board eligible or board-certified orthopaedic surgeons practicing in the greater Cincinnati metropolitan area proposed to form an independent practice association to offer prepaid medical and surgical services on a capitated basis to third party payors and self-insured employers. Currently in ten separate practice groups, the 56-orthopaedist group will be non-exclusive and will contract with third party payors either on a capitated basis or possibly using a discounted fee-for-service schedule with a risk pool withhold of at least 20% of the fees due to members. The risk pool would be distributed only if the group as a whole met pre-established efficiency and quality parameters. No CROSMA member will have access to any other member's fee information, and CROSMA will use a third party administrator (who is restricted from disclosing fee information to members) to negotiate with payors.

Response: CROSMA appears to be a bona fide joint venture in which members will assume significant financial risk. Here, it appears appropriate to treat services provided by orthopaedic surgeons as the relevant service market. Although there is insufficient information to determine if CROSMA's proposed 28-county region is the appropriate geographic market, good evidence indicates that CROSMA's market share (about 35 percent) would not be appreciably greater with a smaller geographic market definition. CROSMA should not create anticompetitive market power since payors have significant alternatives who will constrain CROSMA's pricing and CROSMA members will be able to contract with payors individually if they choose. Several payors expressed support for the formation of CROSMA, and it appears that the network's formation may create operational efficiencies that could lower costs to consumers in the greater Cincinnati area.

Read full Business Review Letter

29. Home Care Alliance, Inc.
October 4, 1996

Facts: Three home health care providers in Mississippi proposed to form a statewide network to contract with managed care plans. Home health agency territories in Mississippi are

designated by the state, and these three agencies compete in only one county, although additional competing agencies may be added to the network in the future. The network would be non-exclusive and would avoid joint price setting by using a "messenger model" contracting process. An independent third party ("messenger") will obtain fee schedules from each member and convey them to payors; payor contract proposals will be forwarded to each member to decide whether to accept the contract terms offered. At a payor's request, the messenger may discuss but not negotiate or agree to non-price issues such as utilization review, credentialing, and quality assurance standards.

Response: Since the proposed initial members compete in only a single county and cannot compete in the future without a change in Mississippi law, there is little possibility of horizontal collusion. While additional competing members may be added in the future, this should not cause competitive harm since the network will use messenger model arrangements that appear to be structured to avoid agreements on price and other competitively sensitive matters.

Read full Business Review Letter

30. Sierra CommCare, Inc. ("Sierra")
August 15, 1996

Facts: An 80-bed community hospital and 23 physicians engaged in group or solo practice proposed to form a nonexclusive network to provide primary care and specialist physician services in the Ridgecrest, California area. Sierra will retain the services of an independent third party to administer the operations of the venture and act as a "messenger" between payors and individual members. The messenger will convey contract offers between payors and individual members without expressing his or her views or otherwise attempting to influence contract decisions, and each member will independently accept or reject such offers. Sierra will also establish policies and procedures to restrict the flow of competitively sensitive information among network members and from the venture to the members. Members may compete with Sierra and will not be discouraged from joining other networks or contracting directly with health plans.

Response: Sierra appears to have structured its messenger model arrangements to avoid agreements on prices and other competitively sensitive matters. If the arrangements are carefully implemented, the network's operations should not result in price collusion or cause anticompetitive harm, even though Sierra's network will include virtually all of the physicians in the Ridgecrest area and the markets for physician services there are highly concentrated.

Read full Business Review Letter

31. El Paso Surgical Group ("EPSG")
July 24, 1996

Facts: Eight general surgeons in El Paso proposed to form a nonexclusive network to provide general surgical services in the El Paso area at reduced costs to managed care plans and other third party payors. EPSG would be non-exclusive and would share risk either through capitation or by withholding at least 20% of fees due as a risk pool. EPSG may expand to include no more than four additional general surgeons and it may also add other types of doctors.

Response: As proposed, EPSG constitutes approximately 23% of the general surgeons in the area; if four more are added, it will comprise 34%. Based on payor interviews, it is not likely that the network would result in market power or cause anticompetitive effects. If EPSG adds other types of physicians but includes no more than 30% of the physicians in any specialty in the area, the network would fit within the safety zone for nonexclusive physician networks. Higher percentages would be judged under the rule of reason.

Read full Business Review Letter

32. Primary and Specialist Medical Center ("PSMC")
July 2, 1996

Facts: Proposal by 48 physicians in eight medical specialties to form a network that will provide medical services in a six-city area including New Haven, Connecticut, and represent its members on an exclusive basis in negotiations with managed care payors. The group will offer both capitated and discounted fee-for-service contracts with a 20% withhold at risk.

The six-city area in which PSMC will operate can be easily traversed by automobile within approximately 20 minutes, a travel time payors view as generally acceptable for patient convenience.

Response: PSMC's members will account for less than 20% of the physicians in each medical specialty in the six-city area in which PSMC will operate and will share substantial financial risk. Thus, PSMC's proposal meets the 20% safety zone for exclusive physician networks. It is unlikely that PSMC would create market power that would lead to anti-competitive harm.

Read full Business Review Letter

33. Allied Colon and Rectal Specialists ("ACRS")
July 1, 1996

Facts: Seven of the nine dedicated colon and rectal specialists in the Phoenix metropolitan area (and seven of ten statewide) proposed to form a non-exclusive independent

practice association ("IPA") in Maricopa County, Arizona. Members would assume significant financial risk by participating in either capitated contracts or in a fee withhold arrangement.

Response: Although this network is the only one in Arizona specializing in colon and rectal surgical services and includes seven of nine specialists in the county and seven of ten in the state, payors confirmed that colon and rectal surgical services are readily available from general surgeons and other types of surgeons. When these surgeons are included in the service market, a reasonable approximation of ACRS's combined market share is 15% in Maricopa County and 9% statewide. The ready availability of substitute providers makes it unlikely that ACRS could successfully act anticompetitively. The network also may have procompetitive effects.

Read full Business Review Letter

34. Plastic Surgery Associates of Connecticut, LLC ("PSAC")
June 28, 1996

Facts: Eight plastic surgeons practicing in southwest Connecticut proposed to form a nonexclusive network joint venture to contract with HMOs, employers, primary care IPAs, PHOs, and other payors to provide a variety of plastic and reconstructive surgical services. Members would contribute capital to the corporation and would share risk through either fee withholds or capitated rates.

Response: PSAC appears to be a *bona fide* joint venture whose members will share substantial financial risk and will not possess anticompetitive levels of market power in any reasonable geographic market. There are adequate reasonable substitutes for the services provided by PSAC's members, and PSAC's formation appears to fall well within the 30% safety zone for non-exclusive physician networks. In addition, it appears that PSAC will likely provide efficiency-based benefits, including lower prices for plastic surgery services, to health care payors and consumers and is likely to foster increased competition.

Read full Business Review Letter

35. Hospice Network of New Jersey, Inc.
April 24, 1996

Facts: Group of institutions that coordinate delivery of care to terminally ill patients proposed to form a joint venture to negotiate and contract with health benefit plans to provide enrollees with hospice services. Each of the seven initial members operates in a different New Jersey county.

Response: Hospice services are provided in local markets. The seven initial members of the venture are in distinct geographic areas and thus not direct competitors. Therefore, joint marketing and other cooperative arrangements among the members are unlikely to have an

anticompetitive effect in any local market. However, if future members are direct competitors with other members, the group must either avoid joint pricing and agreements on other significant terms of competition, or they must assure that such joint decisions are necessarily related to significant economic integration among them.

Read full Business Review Letter

36. Itasca Clinic and Grand Rapids Medical Association
March 19, 1996

Facts: Two small physician clinics (with 13 and 8 physicians respectively) in rural northern Minnesota proposed to merge for the stated purpose of enhancing their ability to provide quality care in a cost-effective manner and to facilitate the recruitment of specialist physicians into the merged group to increase the range of health care services available locally.

Response: Relying substantially on the clinics' presentation of the pertinent market facts, the Department evaluated the proposed merger for its likely competitive effects in two relevant product markets: (1) primary care services provided by primary practice doctors and internists; and (2) general surgical services. In those markets the merged clinic would employ about 40% of the primary care doctors and about 32% of the general surgeons. Given the lack of any competitive concerns among payors and some payors' belief that the merger would increase access to medical care, the merger did not appear likely to substantially lessen competition.

Read full Business Review Letter

37. Allergy and Asthma Consultants, Inc. ("AAC")
March 19, 1996

Facts: Group of allergists serving Massachusetts and six neighboring states proposed to form a non-exclusive physician network joint venture to negotiate and contract with health benefit plans. The group, to be called Allergy and Asthma Consultants, Inc. ("AAC"), would provide services either under a capitated payment plan or using a discounted fee-for-service schedule with a "risk pool" withhold of at least 20% of the fees due each physician.

Response: The proposed activities fall within the "safety zone" of Statement 8 of the Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust issued by the Department of Justice and Federal Trade Commission on September 27, 1994. AAC would represent approximately 10 percent of the practicing allergists in the Commonwealth of Massachusetts. The network will achieve significant integration through risk sharing, and provide utilization review and quality assurance monitoring. Since AAC physician providers will participate on a non-exclusive basis, competing networks will not be adversely affected. The proposal also involves additional competitive safeguards, including provisions

relevant to a previously entered consent decree between the United States and one of the initial participants in AAC.

Read full Business Review Letter

38. Orange Los Angeles Medical Group ("ORLA")
March 8, 1996

Facts: Five large, financially integrated anesthesia medical groups that currently serve as the exclusive or principal anesthesia suppliers for six major Orange County hospitals proposed to form a contracting organization ("ORLA") to negotiate with the hospitals, managed care health plans, and primary provider organizations (such as IPAs and large medical groups) they serve. The proposed joint venture would be exclusive -- its member-groups, and their member-anesthesiologists, would not be free to contract directly with managed care customers in competition with ORLA.

Response: Each of the hospitals served by the five ORLA groups would consider, as a viable competitive alternative to its existing group, only a similarly large, financially integrated anesthesia group with comparable hospital anesthesia management experience. Further, each hospital would substitute a lower-priced alternative group only if the alternative group's anesthesiologists lived and worked in close proximity to that hospital. For each hospital served by one of the five ORLA groups, there currently are at most six such competitive alternatives (*i.e.*, the five groups that propose to form ORLA, and the one comparable Orange County group that is not participating in ORLA); if ORLA is implemented as proposed, it would reduce the number of competitive alternatives to no more than one. (For some of those hospitals, ORLA may eliminate all existing competitive alternatives.) Under current market conditions, entry by credible competitive alternatives is unlikely to occur in the near future on a sufficient scale to offset ORLA's substantial reduction in competition. Thus, hospitals, primary provider groups, and managed care health plans believed that the joint venture would enable ORLA to exercise market power. Finally, any efficiencies ORLA may achieve could otherwise be achieved in ways that would not reduce competition.

Read full Business Review Letter

39. Southern Healthcare Alliance, Inc. ("SHC")
March 5, 1996

Facts: SHC proposed to form a physician hospital organization ("PHO") among its owned and/or operated hospitals and nursing homes in northern Georgia and those facilities' affiliated physicians, to be called the Southern Healthcare Alliance, Inc. While the PHO would include high percentages of the primary care doctors in this rural area, joint price setting among horizontal competitors would be avoided by use of a messenger model to establish contracts with managed care plans and other payors. An agent of the PHO would receive contract offers from

payors and convey these individually to members of the PHO. At the specific written request of payors, the agent would discuss and transmit information regarding potentially competitively significant terms or conditions (*e.g.*, utilization review or credentialing) and would negotiate for the group regarding administrative issues such as billing practices and contract interpretation. The PHO would be non-exclusive, allowing doctors and/or hospitals to join other networks or to contract individually with payors.

Response: By avoiding any horizontal fee-setting or joint agreement on other competitively significant contract terms among competing doctors, the PHO is not likely to cause harm to existing competition in the market for physician services. The market for hospital services will not be affected since the four SHC hospitals are already under common ownership and control. Because providers are free to join other networks or contract individually with plans, the PHO would not impede the development of competing networks as managed care develops in the area.

Read full Business Review Letter

40. Children's Healthcare, P.A. ("CHPA")
March 1, 1996

Facts: Approximately 65 to 70 pediatricians practicing in seven counties in southern New Jersey proposed to form a provider network to contract with managed care plans for the provision of basic health care to children of plan enrollees. The group proposed to share risk either through capitation or via an unspecified percentage fee withhold subject to its meeting certain cost containment goals. CHPA would have a right of first refusal to negotiate with any payor seeking to initiate or renew a contract with an individual member of the group, after which members would be free to contract individually or join other similar networks. CHPA alleged a service market including any other primary care or specialty physicians who treat children, and a geographic market encompassing the greater Delaware Valley (consisting of southern New Jersey, southeastern Pennsylvania, and northern Delaware), and asserted that within those parameters it would possess no market power and thus pose no competitive threat.

Response: Rule of reason analysis led the Department to conclude that CHPA, if implemented as proposed, would likely violate the antitrust laws. In the area to be serviced by CHPA, family practitioners are not acceptable substitutes for pediatricians in the development of managed care physician networks, and markets for basic pediatric services are significantly more localized than CHPA asserted. As a result, in several south New Jersey communities, CHPA would achieve high levels of concentration (50% - 77%) in the relevant service market and would be able to exercise market power to the detriment of consumers. Further, information developed in our investigation suggested a significant danger that CHPA might operate in a *de facto* exclusive manner, thus depriving plans of competitive alternatives in an area where there are, according to plan managers, significant barriers to new entry. On balance, the projected

efficiencies claimed by CHPA, such as risk-sharing, development of practice procedures, sharing of administrative expenses and joint purchasing, do not outweigh the significant threat of anticompetitive effects posed by the venture.

Read full Business Review Letter

41. Oklahoma Physicians Network-IPA, Inc. and PROklahoma Care, Inc
January 17, 1996

Facts: Oklahoma physicians proposed to establish a statewide, non-exclusive physician network and an HMO to provide primary care and specialist services in Oklahoma. The physician network would negotiate contracts with the HMO and other third-party payors, either on a capitated basis or under a fee-for-service schedule utilizing a "risk pool" withhold of 20 percent of the fees due each physician.

Response: The proposal appears to be a bona fide joint venture whose members will share substantial risk with an incentive to achieve cost containment and utilization goals. Participating primary physicians generally comprise no more than 30 percent of the primary physicians in putative local markets in both urban and rural parts of the state. The network has fewer than 30 percent of the specialist physicians in most specialties in urban parts of the state, but does have more than 30 percent of specialists in some putative local markets in rural parts of the state. However, the network will retain an incentive to ensure that its physician services are priced competitively because roughly 90 percent of the physician-members are in specialties in local market in which the network does not have a substantial percentage of the physicians.

Read full Business Review Letter

42. Preferred Laboratory Access Network ("PLAN")
December 7, 1995

Facts: Group of 17 small and mid-sized independent clinical laboratories in California proposed to form a network to compete with several large national laboratories for regional managed care laboratory services contracts, particularly those to be let by the California state Medicaid system, MediCal. PLAN membership will be open to all clinical laboratories, but it will be limited so that it will account for no more than 30 percent of the laboratory sales volume for any relevant market. PLAN intends to share risk by operating primarily using capitated rates; on those rare occasions when a fee-for-service contract is sought, rates will be set using a messenger model to avoid any agreement as to price by member labs. When not bidding for large regional contracts, members of PLAN will continue to compete with one another for traditional laboratory business, which is expected to constitute the majority of PLAN members' revenue for the foreseeable future.

Response: In the markets for "stat" tests (blood counts, throat and urine cultures and other tests that require very quick turnaround) and "routine" tests (those that are generally uncomplicated and widely used but not particularly time sensitive), PLAN members compete with other independent clinical labs and hospital labs. To the extent that PLAN members provide esoteric or exotic tests (those requiring more sophisticated lab procedures or equipment and usually not time sensitive), they compete with reference labs throughout the country. While the market share information provided was limited and necessarily inexact, the combined market shares were sufficiently low to indicate that PLAN's members, as a group, would not possess potentially anti-competitive levels of market power. Furthermore, PLAN will operate in a nonexclusive manner, and payors and California state government officials all agree that competition in lab markets is fierce. The presence of three large national labs in the primary target area for MediCal HMO contracting offsets any market power that these 17 smaller labs might command. In addition, there are many other independent labs available to create similar networks, and hospital labs also provide competition in local markets.

Read full Business Review Letter

43. Dermnet, Inc.
December 5, 1995

Facts: Group of 100 dermatologists, 19 plastic surgeons, and 11 dermatopathologists proposed to offer tailor-made panels of specialists to provide skin treatment services to managed care groups and other third-party payors in Dade, Broward, and Palm Beach counties, Florida, through a single agent. The group will share risk through capitation, but would begin operations by contracting for capitated rates with a certain percentage of standard Medicare reimbursement levels guaranteed. After approximately six months, contracts with payors would be fully capitated. The group will establish quality assurance, utilization review, and credentialing rules and standards and will be non-exclusive in nature, allowing its members to join or continue their present participation in other networks.

Response: Dermnet's members will share significant risk through capitation. Although the group will represent 43.5% of board-certified dermatologists in the tri-county area, its ability to acquire market power in any relevant geographic market will be limited by its non-exclusivity and the presence of other similar networks. Payors did not believe that their ability to contract with dermatologists would be adversely affected by the creation of Dermnet. The group would raise no competitive concern with respect to plastic surgeons since it represents only 12.5% of the board-certified plastic surgeons in the area, and its membership would not exceed 30% of all plastic surgeons in any reasonably drawn market. While eleven of the fifteen dermatopathologists in the tri-county area will be Dermnet members, payors can and do use

dermatopathologists significantly beyond the tri-county area and are not concerned by Dermnet's large panel.

Read full Business Review Letter

44. Georgia Preferred Podiatric Medical Network
November 3, 1995

Facts: Network representing 92 of Georgia's 212 podiatrists (but open to all members of the state podiatry association, of which there are 187) proposed to employ or contract with an agent to act as an intermediary for soliciting and managing managed care contracts between the network's members and third party payors. The non-exclusive group would operate under a messenger model, transmitting terms and conditions from individual doctors to payors, and transmitting contract offers from payors to physicians, who would then decide unilaterally whether or not to accept each payor's contract offer. If payors so request, the Network may discuss with payors such potentially competitively significant non-price issues as utilization review, credentialing, and quality assurance standards, but may not negotiate such standards or terms on behalf of the members.

Response: The Network will function as a bona fide messenger to facilitate contract agreements and may facilitate the adoption of efficiency-enhancing utilization review and quality assurance procedures through non-binding discussions undertaken at the request of payors. Such discussions will not be used to facilitate collusive behavior among the network's members. Non-exclusivity further assures that competing networks can be formed and joined by members of the Network.

Read full Business Review Letter

45. Southwest Oncology Group ("SWOG")
November 2, 1995

Facts: An association of cancer research institutions (hospitals and universities) proposed to collect data from its members regarding the cost effectiveness and resource utilization of clinical trials. Results would be made public and used in part to convince insurance companies that treatment in clinical trials is a cost-effective alternative to standard care and that therefore patients participating in such trials should not be denied insurance coverage. The association will track numbers of physician visits, laboratory tests, x-rays, nurses' visits, drugs, and hospitalizations, and will assign costs to all treatments based on standardized data bases. Data would be collected from at least five providers and would be more than three months old at the time of analysis. Results would be stated so as to allow providers to draw their own conclusions about the cost effectiveness of any given treatment.

Response: SWOG's proposed activities involving the exchange of cost information would fall under the Statement 6 safety zone. Also there is no agreement among SWOG members to approach or negotiate with insurance companies collectively or to attempt to coerce concessions from them by taking a unified position in separate negotiations. The study promises to benefit consumers by providing information that can be used to control health care costs and ensure the most cost-effective use of health care resources.

Read full Business Review Letter

46. South Carolina Dermatologists
November 1, 1995

Facts: South Carolina dermatologist proposed to form a network of all South Carolina board-certified dermatologists to contract with managed care entities and third party payors, but only for those services not uniquely provided by dermatologists. The group of approximately 85 doctors (if all join) would be non-exclusive and would share substantial financial risk either by accepting capitated rates or by withholding a minimum of 20 percent of fees as a risk pool to be distributed only if certain efficiency goals are met. Inpatient hospital care and any procedure that dermatologists perform in more than 30 percent of all cases would not be covered in any contracts handled by the network.

Response: The service market would include many different types of doctors, including internists, general practitioners, family practitioners, and plastic surgeons. The letter is premised on the assumption that in any relevant local market, the network's members will not exceed 30 percent of all physicians available to provide services of the type offered by the network in that market. Thus, it is unlikely the network would attain market power. In addition, the group will share significant risk, provide incentives to achieve cost-containment goals, and be non-exclusive in nature.

Read full Business Review Letter

47. Hanger Orthopedic Group Inc. (“Hanger”)
September 15, 1995

Facts: Manufacturer and distributor of orthotic and prosthetic devices, and owner and operator of over 80 orthotics and prosthetic clinics nationwide proposed to form a national network of prosthetists and orthotists to contract with third-party payors. The network will not include any competitors in any relevant geographic market. Further, it will be exclusive in relevant geographic markets where Hanger contracts with an orthotic and prosthetic clinic only if the total revenues the contracted clinic earns from providing orthotic or prosthetic services does not exceed 20% of the total revenues for orthotic or prosthetic services in the relevant geographic market.

Response: Since none of the members of the Hanger network will be competitors in any relevant geographic market, and since Hanger will enter into exclusive contracts with orthotics and prosthetics clinics only where the clinic earns no more than 20% of total local market revenue, Hanger's network is unlikely to cause anticompetitive effects.

Read full Business Review Letter

48. Pennsylvania Orthotics and Prosthetics Enterprise ("POPE")
July 17, 1995

Facts: Group of orthotists and prosthetists proposed to form an IPA (POPE) to contract with third-party payors. POPE would be non-exclusive and limit its membership to 20% of each type of practitioner in any relevant geographic market. A management company will negotiate on behalf of the members, and sensitive information will not be shared among the members. POPE will establish a "risk pool" by withholding no less than 20% of each member's billings to create incentives to achieve efficiency and quality goals. The risk pool will be distributed to POPE members only if as a group they meet those goals.

Response: Because of its low percentages of each type of specialist in any relevant geographic market, its intention to withhold 20% of all fees as a means of creating shared financial risk among members, its non-exclusivity, and lack of any concerns among third-party payors, POPE is unlikely to cause anticompetitive effects in the market for the provision of prosthetic and orthotic devices.

Read full Business Review Letter

49. AdviNet, Inc.
May 12, 1995

Facts: A subsidiary of the nation's largest operator of nursing homes proposed to provide a nationwide database of services offered by nursing homes and other long-term care facilities. AdviNet, Inc. would contract with employers, insurers, associations, and individuals to make such information available through a toll-free number. Members of the network would be encouraged but not required to provide discounts to subscribers of the service and their listings would be more detailed than those of non-members. AdviNet would also assist in scheduling site visits by customers.

Response: AdviNet would operate independently of its parent corporation and with a separate computer system. Specific pricing information received from providers would not be made available to any other provider. This network appears to meet a consumer need and should promote competition by facilitating informed consumer choices.

Read full Business Review Letter

50. Mid-South Physician Alliance, Inc. and Mid-South Health Plan
March 30, 1995

Facts: Physician-owned corporations proposed to create a nonexclusive physician network and affiliated HMO to provide primary care and specialist physician services within 100 miles of Memphis, Tennessee. The physician network would negotiate contracts with the HMO and other third-party payors, either on a capitated basis or under a fee-for-service schedule utilizing a "risk pool" withhold of at least 20% of the fees due each physician. Fees would be established by an independent consultant after gathering a variety of information from the participating physicians. No participating physician will have access to any of the information collected. The physician members will comprise no more than 30 percent of any type of primary care physician in Memphis or in any of the five surrounding counties. For all but two of the physician specialties in its panel, the Alliance will have fewer than 30 percent of area specialists.

Response: The Alliance appears to be a bona fide joint venture whose members will share substantial risk with an incentive to achieve quality and efficiency objectives. Without attempting to define precisely the boundaries of the relevant geographic market for primary care physicians or for each physician specialty, for any reasonable market, the concentrations of specialists and primary care physicians expected in the network are unlikely to have anticompetitive effects. Area payors view the formation of the Alliance as procompetitive since it will serve as an alternative to existing networks of providers formed by large hospitals in the area.

Read full Business Review Letter

51. Wisconsin Subacute Preferred Provider Network
March 29, 1995

Facts: Hillhaven, an operator of nursing homes, proposed a joint venture with three other nursing home operators to offer managed care customers a statewide network of subacute-care medical and rehabilitation beds in nursing home facilities. None of the four participating firms offers nursing home services, or will offer subacute-care services, in the same local markets. Hillhaven will establish a "network price" for subacute-care services and provide a central referral process for the network, but each of the joint venturers will remain free to offer its services independently of the others, at an independently-determined price.

Response: The joint venture will enable managed care customers to contract prospectively with a single statewide network of subacute-care providers, which will compete with hospitals that offer subacute-care beds. Competition will not be affected since the four providers are not located and do not compete in the same local markets.

Read full Business Review Letter

52. Northwestern National Life Insurance Co. ("NWNL")
March 9, 1995

Facts: Minneapolis health and life insurance company proposed to offer its internal medical claims fraud and abuse detection services to outside parties for a fee. The current in-house fraud detection unit would become a separate division of the company, offering its services to third party payors, employers, and insurance companies. NWNL would continue to process its own medical claims and deal with its own claims disputes, using the fraud detection unit as any other customer.

Response: NWNL would establish sufficient protections to assure that claims information submitted by outside clients to its fraud detection unit would not be shared with NWNL, and vice versa, or among the outside clients. A nationwide databank of medical practitioners' fraud and abuse histories would be available for use by all clients of the fraud and abuse detection unit, but only after cases were closed.

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53. Chicagoland Radiological Network ("CRN")
December 8, 1994

Facts: Group of radiologists proposed to offer prepaid radiological services on capitated and discounted fee-for-service (with a substantial withhold) bases to third party payors and self-insured employers in an eight-county area in and around Chicago. Membership would include about 25% of the more than 780 radiologists in the Chicago area, and is not expected to exceed that level in any relevant local market within that area.

Response: The group is assuming significant financial risk through capitation and withholds on fee-for-service payments. It has developed safeguards to address concerns regarding the sharing of price information when using fee-for-service contracts. Each CRN physician will be expressly prohibited from disclosing any information regarding usual and customary charges or the charges he/she has agreed to accept under any managed care arrangement to any other CRN physician, and CRN will not develop a fee schedule. Rather, each physician will receive the lesser of his usual and customary charges or the payor's fee schedule, less at least 20% to be distributed only if cost control goals are met. In addition, other radiological groups, and at least one other radiological network, are competing in the area. The network will provide cost savings to payors by educating referring physicians on more effective utilization of radiologist services.

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54. Merger of Pulmonary Associates Ltd. and Albuquerque Pulmonary Consultants P.A.
October 31, 1994

Facts: Two pulmonary specialist physician groups in Albuquerque, New Mexico, each employing five doctors, four full-time and one part-time, proposed to merge. The combined firm, with 8 full-time and 2 part-time doctors, would be competing against at least 100 other physicians offering similar services in the area.

Response: Because board-certified pulmonologists are not the exclusive providers of the services they provide, but face competition in these services from general surgeons, cardiac surgeons, thoracic surgeons, and internists as well as family physicians; because HMOs and other third-party payors in the area currently employ, contract with, or reimburse many non-pulmonologists for the same type of services provided by pulmonologists; and because staff privileges at area hospitals are extended to many non-pulmonologists to perform these services, it appears that the new firm would be unable to exercise market power.

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55. Physician Care Inc. ("PCI")
October 28, 1994

Facts: Over 100 of the 276 physicians in south-central Kentucky proposed to form a provider network to offer services to self-insured employers and other third-party payors in the area. Care will be provided using either capitated or discounted fee-for-service rates with a 20% withhold. PCI will establish utilization standards and other measures to help contain health care costs.

Response: This non-exclusive venture will provide alternative health care services to consumers, and its members will share significant financial risk. The proposed network will have as much as 37% of primary care physicians in some local markets, and a higher percentage of some specialties; but, in the largely rural areas where this network will operate, those percentages appear to be necessary to provide adequate coverage for enrollees. No PCI member will have access to another member's fees, pricing data, or other financial information.

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56. International Chiropractor's Ass'n of California ("ICAC")
October 27, 1994

Facts: Nonprofit chiropractor's association proposed to form a for-profit network of its members statewide that would contract with third-party payors, limiting membership to no more than 50% of the chiropractors in any relevant geographic market. The network will negotiate maximum fee-for-service rates with each of its network-user clients. Members will not charge more than the negotiated rate, and must charge their usual rates if those are lower than the

network rate. The network will monitor utilization patterns and will drop providers whom it deems to be over-utilizers.

Response: The group will be a bona fide joint venture in which the participating chiropractors will assume significant financial risk by participating in fee withhold arrangements and a risk pool. Absent the overall network's efficient operation, all or part of the risk pool will not be available to the participating chiropractors for distribution. Further, ICAC will be genuinely non-exclusive and will be but one of several competing chiropractic networks. Since potential users of ICAC need only a small number of chiropractors, if ICAC attempted to demand noncompetitive terms, alternative chiropractors with the ability and incentive to supplant ICAC on competitive terms would be available to users.

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57. Preferred Podiatric Network Inc.
September 14, 1994

Facts: A subsidiary of the New York State Podiatric Medical Association proposed to act as an intermediary to facilitate communication between managed care plans and non-integrated groups of podiatrists (members of the Association) who desire to enroll as providers in such plans. The Network would not negotiate fees on behalf of its members, and only at the specific written request of payors may the Network negotiate certain non-price matters.

Response: Fee information would not be shared with or among members; the Network would be a *bona fide* intermediary, would not negotiate fees for competing podiatrists, and each podiatrist would independently accept or reject any contract offer; the Network is non-exclusive and should not impede the participation of its members as podiatric providers in other managed care networks.

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58. Collaborative Provider Organization, Inc. ("CPO")
July 6, 1994

Facts: Des Moines General Hospital and 177 physicians in south-central Iowa proposed to form a PHO to offer a health care plan to business owners seeking new ways to cover their workers' medical needs in a 25 county area. The providers would contract with payors at capitated (per subscriber) rates or discounted fee-for-service rates with a 20% withhold.

Response: The members of CPO will share risk via both capitation and a withhold of discounted fee-for-service rates. CPO members will not be directly involved in setting fees, but will retain a third party administrator who will survey CPO members and compile aggregate fee data to be used in negotiating contracts for health care services. In the most populous county, less than 20% of all licensed physicians will join CPO, including less than 20% of all primary care

physicians. In 18 of 30 identified specialties, membership will also be less than 20%, but in 12 specialty areas membership would exceed 20%. No CPO member will have access to another member's fees, pricing data, or other financial information. The proposal will provide an additional alternative health care delivery system and could increase competition and lower health care costs for consumers.

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59. Seeskin, Paas, Blackburn and Company ("SPB")
June 29, 1994

Facts: Accounting firm representing 5 - 10% of dentists in the Cincinnati, Ohio area proposed to collect price information from its dental clients on approximately 400 procedures and publish a report showing the high, low, and average price for a given procedure, citing a need for the firm and the dentists to have reliable statistical data on prices for various services provided to patients.

Response: The data collected would be historical, identity of dentists in the program would not be disclosed, no prices would be included for any specialty containing fewer than five dentists, and price information would be collected from only 5 - 10% of the dentists in the market. In addition, no discounts from list price would be reported.

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60. The Birmingham Cooperative Clinical Benchmarking Demonstration Project
June 20, 1994

Facts: A group of 24 businesses and 10 hospitals in the Birmingham area proposed to collect and analyze data about the clinical effectiveness and cost of three types of services: obstetrical delivery, pneumonia, and acute myocardial infarction, and to compare outcomes with Birmingham averages, national averages, and national "benchmark" averages.

Response: The information will be collected by an independent corporation and will for each report be based on data more than three months old. This project was initiated by purchasers of hospital services and is the result of collaboration between these purchasers and providers of hospital services. Such collaboration has the potential of allowing businesses that provide health care benefits to make better informed purchasing decisions and should also promote hospital effectiveness and efficiency.

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61. Hotel Employees and Restaurant Employees International Union Welfare Fund
May 20, 1994

Facts: Union proposed to provide a one-time historical claims report to the PPO with which it contracts to provide health care services to its members. The report would compare the amounts the union actually paid for each procedure to each PPO physician between 9/1/91 and 8/31/92 with the amount the physician would have received under the Resource-Based Relative Value Scale fee schedule it has developed in order to help each physician make an informed decision as to whether or not to accept the RBRVS fee schedule for future services.

Response: The limited information exchange has the potential to enable individual physicians to make more informed decisions about selling their services to the Welfare Fund and make health care available to more employees at a reasonable cost. The PPO agreed with the union not to disclose to any physician another physician's payments.

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62. Houston Health Care Coalition
March 23, 1994

Facts: The Coalition proposed that it form a Group Purchasing Association to contract with health care providers to deliver health care services to Coalition members' employees and their dependents in a 13-county area surrounding Houston at predetermined rates. Not all Coalition members will choose to become members of the Association; those Coalition members who are also providers will be in an “associate member” category and will not be permitted to vote on any matters involving the Association's activities, be represented on the Board of Trustees, or take part in decisions involving reimbursement rates. An independent consultant will compile data from providers regarding the costs associated with various Diagnostic Related Groups (“DRGs”), and will survey average historical costs for various procedures at approximately 65 health care facilities in the area to assemble a database of prevailing charges for those DRGs available for program coverage. No provider will have access to the data submitted by any other provider, and only Association members will have access to the data or the study. The schedule of reimbursement rates thus compiled by the Association will be distributed to providers so they may decide whether to contract with the Association.

Response: No more than 20% of any specialist physician providers in any relevant market in which the Association operates will be associate members. This limitation on specialty provider participation will significantly reduce any risk of provider collusion. No provider that is also an associate member may take part in negotiating reimbursement rates or setting those rates on the Association's behalf. Also, providers will not have access to any specific cost data obtained by the Association from any other providers. The Association has the potential to create efficiencies in delivering health care services that could result in lower health care costs. Finally,

members are free to deal with or approach any providers individually, including providers who contract with the Association.

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63. New Jersey Hospital Association

February 18, 1994

Facts: The association proposed that it produce a survey and report of employee wages and salaries paid by hospitals in New Jersey.

Response: The survey and report would be compiled and published by an independent third party, set forth information solely on an aggregated basis, and in a manner so that the responses of individual hospitals or hospital chains were not detectable, and contain information that was at least three months old.

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64. Bay Area Business Group on Health

February 18, 1994

Facts: BBGH, a San Francisco non-profit organization, proposed that it ask several HMOs to bid on two standard benefit plans and negotiate prices. Sixteen California companies expressed interest in joining BBGH. Participating companies were free to negotiate independently of the group with HMOs not dealing with or approved by the group.

Response: A substantial majority of all potential HMO customers will not be represented by BBGH; although some current BBGH members are direct competitors, the members' costs of purchasing HMO health benefits account for only a small percentage of the selling price of the products and services they provide; the BBGH has the potential to create efficiencies in the delivery of HMO services that could result in lower health care costs.

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65. California Chiropractic Association
December 8, 1993

Facts: The association proposed to form a statewide chiropractic managed care organization (MCO) that would contract with third-party payors at a capitated rate and allow the third-party payors to enter into a single statewide contract for chiropractic services through the MCO.

Response: The MCO will be a bona fide joint venture in which the participating chiropractors will share significant financial risk via capitation; efficiency will be enhanced via

utilization standards; the MCO will be non-exclusive; and the MCO will take steps to include no more than 50% of the chiropractors in any local market. In addition, if the MCO attempted to raise prices above competitive levels, managed care plans and other payors believe that they have reasonable alternatives to the MCO that would allow them to defeat such a price increase.

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66. Saint Anthony Medical Center
November 8, 1993

Facts: General acute care hospital in Rockford, Illinois proposed to offer multi-provider preferred provider contracts to employers and other third-party payors. Providers were free to contract independently of the multi-provider contract. The hospital also proposed to contract with a second hospital to cover services that St. Anthony does not, or cannot, provide (overflow services) and to allow for patients' choice of hospitals (patient-choice). Both patient-choice and overflow referrals to the second hospital would be limited to 20 percent of admissions at that hospital.

Response: The proposal provides employers and payors with an additional managed care plan. This should increase competition for managed care plans and should help drive down costs for the consumers. Additionally, since the second hospital would be limited to only 20 percent of admissions for patient-choice and overflow referrals, it would be motivated to compete with St. Anthony for a larger share of the managed care business.

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67. The Health and Personal Care Distribution Conference, Inc.
October 13, 1993

Facts: National manufacturers' trade association proposed to undertake a voluntary data exchange program among its members regarding the transportation and distribution costs of its members' goods sold to wholesale and retail customers, which are drugs, toiletries, and other products commonly sold in drug stores.

Response: The shared information would not result in monopsony power, as HPCDC does not intend to negotiate transportation rates collectively on behalf of its members; HPCDC's members, further, account for only 3% of nationwide revenue of motor carriers. The information will not result in price coordination because the cost of transportation of members' goods as a percentage of total cost is very low; also, an independent third party will collect, organize, compile, and ultimately publish the data, which will not reveal individual identities of any survey participants.

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68. Pharmaceutical Manufacturers Association
October 1, 1993

Facts: The Association proposed that each participating member company would agree to limit the annual increase in the average change in the prices of its prescription drug products to a level not greater than the annual increase in the consumer price index. The proposal was not to have applied to any individual product and specifically excluded new products.

Response: "Agreements among competitors, including agreements setting maximum prices, that interfere with the ability of each firm in a market to determine its own prices have long been illegal. Maximum price agreements often become agreements on actual price increases. Courts have recognized this danger and have held such agreements to be clearly unlawful."

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69. National Cardiovascular Network, Inc.
September 28, 1993

Facts: A proposal to establish a national network (PPO) of cardiologists, cardiovascular surgeons, and acute care hospitals in 41 metropolitan areas around the country to provide cardiac care to beneficiaries of large third-party payors, such as insurers, unions, and multi-site employers.

Response: The network will assume significant financial risk by providing specialized cardiac care services at all-inclusive, global prices covering all hospitalization and physician expenses of plan beneficiaries. In addition, in areas where it contracts with competitors, the network will not sign up more than 20% of the cardiologists, or more than 20% of the cardiovascular surgeons with active admitting privileges at hospitals in any relevant geographic market, thereby qualifying for an antitrust safety zone under the health care industry policy statements.

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