UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA, and STATE OF CONNECTICUT, ex rel., RICHARD BLUMENTHAL, ATTORNEY GENERAL, Plaintiffs, vs. HEALTHCARE PARTNERS, INC., DANBURY AREA IPA, INC., and DANBURY HEALTH SYSTEMS, INC., Defendants.	Civil Action No: 395-CV-01946RNC Filed: September 13, 1995

COMPETITIVE IMPACT STATEMENT

Pursuant to Section 2(b) of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)-(h) ("APPA"), the United States files this Competitive Impact Statement relating to the proposed Final Judgment submitted for entry in this civil antitrust proceeding.

I.

NATURE AND PURPOSE OF THE PROCEEDING

On September 14, 1995, the United States and the State of Connecticut filed a civil antitrust complaint alleging that defendant HealthCare Partners, Inc. ("HealthCare Partners"), defendant Danbury Area IPA, Inc. ("DAIPA"), and defendant Danbury Health Systems, Inc. ("DHS"), with others not named as defendants, entered into an agreement and took other actions, the purpose and effect of which were, among other things, to restrain competition unreasonably by preventing or delaying the development of managed care in the Danbury, Connecticut area ("Danbury"), to willfully maintain DHS' market power in acute, inpatient care, and to gain an unfair advantage in markets for outpatient services, in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2. The Complaint seeks injunctive relief to enjoin continuance or recurrence of these violations.

The United States and the State of Connecticut filed with the Complaint a proposed Final Judgment intended to settle this matter. Entry of the proposed

Final Judgment by the Court will terminate this action, except that the Court will retain jurisdiction over the matter for further proceedings that may be required to interpret, enforce, or modify the Judgment, or to punish violations of any of its provisions.

Plaintiffs and all defendants have stipulated that the Court may enter the proposed Final Judgment after compliance with the APPA, unless prior to entry plaintiffs have withdrawn their consent. The proposed Final Judgment provides that its entry does not constitute any evidence against, or admission by, any party concerning any issue of fact or law.

The present proceeding is designed to ensure full compliance with the public notice and other requirements of the APPA. In the Stipulation to the proposed Final Judgment, defendants have also agreed to be bound by the provisions of the proposed Final Judgment pending its entry by the Court.

II.

PRACTICES GIVING RISE TO THE ALLEGED VIOLATIONS

DHS's 450-bed acute care facility, Danbury Hospital, is the sole source of acute inpatient care in the Danbury area. It faces no competition from other general acute care hospitals in the market for these services and, accordingly, possesses a monopoly in general acute inpatient care. The Hospital also provides outpatient surgical care and other services.

By 1992, managed care organizations had recruited a sufficient number of physicians with active staff privileges at Danbury Hospital to offer managed care plans to employers and individuals in the Danbury area. The introduction of managed care plans into the Danbury area reduced the Hospital's market power in inpatient services by decreasing the number of hospital admissions and the length of hospital stays, thereby causing the Hospital to lose significant inpatient volume. Additionally, the introduction of managed care plans resulted in increased competition among doctors and reduced referrals to specialists in DOPS (Danbury Hospital's affiliated multispecialty practice group).

In 1993, DHS took steps to form an alliance with virtually every doctor on its Hospital's medical staff to protect the economic interests of both the Hospital and the doctors and forestall the continued development of managed care plans in Danbury. On May 6, 1994, HealthCare Partners was incorporated to represent jointly Danbury Hospital and physicians in negotiations with managed care organizations, and DAIPA was created as the vehicle for physician ownership in HealthCare Partners. Danbury Hospital and DAIPA jointly own HealthCare Partners, and each appoints six of the twelve directors of HealthCare Partners' board of directors.

Only active members of Danbury Hospital's medical staff could be owners of DAIPA. Over 98% of the doctors on Danbury Hospital's medical staff joined DAIPA. Each paid a small fee. None committed to any integration of their practices.

Each doctor who joined DAIPA contracted with HealthCare Partners and authorized it to negotiate fees on the doctor's behalf. The doctors authorized

HealthCare Partners to enter into non-risk-bearing contracts in one of two ways.[1]

First, it could prepare a minimum fee schedule and present it to each doctor for approval. A doctor's approval would then authorize HealthCare Partners to enter into non-risk-bearing contracts on behalf of the doctor without further consultation so long as the resulting fees equalled or exceeded the minimum fee schedule.

Alternatively, HealthCare Partners could negotiate fees on behalf of all the doctors and then present each doctor with the collectively negotiated fee schedule. Each doctor would then have the opportunity to accept this jointly negotiated fee schedule.

HealthCare Partners negotiated two contracts using this latter approach and succeeded in obtaining generous fees for the DAIPA doctors. Indeed, one of

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[1] While the doctors also authorized HealthCare Partners to enter into risk-bearing contracts, HealthCare Partners has not exercised this authority. Even if it had, or does in the future, the negotiation of risk-bearing contracts would not justify the unlawful negotiation of non-risk-bearing contracts that occurred here. See Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust ("Health Care Policy Statements") that the U.S. Department of Justice and the Federal Trade Commission issued jointly on September 27, 1994, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,794 n.35.

the contracting managed care plans was forced to increase its fees to doctors outside of the Danbury area to avoid the excessive administrative costs it would have incurred to administer one fee schedule for Danbury and a separate schedule for the other areas in which it operated.

The Hospital's goal in forming HealthCare Partners was to eliminate competition among physicians in order to further its broader goal of reducing or limiting the impact of managed care plans on its monopoly in acute inpatient services. In furtherance of these goals, the Hospital also used its control over admitting privileges to reduce competition in physician and outpatient services markets. The Hospital adopted a Medical Staff Development Plan in part to limit the size and mix of its medical staff. This Plan effectively controlled the entry of new physicians into Danbury and thereby insulated HealthCare Partners from competition. The Hospital also announced a policy that required its doctors to perform at least 30% of their procedures at the Hospital. This announcement caused a

reduction in the use of a competing outpatient surgery center.

Based on the facts described above, the Complaint alleges (1) that the defendants entered into a contract, combination, or conspiracy that eliminated competition among physicians, reduced or limited the development of managed care plans, and reduced or limited competition among outpatient service providers, all in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 and (2) that DHS took exclusionary acts that had the purpose and effect of maintaining Danbury Hospital's market power in acute inpatient hospital services and gaining an unfair advantage in markets for outpatient services, in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

III.

EXPLANATION OF THE PROPOSED FINAL JUDGMENT

The proposed Final Judgment is intended to prevent the continuance or recurrence of defendants' agreement to eliminate competition among doctors and reduce or limit the development of managed care in the Danbury area. The proposed Final Judgment is also intended to prevent the continuance or recurrence of DHS's exclusionary conduct. The overarching goal of the proposed Final Judgment is to enjoin defendants from engaging in any activity that unreasonably restrains competition among physicians, outpatient service providers, or managed care plans in the Danbury area, or that willfully maintains Danbury Hospital's market power in acute inpatient services, or gains Danbury Hospital an unfair advantage in markets for outpatient services, while still permitting defendants to market a provider-controlled managed care plan.[2]

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[2] This relief comports with the Health Care Policy Statements, and in particular with the principles enunciated therein that a provider network (1) should not prevent the formation of rival networks and (2) may not negotiate on behalf of providers, unless those providers share substantial financial risk or offer a new product to the market place. Statement 8, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788-89; Statement 9, id. at 20,793-94, 20,796.

A. Scope of the Proposed Final Judgment

Section III of the proposed Final Judgment provides that the Final Judgment shall apply to defendants and to all other persons who receive actual notice of this proposed Final Judgment by personal service or otherwise and then participate in active concert with any defendant. The proposed Final Judgment applies to DHS, DAIPA, and HealthCare Partners.

B. Prohibitions and Obligations

Sections IV and V of the proposed Final Judgment contain the substantive provisions of the Judgment.

In Section IV(A), DAIPA and HealthCare Partners are enjoined from setting or expressing views on the prices or other competitive terms and conditions or negotiating for competing physicians, unless the negotiating entity is a Qualified Managed Care Plan ("QMCP" -- as defined in the proposed Final Judgment and discussed below). However, DAIPA and HealthCare Partners are permitted to use a messenger model, as discussed below.

Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788-89; Statement 9, id. at 20,793-94, 20,796.

Section IV(B)(1) enjoins DHS, DAIPA, and HealthCare Partners from precluding or discouraging any physician from contracting with any payer, providing incentives for any physician to deal exclusively with DAIPA, HealthCare Partners, or any payer, or agreeing to any priority among themselves as to which will have the right to negotiate first with any payer. Nothing in Section IV(B), however, prohibits physicians from agreeing to exclusivity in connection with an ownership interest or membership in a QMCP.

Section IV(B)(2) prohibits the sharing of competitively sensitive information. DHS, DAIPA, and HealthCare Partners are enjoined from disclosing to any physician any financial or other competitively sensitive business information about any competing physician and from requiring any physician to disclose any financial or other competitively sensitive information about any payer. An exception permits any defendant to disclose such information if disclosure is reasonably necessary for the operation of a QMCP in which that defendant has an ownership interest, or if

the information is already generally available to the medical community or the public.

Section IV(B)(3) enjoins DHS, DAIPA, and HealthCare Partners from owning an interest in any organization that directly or through an agent or other third party sets fees or other terms of reimbursement, or negotiates for competing physicians, unless that organization is a QMCP and complies with Sections IV(B)(1) and (B)(2). However, defendants may own an interest in an organization that uses a messenger model.

Section IV(C)(1) enjoins DHS from exercising its control over staff privileges with the purpose of reducing competition with DHS in any line of business, including managed care, outpatient services, and physician services. Nothing in the Final Judgment limits DHS' authority to make staff decisions for assuring quality of care.

Section IV(C)(2) prohibits DHS from conditioning the provision of inpatient hospital services to individuals covered by any payer on the purchase or use of DHS' utilization review program, qualified managed

care plan, ancillary or outpatient services, or any physician's services, unless the physician services are intrinsically related to the provision of inpatient care. (These prohibitions, however, do not apply to any organization or any contract in which DHS has a substantial financial risk.)

Section IV(C)(3) prohibits DHS from conditioning rates to any payer for inpatient hospital services on the exclusive use of the Hospital's outpatient services. Nothing in this Section limits the terms and conditions on which DHS may contract with any payer pursuant to which DHS bears substantial financial risk for the delivery of outpatient services.

Section V of the proposed Final Judgment contains additional provisions with respect to DAIPA and HealthCare Partners. Section V(A) requires DAIPA and HealthCare Partners to notify participating physicians annually that they are free to contract separately with any payer on any terms, except with regard to those physicians who have agreed to exclusivity in connection with an ownership interest or membership in a QMCP. Similarly, DAIPA and HealthCare Partners must notify in

writing each payer with whom HealthCare Partners has or is negotiating a contract, or which subsequently inquires about contracting, that each of its participating physicians is free to contract separately with such payer on any terms and without consultation with DAIPA or HealthCare Partners.

Under Section V(B), DHS must file with plaintiffs annually on the anniversary of the filing of the Complaint a written report disclosing the rates for inpatient hospital services to any payer, including any plan affiliated with DHS. In lieu of a report, DHS may file documents disclosing the rates for each payer other than Medicare and Medicaid.

Section VI of the proposed Final Judgment requires defendants to implement a judgment compliance program. Section VI(A) requires that within 60 days of entry of the Final Judgment, defendants must provide a copy of the proposed Final Judgment and the Competitive Impact Statement to all officers and directors. Sections VI(B) and (C) require defendants to provide a copy of the proposed Final Judgment and Competitive Impact Statement to persons who assume those positions in the

future and to brief such persons annually on the meaning and requirements of the proposed Final Judgment and the antitrust laws, including penalties for violating them. Section VI(D) requires defendants to maintain records of such persons' written certifications indicating that they (1) have read, understand, and agree to abide by the terms of the proposed Final Judgment, (2) understand that their noncompliance with the proposed Final Judgment may result in conviction for criminal contempt of court, and imprisonment, and/or fine, and (3) have reported any violation of the proposed Final Judgment of which they are aware to counsel for defendants. Section VI(E) requires defendants to maintain for inspection by plaintiffs a record of recipients to whom the proposed Final Judgment and Competitive Impact Statement have been distributed and from whom annual written certifications regarding the proposed Final Judgment have been received.

The proposed Final Judgment also contains provisions in Section VII requiring defendants to certify their compliance with specified obligations of

Section VI(A) of the proposed Final Judgment. Section VIII of the proposed Final Judgment sets forth a series of measures by which plaintiffs may have access to information needed to determine or secure defendants' compliance with the proposed Final Judgment. Section IX provides that each defendant must notify plaintiffs of any proposed change in corporate structure at least 30 days before that change to the extent the change may affect compliance obligations arising out of the proposed Final Judgment.

Finally, Section XI states that the Judgment expires ten years from the date of entry.

C. Effect of the Proposed Final Judgment on Competition

1. The Prohibitions on Setting and Negotiating Fees and Other Contract Terms

The prohibitions on setting or expressing views on prices and other contract terms or negotiating for competing physicians, set forth in Section IV(A), provide defendants with essentially two options for complying with the proposed Final Judgment. First, HealthCare Partners and DAIPA may change their manner of operation and no longer set or negotiate fees on

behalf of competing physicians, for example by using a "messenger model," a term defined in the proposed Final Judgment. Second, HealthCare Partners and DAIPA may restructure their ownership and provider panels to become a QMCP.[3]

DAIPA jointly owns HealthCare Partners with DHS and appoints six of HealthCare Partners directors. DAIPA includes competing physicians among its owners on whose behalf HealthCare Partners negotiates fees and other competitively sensitive terms and conditions. These physicians do not share financial risk. The proposed Final Judgment prevents HealthCare Partners and DAIPA, under their present structures, from continuing to set or negotiate fees or other terms of reimbursement collectively on behalf of the competing physicians. (Section IV(A)) Such conduct would constitute naked price fixing. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 356-57 (1982).

The proposed Final Judgment does not, however, prohibit HealthCare Partners and DAIPA, as presently structured, from engaging in activities that are not

[3] Of course, HealthCare Partners and DAIPA could simply cease operations and dissolve.

anticompetitive. In particular, while the proposed Judgment enjoins HealthCare Partners and DAIPA from engaging in price fixing or similar anticompetitive conduct, it permits HealthCare Partners and DAIPA to use an agent or third party to facilitate the transfer of information between individual physicians and purchasers of physician services. Appropriately designed and administered, such messenger models rarely present substantial competitive concerns and indeed have the potential to reduce the transaction costs of negotiations between health plans and numerous physicians.

The proposed Final Judgment makes clear that the critical feature of a properly devised and operated messenger model is that individual providers make their own separate decisions about whether to accept or reject a purchaser's proposal, independent of other physicians' decisions and without any influence by the messenger. (Section II(H)) The messenger may not, under the proposed Judgment, coordinate individual providers' responses to a particular proposal, disseminate to physicians the messenger's or other

physicians' views or intentions concerning the proposal, act as an agent for collective negotiation and agreement, or otherwise serve to facilitate collusive behavior.[4] The proper role of the messenger is simply to facilitate the transfer of information between purchasers of physician services and individual physicians or physician group practices and not to coordinate or otherwise influence the physicians' decision-making process.[5]

If, on the other hand, HealthCare Partners or DAIPA wants to negotiate on behalf of competing physicians, it must restructure itself to meet the requirements of

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[4] For example, it would be a violation of the proposed Final Judgment if the messenger were to select a fee for a particular procedure from a range of fees previously authorized by the individual physician, or if the messenger were to convey collective price offers from physicians to purchasers or negotiate collective agreements with purchasers on behalf of physicians. This would be so even if individual physicians were given the opportunity to "opt in" to any agreement. In each instance, it would in fact be the messenger, not the individual physician, who would be making the critical decision, and the purchaser would be faced with the prospect of a collective response.

[5] For example, the messenger may convey to a physician objective or empirical information about proposed contract terms, convey to a purchaser any individual physician's acceptance or rejection of a contract offer, canvass member physicians for the rates at which each would be willing to contract even before a purchaser's offer is made, and charge a reasonable, non-discriminatory fee for messenger services. The proposed Final Judgment gives guidelines for these and other activities that a messenger may undertake without violating the Final Judgment. (Section II(H))

a QMCP as set forth in the proposed Final Judgment. To comply, (1) the owners or members of HealthCare Partners or DAIPA (to the extent they compete with other owners or members or compete with physicians on their provider panels) must share substantial financial risk, and comprise no more than 30% on a nonexclusive basis, or 20% on an exclusive basis, of the physicians in any relevant market; and (2) to the extent HealthCare Partners or DAIPA has a provider panel that exceeds either of these limits in any relevant market, there must be a divergence of economic interest between the owners and the subcontracting physicians, such that the owners have the incentive to bargain down the fees of the subcontracting physicians. (Section II (L)(1) and (2)) As explained below, the requirements of a QMCP are necessary to avoid the creation of a physician cartel while at the same time allowing payers access to larger physician panels.

a. QMCP Ownership Requirements

The financial risk-sharing requirement of a QMCP ensures that the physician owners in the venture share a clear economic incentive to achieve substantial cost

savings and provide better services at lower prices to consumers. This requirement is applicable to all provider-controlled organizations since without this requirement a network of competing providers would have both the incentive and the ability to increase prices for health care services.

The requirement that a QMCP not include more than 30% on a nonexclusive basis, and 20% on an exclusive basis, of the local physicians in certain instances is designed to ensure that there are available sufficient remaining physicians in the market with the incentive to contract with competing managed care plans or to form their own plans.[6] These limitations are

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[6] The proposed Final Judgment embodies the parties' stipulation that only physicians with active staff privileges (not including those with just courtesy privileges) at Danbury Hospital are in any relevant physician market. One anticompetitive effect remedied by the proposed Final Judgment was the reduction in competition among these physicians, which allowed both the exercise of horizontal market power in physician markets and the willful maintenance of the Hospital's market power in acute inpatient hospital services. Accordingly, the 20% and 30% limitations apply to this universe of doctors. The proposed Final Judgment specifies three separate product markets to which these limitations apply: adult primary care doctors (Section II(M)(1)), OB/GYNs (Section II(M)(2)), and pediatricians (Section II(M)(3)). The limitations also apply to any other relevant product market for physician services. (Section II(M)(4)) The proposed Final Judgment permits plaintiffs to give written approval of relevant markets differing from those specified.

particularly critical in this case in view of defendants' prior conduct in forming negotiating groups with nearly every physician with active staff privileges at Danbury Hospital.

The 20% and 30% limitations will prevent defendants from aggregating market power to pursue and achieve the same type of anticompetitive effects that led to this action. Consistent with the reasons for these limitations, the proposed Final Judgment permits recruitment of new physicians, and thus an increase in the supply of physicians in the Danbury area, even if that recruitment causes a QMCP to exceed the 20% or 30% limitation. Similarly, defendants will not violate the proposed Final Judgment if these limits are exceeded as a result of a physician exiting any relevant market.

In addition, the 30% limitation does not apply where a QMCP includes any single physician or pre-existing practice group that already has more than a 30% market share. In these circumstances, no aggregation of market power could occur as a result of the practice group joining the QMCP. To qualify for this exemption, the pre-existing practice group must

exist as of the date of the filing of the Complaint in this action. (Section II(I)) For example, Danbury Hospital would violate the Final Judgment if it owns an interest in a QMCP in which DOPS participates as an owner on a nonexclusive basis and, after the filing of the Complaint, DOPS acquires physician practices that cause it to exceed the 30% limitation or increase its market share in markets where it already exceeds 30%.[7]

b. QMCP Subcontracting Requirements

Many employers and payers may want managed care products with panels larger than permitted by the 20% and 30% limitations. The QMCP's subcontracting requirements are designed to permit a larger physician panel, but with restrictions to avoid the risk of competitive harm. To offer panels above the 20% and 30% limits, a QMCP must operate with the same incentives as a nonprovider-controlled plan. Specifically, the owners of a QMCP must bear significant financial risk for the payments to, and

[7] In contrast, the 20% limitation does not have an exception for pre-existing practice groups because in an exclusive arrangement such practice groups could have the incentives and ability to create the same type of cartel that the proposed Final Judgment is intended to break up.

utilization practices of, the panel physicians in excess of the 20% and 30% limitations. These requirements significantly reduce the incentives for a QMCP to use the subcontracts as a mechanism for increasing fees for physician services.

Consequently, the proposed Final Judgment permits a QMCP to subcontract with any number of physicians in a market provided important safeguards are met. Under Section II(L)(2) of the proposed Final Judgment, the subcontracting physician panel may exceed the 20% or 30% limitation if the organization bears significant financial risk for payments to and the utilization practices of the subcontracting physicians and does not compensate those subcontracting physicians in a manner that substantially replicates ownership. These requirements will assure that there is a sufficient divergence of economic interest between those subcontracting physicians and the owners such that the owners have the incentive to bargain down the fees of the subcontracting physicians. Indeed, without these requirements, the organization could serve as a cartel manager for all members of Danbury Hospital's active

medical staff by, for example, passing through directly to payers substantial liability for making payments to the subcontracting physicians.

A QMCP would meet the subcontracting requirements if, for example, a QMCP were compensated on a capitated, per diem, or diagnostic related group basis and, in turn, reimbursed subcontracting physicians pursuant to a fee schedule. In such a situation, an increase in the fee schedule to subcontracting physicians during the term of a QMCP's contract with the particular payer would not be directly passed through to the payer but rather would be borne by a QMCP itself. This would provide a substantial incentive for a QMCP to bargain down its fees to the subcontracting physicians.

On the other hand, the subcontracting requirements would not be met if a QMCP's contract with a payer were structured so that significant changes in the payments by a QMCP to its physicians directly affected payments from the payer to a QMCP, or if the payer directly bears the risk for paying the panel physicians or pays the panel physicians pursuant to a fee-for-service

schedule. The requirements would also not be satisfied if contracts between a QMCP and the subcontracting physicians provided that payments to the physicians depended on, or varied in response to, the terms and conditions of a QMCP's contracts with payers.[8] Any of these scenarios would permit a QMCP to pass through to payers, rather than bear, the risk that its provider panel will charge fees that are too high or deliver services inefficiently.[9]

2. Prohibitions Against Exclusionary Acts

In addition to helping to organize HealthCare Partners and DAIPA, DHS used other exclusionary acts to maintain its market power in acute inpatient hospital services and to gain an unfair advantage in markets for outpatient services. The proposed Final Judgment

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[8] Nothing in the proposed Final Judgment prohibits a QMCP from entering into arrangements that shift risk to subcontracting physicians, such as may be desirable to create cost-reducing incentives, so long as those arrangements are consistent with the criteria for a QMCP set forth in Section II(L) of the Judgment.

[9] Similarly, a QMCP would fail the ownership replication restriction of Section II(L) of the proposed Final Judgment if, for example, the owners paid themselves a dividend and then, through declaration of a bonus, paid the same or similar amount to the subcontracting physicians. The same would be true if the owners otherwise structured dividends, bonuses, and incentive payments in such a way that ensures that subcontracting and owning physicians receive equal overall compensation.

eliminates the continuance or recurrence of such exclusionary acts.

Section IV(C) of the proposed Final Judgment prohibits Danbury Hospital from exercising its control over staff privileges with the purpose of reducing competition with the Hospital in any line of business, tying the availability of inpatient services to any other service, or conditioning favorable inpatient rates on exclusive use of Danbury Hospital's outpatient services. These prohibitions are crafted to permit Danbury Hospital to assure the quality of care delivered at the Hospital, participate in managed care plans, retain freedom to contract on acceptable terms, and compete aggressively in outpatient markets, while at the same time ensure that Danbury Hospital does not unlawfully abuse its monopoly in acute inpatient services. The Hospital is also required to report annually its inpatient rates to payers. (Section V(B))

3. Other Substantive Provisions

Section IV(B)(2) of the proposed Final Judgment enjoins the disclosure to any physician of any financial or competitively sensitive business

information about any competing physician. It also enjoins defendants' requiring any physician to disclose competitively sensitive information about any payer. This provision will ensure that defendants do not exchange information that could facilitate price fixing or other anticompetitive harm.

Section V(A) requires DAIPA and HealthCare Partners to give notice to doctors and managed care plans that each doctor currently under contract with HealthCare Partners is free to contract separately from DAIPA and HealthCare Partners. This will help abate any continuing effect from the unlawful conspiracy.

4. Conclusion

The Department of Justice believes that the proposed Final Judgment contains adequate provisions to prevent further violations of the type upon which the Complaint is based and to remedy the effects of the alleged conspiracy and DHS' exclusionary acts. The proposed Final Judgment's injunctions will restore the benefits of free and open competition in the Danbury area and will provide consumers with a broader selection of competitive health care plans.

IV.

ALTERNATIVE TO THE PROPOSED FINAL JUDGMENT

The alternative to the proposed Final Judgment would be a full trial on the merits of the case. In the view of the Department of Justice, such a trial would involve substantial costs to the United States, the State of Connecticut, and defendants and is not warranted because the proposed Final Judgment provides all of the relief necessary to remedy the violations of the Sherman Act alleged in the Complaint.

V.

REMEDIES AVAILABLE TO PRIVATE LITIGANTS

Section 4 of the Clayton Act, 15 U.S.C. § 15, provides that any person who has been injured as a result of conduct prohibited by the antitrust laws may bring suit in federal court to recover three times the damages suffered, as well as costs and a reasonable attorney's fee. Entry of the proposed Final Judgment will neither impair nor assist in the bringing of such actions. Under the provisions of Section 5(a) of the Clayton Act, 15 U.S.C. § 16(a), the proposed Final Judgment has no prima facie effect in any subsequent

lawsuits that may be brought against one or more defendants in this matter.

VI.

PROCEDURES AVAILABLE FOR MODIFICATION OF THE PROPOSED FINAL JUDGMENT

As provided by Sections 2(b) and (d) of the APPA, 15 U.S.C. § 16(b) and (d), any person believing that the proposed Final Judgment should be modified may submit written comments to Gail Kursh, Chief; Professions & Intellectual Property Section/Health Care Task Force; United States Department of Justice; Antitrust Division; 600 E Street, N.W.; Room 9300; Washington, D.C. 20530, within the 60-day period provided by the Act. Comments received, and the Government's responses to them, will be filed with the Court and published in the Federal Register. All comments will be given due consideration by the Department of Justice, which remains free, pursuant to Paragraph 2 of the Stipulation, to withdraw its consent to the proposed Final Judgment at any time before its entry, if the Department should determine that some modification of the Final Judgment is necessary for the public interest. Moreover, the proposed Final Judgment

provides in Section X that the Court will retain jurisdiction over this action, and that the parties may apply to the Court for such orders as may be necessary or appropriate for the modification, interpretation, or enforcement of the proposed Final Judgment.

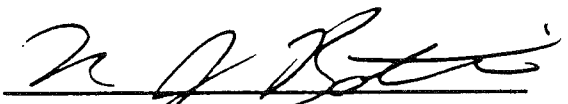
VII.

DETERMINATIVE DOCUMENTS

No materials and documents of the type described in Section 2(b) of the APPA, 15 U.S.C. § 16(b), were considered in formulating the proposed Final Judgment. Consequently, none are filed herewith.

Dated: September 13, 1995

Respectfully submitted,



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