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Dear Mr. Lipson:

This letter responds to your request, pursuant to the Department of Justice's Business Review Procedure, 28 C.F.R. § 50.6, for a statement of the Department's enforcement intentions regarding a proposed merger among three groups of gastroenterologists in Allentown, Pennsylvania. Three groups practices, Gastroenterology Associates, Ltd., GI Associates, P.C., and Valley Gastroenterologists, propose to merge into a single professional corporation specializing in gastroenterology. Based upon materials that you submitted, along with our own independent investigation, the Department of Justice cannot say at this time that it would not take enforcement action against the merger if it is consummated as proposed.

As we understand from the information you have provided, each of the above-named professional corporations has four physician-shareholders/employees who are board-certified in gastroenterology and who provide medical services to patients throughout the greater Lehigh Valley and in contiguous areas. The Lehigh Valley is situated in Eastern Pennsylvania about 60 miles north of Philadelphia. It consists primarily of two counties, Lehigh and Northampton, and three cities -- Allentown, Bethlehem and Easton. While the physicians who are proposing to merge advertise in the Yellow Pages of all three cities, none of them has privileges at the only hospital in Easton or the major hospital in Bethlehem, and only one of the groups has privileges at 148-bed Muhlenberg Hospital in Bethlehem. The merging physicians comprise 12 of the 14 gastroenterologists with business addresses in Allentown. You state that the merging physicians believe that they can maintain and improve the quality of their care, and maintain or reduce their costs, if they merge into a single practice as proposed.

Merger Analysis

The Department and the courts examine the lawfulness under the antitrust laws of a merger of physician practices using the same antitrust standards that they apply to any other merger or combination of competing entities. The Clayton Act requires the delineation of the proper "line of commerce" and "area of the country" (*i.e.*, relevant product and geographic markets) and then the evaluation of the likely economic effect of the merger in that market (or markets). The merger is unlawful if it may tend substantially to lessen competition in any relevant market by creating, enhancing or facilitating the exercise of market power. *See* Department of Justice/Federal Trade Commission Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,104 (April 2, 1992), § 2 ("Merger Guidelines"). "Market power" is generally defined as "the power to control prices [or restrict output] or exclude competition." United States v. E. I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956).

To determine whether a merger is likely to create or enhance market power, the Department first assesses whether the merger would significantly increase concentration in a properly defined market. Next, we assess whether the merger, in light of market concentration and other factors that characterize the market, raises concern about potential adverse competitive effects. We then assess whether entry would be timely, likely, and sufficient either to deter or to counteract any anticompetitive effects. When potential failure of one of the merging firms is not at issue, the last step in our analysis is to assess whether any merger-related efficiency gains not achievable by other means are sufficient to offset any potential adverse competitive effects.

A. Concentration

1. Product Market

In defining the relevant product (or service) market for a particular merger, the Department determines what substitutes, as a practical matter, are reasonably available to consumers of each product of the merging firms if the price of the product were raised by a small but significant amount. *See* Merger Guidelines at §1.11. Services provided by a particular physician specialty may often be a relevant service market. *See* Statements of Antitrust Enforcement Policy in Health Care, Issued by the U.S. Department of Justice and the Federal Trade Commission, August 1996, at 76 ("Statements"). In this case, you contend that there are several other types of specialists as well as generalists who perform some of the procedures carried out by gastroenterologists, and that therefore these other types of doctors would be reasonable substitutes for gastroenterologists in the event that the merged group were to restrict supply or raise prices for gastroenterology services. For example, you note that family practitioners and internists perform flexible sigmoidoscopies, general and rectal

surgeons perform colonoscopies, and general surgeons also perform upper endoscopies. You also state that much

routine treatment connected with stomach and intestinal disorders is handled by primary doctors without ever enlisting the services of gastroenterologists.

Payers we interviewed in this matter agree that in the Lehigh Valley area some of the procedures performed by gastroenterologists are, in fact, performed by other types of physicians. They say, however, that at least half of all colonoscopies are performed by gastroenterologists, that the vast majority of all upper endoscopic-type procedures are performed by gastroenterologists, and that flexible sigmoidoscopies are seldom performed by gastroenterologists these days, as the tendency is to go directly to a colonoscopy. Some payers declared that under no circumstances would they consider colon-rectal surgeons or other specialists to be substitutes for gastroenterologists. They also tell us that there are quality and efficiency considerations to having these procedures performed by gastroenterologists. They believe that patients suffer fewer complications and require fewer repeat procedures when the procedures are done by gastroenterologists in the first instance.

The fact that some procedures performed by gastroenterologists are also performed by other types of physicians does not mean that gastroenterologists, as a group, could not raise prices. First, payers state that in order to sell an insurance product, it is important to have a physician panel that includes a broad selection of physician categories and of physicians within each category. Potential customers ask about the scope of the panel when selecting between plans. Particularly in this area of Pennsylvania (which we are told has a particularly large Medicare population that frequently requires the attention of gastroenterologists), the presence of a variety of gastroenterologists is a critical selling point. Payers stated that they could not market a product in the Lehigh Valley area that excluded gastroenterologists but included other types of doctors who also performed some of the procedures gastroenterologists perform. Second, once the panel includes gastroenterologists, common referral practices make it difficult to steer patients away from them. Payers explain that in a managed care setting, the primary, referring physician generally does not refer a patient to a specialist to obtain a specific procedure; rather, he or she determines what type of specialist the patient needs to see based on the symptoms presented. The specialist then exercises expert judgment about the medical problem and decides what procedures are required.

The need for a broad panel and the predominance of symptom-based rather than procedure-based referral practices suggest that plans will find it difficult to discipline a price increase by moving sufficient volume away from gastroenterologists. Consequently, we have concluded that for purposes of analyzing this merger, the product or service market is the medical specialty of gastroenterology.

2. Geographic Market

Next, we determine the relevant geographic market by identifying where physicians in the relevant product market could practice in order to be good substitutes for any of the merging physicians if the prices for the merging parties' services rose by a small but significant amount. The participants in the market would comprise all gastroenterologists who currently practice in the relevant geographic market or who, in response to a price increase, would likely enter the relevant geographic market within a year and without incurring significant sunk costs. *See* Merger Guidelines at §1.3.

You have suggested that the geographic market relevant to this merger is the "Greater Lehigh Valley," which encompasses Lehigh and Northampton Counties, Carbon County to the north, the eastern portion of Berks County to the west, and the northern portion of Bucks County to the south. Within this area, you state that there are 33 gastroenterologists, of which the merging physicians would comprise 36%. Among those 33 you have identified are five gastroenterologists located in Bethlehem, three in Easton, three in Phillipsburg, New Jersey (about three miles from Easton) and one each in East Stroudsburg, Pennsylvania and Hackettstown, New Jersey. You identify the latter two physicians as being located in the "Easton area"; however, both East Stroudsburg and Hackettstown are located nearly 25 miles beyond Easton and the Lehigh Valley. You posit the "Greater Lehigh Valley" as the relevant geographic market because some, but not all, of the merging physicians perform procedures at Gnaden Huetten Memorial Hospital and Palmerton Hospital in Carbon County, and Quakertown Hospital in Bucks County. You also state that an analysis of the zip codes of patients of the three groups shows substantial patient addresses in Northampton, Bucks, Berks and Carbon Counties (albeit over 50% of all patients are located in Lehigh County). You further state that the three groups separately advertise in the Yellow Pages of Allentown, Bethlehem and Easton, and offer their services to patients in all of those cities.

It has been our experience that, in general, and especially in urban and semi-urban areas, health care geographic markets are localized, although somewhat less so for specialist markets than for primary care markets. As with assertions about product market definitions, however, we take into account the experiences of those contracting for physician services when assessing the validity of claims regarding geographic markets.

In this case, the information provided by payers suggests that the relevant geographic market is significantly smaller than the "Greater Lehigh Valley," for a number of reasons. First, payers tell us that Allentown's 659-bed Lehigh Valley Hospital ("LVH") is the pre-eminent health care facility in the area, and is the one area hospital that all managed care plans must have in their network. The merging doctors comprise a large percentage of the gastroenterologists with privileges at LVH (they are 12 of 14 with privileges, or about 86%). In addition, payers state that Sacred Heart Hospital in

Allentown is very well known for its gastroenterology program, and thus an important location for the performance of gastroenterologic procedures in the Lehigh Valley. Only eight gastroenterologists have privileges at Sacred Heart, and at least seven of these are among the merging physicians, a total of 87.5%.

The large geographic market that you have suggested would be appropriate if payers could and would defeat a small hypothetical price increase in Allentown by sending patients to the other towns you have identified. However, that does not seem to be the case. It is immaterial that the merging physicians have privileges at outlying hospitals and in fact perform procedures in places such as Lehighton and Quakertown. Payers confirmed our assessment that the availability of substitutes for Allentown gastroenterologists depends not on where the physicians are willing to travel to treat patients, but where patients are willing to travel to obtain treatment, and hence where plans can reasonably send enrollees and still be marketable.

For their patients in and around the populous Allentown-Bethlehem area, payers are concerned about the travel time, distance, and inconvenience associated with reaching appropriate substitutes if gastroenterologists in Allentown raise prices by a small but significant amount. Payers claim that, even though Bethlehem is no more than 15 minutes from Allentown, there is a significant psychological barrier in traveling from Allentown to Bethlehem to receive treatment, since the Lehigh River separates Allentown from Bethlehem. Many patients view the river as a barrier that they are not inclined to cross in order to receive medical treatment. Not surprisingly, payers generally agreed that Easton, located another 10 miles beyond Bethlehem, would be an unacceptable distance for their Allentown area subscribers to travel for gastroenterology services. For many older patients, the inconvenience and effort involved in traveling beyond Allentown for treatment are more than perceptions, and older patients are significant consumers of gastroenterology services. Payers also contend that managed care markets are so sensitive that they would be at a severe disadvantage trying to market a panel that did not include gastroenterologists in Allentown, regardless of the distance to the next best substitute.

Given these market realities, it appears that the likely relevant geographic market in which to assess the effects of the proposed merger is Allentown, and at most, Allentown and Bethlehem. The merging physicians constitute 12 of 14 board-certified gastroenterologists (85.7%) in Allentown, and 12 of 19 board-certified gastroenterologists (63%) in Allentown and Bethlehem. The actual concentration may be higher since one of the two gastroenterologists who would remain in Allentown apart from the merged entity has "emeritus" status with at least one of the local physician hospital organizations ("PHOs"), which we are told by the PHO indicates that he is over 65 years old and therefore likely soon to retire, or at least reduce his practice.[1] Thus, the

[1] We note that this particular physician is located in the same office suite and has the same telephone number as one of the merging groups, Valley Gastroenterologists.

more realistic concentration numbers may be 92.3% for Allentown, and 66.7% for the combination of Allentown and Bethlehem.

B. Potential Adverse Competitive Effects

Payers were unanimous in expressing concern about the high concentration of the Allentown gastroenterology market post-merger, and about the potential anticompetitive effects of such concentration. Payers were concerned that if they were unable to offer a sufficient panel of qualified gastroenterologists in Allentown, their health plans would become unattractive to area employers and consumers of health care services. More than one payer expressed the view that the only apparent reason for such a merger is to acquire leverage in prices for gastroenterology services.

The available facts seem to support these misgivings. For example, one managed care payer stated that the three merging groups are the only participating gastroenterologists in its plan. The plan has solicited other gastroenterologists in the area, who have refused to join its panel. Thus, the merged group would likely become a single, unchallenged negotiating entity, preventing the payer from negotiating reasonable prices for gastroenterology services. Another payer noted that it already was paying a premium for coverage in the Lehigh Valley, and that this merger could well lead to even higher prices.

Based on the information we obtained with respect to both purpose and effect, we conclude that there is a substantial likelihood that the proposed merger would cause significant competitive harm.

C. Entry

Our investigation disclosed that the likelihood of new entry of gastroenterologists into the Allentown area in response to a small but significant and non-transitory price increase is not great. First, we have been told that there is already an oversupply of gastroenterologists in the Allentown area. This is borne out by the merging physicians' willingness to travel long distances to service other geographic markets and their previous attempts to coordinate resistance to lowered fee schedules. It is also verified by hospital administrators in the area who say that, based on specialist-to-covered-lives ratios established in mature managed care markets such as California, there is an oversupply of gastroenterologists in Allentown.

Second, payers told us that essentially two hospitals (LVH in Allentown and St. Luke's in Bethlehem) dominate the Lehigh Valley market, and that both have powerful PHO networks with which no entering gastroenterologist could successfully compete. We were informed that LVH either is in the process of closing or has already closed its staff to new medical appointments, as it is attempting to reduce its numbers, particularly of specialists, to conform with managed care models

elsewhere in the country. One hospital official also noted that since one of the merging physicians is the head of the highly-regarded gastroenterology department at Allentown's Sacred Heart Hospital, he would hold approval authority over any new entrant as well as the ability to schedule procedure times and use of space in the hospital. Any new entrants into Allentown would have great difficulties in establishing a practice without access to either LVH or Sacred Heart. Finally, while managed care plans said that they would accept the applications of any new entrants, one plan representative told us that, in light of the aforementioned barriers to new entry, plans would never invest time attempting to recruit new medical school graduates into the Lehigh Valley area. Thus, we are unable to conclude that timely and sufficient entry would likely occur to offset any anticompetitive effects that this merger might produce.

D. Efficiencies

When imminent failure of one of the merging firms is not a consideration, the last step of our analysis is to examine whether merger-specific efficiencies exist to counteract any potential anticompetitive effects that the merger may produce. Merger-specific efficiencies are those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. The greater the potential adverse competitive effect of a merger, the greater must be cognizable efficiencies in order for the Department to conclude that the merger will not have an anticompetitive effect in the relevant market. Even where efficiencies can be proved, the recently revised Merger Guidelines note that efficiencies almost never justify a merger to monopoly or near-monopoly.

In this case, the merging parties have not put forth a strong efficiency justification for their merger. They state that the physicians intend to include utilization review and quality assurance monitoring in the new corporation, and to establish efficiency and quality parameters in order to provide services at a cost-effective rate. However, they do not state, for example, that they will consolidate office locations to reduce overhead or administrative expenses. Furthermore, the establishment of utilization review, quality assurance monitoring, and efficiency and quality parameters are likely all occurring already due to the physicians' participation in various networks and PHOs in the area that are positioning themselves to vie for managed care contracts, such as Eastern Pennsylvania Health Network (jointly owned by St. Luke's Hospital in Bethlehem and Sacred Heart Hospital in Allentown), and Valley Preferred PHO at Lehigh Valley Hospital. There is no contention that the merging groups could somehow achieve greater efficiencies of this type than the PHOs. The groups have not attempted to demonstrate any particular efficiencies that could only be achieved through their merger. Thus, we are unable to conclude that the merger of the three groups would produce merger-specific efficiencies that would offset its likely anticompetitive effects.

Conclusion

Given these considerations, we conclude that this proposed merger is likely substantially to lessen competition in the market for gastroenterology services in Allentown and Bethlehem. Consequently, we are unable to state that the Department would not take enforcement action against the merger if it were consummated.

This statement is made in accordance with the Department's Business Review Procedure, 28 C.F.R. § 50.6, a copy of which is enclosed. Pursuant to its terms, your business review request and this letter will be made available to the public immediately. Your supporting documents will be publicly available within 30 days of the date of this letter unless you request that any part of the material be withheld in accordance with paragraph 10(c) of the Business Review Procedure.

Sincerely,

Joel I. Klein