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Office of the Secretary
Federal Trade Commission
6th and Pennsylvania Avenue, N.W.
Washington, D.C. 20580

Dear Sir/Madam:

The purpose of this letter is to request an advisory opinion from the Federal Trade Commission ("FTC" or "Commission") on the legality of a proposed merger of two physician networks, pursuant to 16 C.F.R. Section 1.1.

I represent The Heritage Alliance ("THA"), a primary care Independent Practice Association ("IPA") based in northeastern Pennsylvania. THA and Lackawanna Physicians Organization ("LPO"), another physician network based in northeastern Pennsylvania, propose to merge by September 30, 1998. This letter seeks an opinion on whether the proposed merger is likely to be challenged by the FTC or the Department of Justice ("DOJ") (collectively, "the Agencies") as an anticompetitive merger under Section 7 of the Clayton Act, 15 U.S.C. Section 18 (1988).

This letter and the accompanying documents contain information that we believe will aid the Agencies in analyzing the proposed merger under the Horizontal Merger Guidelines ("Guidelines").[1] In addition, because this would be a merger of two entities each of which could be considered a "physician network joint venture" under Statement 8 of the Statements of Antitrust Enforcement Policy in Health Care, Issued by the DOJ and FTC, August 1996 ("Statements"), we have provided information to help the Agencies

[1] DOJ/FTC Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) Section 13, 104 (April 2, 1992).

analyze the proposed merger and the resulting physician network under the Statements as well.

Because we believe that the Statements are applicable to the proposed merger, we ask that this request for an advisory opinion receive the expedited treatment set forth in the Statements, *i.e.*, a response within 90 days of the Agencies' receipt of "all necessary information." Statements, pp. 6-7.

I. MERGER ANALYSIS

A. The Merging Parties and The Proposed Transaction

THA and LPO are both physician networks that have physician members and provide for joint marketing and provision of health care services. Both THA and LPO are "non-exclusive," *i.e.*, any physician belonging to either network may belong to any other network, and physician members are free to contract individually with managed care plans and other payers.

THA was formed in 1996 and currently has approximately 82 Primary Care Physicians ("PCPs") in its network.[2] PCPs practice in one of four areas: family practice, general practice, internal medicine, or pediatrics. 75 of the 82 THA doctors have practices based in Lackawanna (41 physicians) and Luzerne (34 physicians) counties; the remaining seven have practices based in Wayne, Wyoming, Susquehanna and Monroe counties.

[2] Several physicians are now in the process of joining THA. We will provide updated information if the staff finds it necessary during its review.

The following chart is a breakdown of the PCPs in THA:

County	Family	General	Int. Med.	Pediatrics	TOTAL
Lackawanna	11	1	23	6	41
Luzerne	25	0	4	5	34
Wayne	0	0	2	0	2
Wyoming	2	0	0	0	2
Susquehanna	1	0	1	0	2
Monroe	1	0	0	0	1
TOTAL	40	1	30	11	82

LPO was formed in December 1995, and currently has approximately 164 Specialty Care Physicians ("SCPs")[3] and 26 PCPs, all with practices based in Lackawanna County. The following chart is a breakdown of the LPO physicians by specialty:

Specialty	# of LPO Physicians
Allergy & Immunology	1
Anesthesiology	8
Cardio Diseases	7
Cardio Surgery	2
Dermatology	3
Endocrinology	1
Family Practice	3
Gastroenterology	7

Specialty	# of LPO Physicians
General Practice	1
General Surgery	20
Gynecology	1
Hematology/Oncology	8
Internal Medicine	16
Neurology	5
Neurosurgery	4
Obstetrics/Gynecology	12
Ophthalmology	11
Orthopedic Surgery	14
Otolaryngology	3
Pathology	4
Pediatrics	6
Phy. Med. & Rehab.	6
Plastic Surgery	2
Podiatry	4
Psychiatry	1
Pulmonary Disease	2
Radiation Oncology	3
Radiology	27
Rheumatology	1
Thoracic Surgery	1
Urology	6
TOTAL	**190**

[3] SCPs are physicians with a specialty other than the four PCP specialties.

On November 3, 1997, THA and LPO entered into a strategic alliance agreement to develop a regional alliance of primary care and specialty physicians. In keeping with this agreement, a formal Strategic Alliance is being created in the form of a Management Service Organization ("MSO"), which has not yet been named. Although currently THA and LPO maintain their separate legal autonomy and independent governance, THA and LPO intend to merge by September 30, 1998, and form a new multi-specialty based physicians network, which we will call, for purposes of this letter, "THA/LPO."

THA/LPO would negotiate both risk and non-risk contracts with payers, provide medical management services and practice management support to its members (through the MSO), and market its services on behalf of its members. The MSO will have an Interim Board consisting of seven physicians, 5 PCPs and 2 SCPs.

The current plans call for the MSO to be located at the corporate headquarters of THA, namely 212 East Drinker Street, Dunmore, Pennsylvania. During the pendency of the Agencies' review of the legality of the proposed merger, LPO and THA will remain separate legal entities, with separate boards of directors and separate administrators. Each will work with the MSO to arrange for joint contracting with payers and joint management of those contracts through the MSO. Merger discussions and plans will continue during the pendency of this review.

If the proposed merger takes place, THA/LPO would recruit new physician members, provide all physicians in the network with joint marketing and purchasing opportunities, and negotiate contracts with payers. The MSO would manage all payer contracts, provide utilization and quality management, and manage risk pools. Personnel of the MSO and THA/LPO would be shared.

B. Service and Geographic Markets

1. Service Market

The Statements provide guidance on the question of the relevant service market[4] that should apply in analyzing the proposed merger. In discussing product/service market in the context of physician network joint ventures, the Agencies state: "Although all services provided by each physician specialty might be a separate relevant service market, there may be instances in which significant overlap of services provided by different physician specialties, or in some circumstances, certain nonphysician health care providers, justifies including services from more than one physician specialty or category of providers in the same market." Statements, p. 76.

One relevant service market in which to analyze the competitive effects of the proposed merger is PCP services. This is a logical choice because it is the service market in which THA and LPO overlap. In addition, all PCPs act as "gatekeepers" under managed care plans, and thus offer a service to enrollees of managed care plans that SCPs do not, namely, initial evaluation of a patient's condition before referral to a SCP. Thus, managed care enrollees who need an initial diagnosis would go to a PCP and would not switch to a SCP in response to a 5-10% price increase by all PCPs. Subscribers of indemnity plans would probably not switch to a SCP in response to such a price increase either, because a PCP typically can evaluate a range of conditions whereas a SCP is narrowly focused on his or her specialty. For these reasons it seems clear that PCP services and SCP services should be considered separate service markets.

[4] Because we are dealing with health care services, this letter will use the term "service market" rather than "product market."

The more difficult question is whether the PCP specialty services -- family practice, general practice, internal medicine and pediatrics – should be considered as part of one large PCP service market or as separate service markets. In general, all PCPs perform the same services, regardless of whether they are family practitioners, general practitioners, internal medicine physicians or pediatricians. So, theoretically, patients could switch among all PCPs in response to a 5-10% price increase by all the physicians of one PCP specialty.

However, in Lackawanna County, there are factors which tend to suggest four, or at least three,[5] separate PCP markets. First, unlike some rural areas where family practitioners treat children and adults, Lackawanna County pediatricians generally treat only children. Thus, an adult patient of a family practice physician, for example, would not be able to switch to a pediatrician in response to a 5-10% price increase by all family practice physicians in the market. In addition, while family practice and internal medicine physicians treat patients of all ages, some internal medicine physicians have specialties which make them more qualified to handle certain types of procedures.

The Commission has signaled that separate markets within PCP services may be appropriate in some instances. In the FTC's advisory opinion letter concerning Yellowstone Physicians, L.L.C.,[6] the Commission staff analyzed a physician network under the primary care specialty fields of family practice, internal medicine and pediatrics. The Lackawanna County Medical Society, whose members include approximately two-thirds of the physicians in Lackawanna County, contains in its directory separate listings for family practice, general practice, internal medicine and pediatrics. Lists of physicians provided by local hospitals contain similar breakdowns.

[5] There appears to be little difference between family practice physicians and general practice physicians. Because every physician list we looked at listed them separately, however, we consider them as separate service markets, as well as part of an overall PCP service market.

Thus, while there is undoubtedly some overlap among the three types of PCPs, we have considered the effects of the proposed merger in both an overall PCP market, as well as separate markets consisting of family practice, general practice, internal medicine, and pediatrics.

2. Geographic Market

The geographic market in which to analyze the competitive effects of the proposed merger is most likely Lackawanna County, the overlap area.[7] Lackawanna County sits in an area once known for producing anthracite coal, but which has seen population decline steadily in the past fifty years with the decline of coal as a home heating source. Northeastern Pennsylvania has a very high Medicare population, one of the highest in the nation. As of the 1990 census,[8] Lackawanna County had just over 219,000 residents. The largest municipality is the City of Scranton, with a population of approximately 82,000. Scranton is the third-largest city in the state and is clearly the health care center of Lackawanna County. The three major hospitals in the county, Mercy Hospital, Community Medical Center, and Moses Taylor Hospital, are located in Scranton.[9]

Scranton is surrounded by several residential areas, each of which has its own business district, but none that approaches Scranton in terms of size or influence. These suburbs include the Borough of Dunmore (population 15,000), the City of Carbondale (population 11,000), Old Forge (9,000), Blakely (7,000), Taylor (7,000), Archbald

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[6] May 14, 1997, letter from Robert F. Leibenluft, Assistant Director, to David V. Meany, Esq..
[7] A map of northeastern Pennsylvania is attached to this letter as Exhibit A.
[8] All population figures in this letter are 1990 Census figures, rounded to the thousands.
[9] Two smaller hospitals in Lackawanna County are Marian Community Hospital in Carbondale and Mid-Valley Hospital in Peckville.

(6,000), Dickson City (6,000), South Abington Township (6,000), Clarks Summit (5,000), Moosic (5,000), Olyphant (5,000), Scott Township (5,000), and several smaller communities. Many physicians have offices in these communities.

The nearest city of comparable size to Scranton is Wilkes Barre, approximately 15 miles south of Scranton in Luzerne County. Interstate route 81 runs directly from downtown Scranton to Wilkes Barre, a trip that takes about 25-30 minutes by car. While accessible, Wilkes Barre is not generally viewed by residents of Scranton and Lackawanna County as an alternative location for services, including health care services. There has historically been a psychological barrier separating the two cities, such that Scrantonians do not routinely travel to Wilkes Barre for services, and vice versa. The remaining counties that surround Lackawanna are rural counties – Wyoming County to the west, Susquehanna County to the north, Wayne County to the east, and Monroe County to the southeast. Physicians in these counties generally are not viewed as alternatives for patients in Lackawanna County. While there are some physicians in those counties who see some patients from Lackawanna County, it is unlikely that sufficient numbers of patients would switch to physicians outside the county in response to a 5-10% price increase by all physicians in the county, so as to make the price increase unprofitable.

The zip code data that we have been able to obtain from physicians in THA showing where their patients reside support the notion that Lackawanna County defines the relevant geographic market. Two family practice groups, each with four physicans who are members of THA, confirm that 100% of their patients live in a Lackawanna County zip code.[10] Two other physicians, each located in Wyoming County (adjacent to

[10] One of the groups, located in Scranton, reports a patient population from throughout the county, with 20% residing in Scranton, 15% in Dickson City, 12% in Dunmore, 10% in Clarks Summit, and the rest living in other communities within the county. The other group, located in Clarks Summit, reports that 75%

Lackawanna County to the west), report that a majority of their patients live in a Wyoming County zip code.[11]

While this sampling of data is obviously not definitive proof of the relevant geographic market, it tends to confirm our belief that Lackawanna County is the relevant geographic market for PCP services. These data suggest that managed care plans could not substitute PCPs based outside the county for Lackawanna County PCPs, in the event of a 5-10% price increase by all Lackawanna County PCPs.

We attempted to obtain more complete zip code data from the physicians in both THA and LPO. Many of them do not keep such data, and for some collecting the data and aggregating it for each zip code would be very burdensome. If the Commission staff finds it necessary to see more of these data, we will attempt to provide a larger sample.

For all these reasons, the most likely geographic market in which to analyze the effects of the proposed merger is Lackawanna County.

We have considered the possibility that smaller geographic markets could exist within the county, defined by municipalities or regions. The most likely of such markets would be the City of Scranton. But because of the many PCPs with offices outside the city which are easily accessible to patients of Scranton PCPs, it is unlikely that all PCPs in Scranton could impose a price increase of 5-10% without losing sufficient numbers of

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of its patients live in Clarks Summit, 10% in Scranton, and the rest live in other communities within the county.

[11] One of the physicians reports that 71% of his patients live in Wyoming County, and 29% live in a Lackawanna County zip code just over the Wyoming/Lackawanna County line. The other physician reports that 64% of his patients live in zip codes in Wyoming County and the remainder live in Sullivan, Bradford and Susquehanna Counties, with no patients from Lackawanna County. While these data say more about Wyoming County than they do about Lackawanna, they do suggest that the region's health care demand is defined, to an extent, by county lines.

patients to PCPs in surrounding communities to make the price increase unprofitable. Thus, we have not analyzed the effects of the proposed merger on a Scranton market.

C. Concentration

Standard market concentration analysis using HHI data does not seem useful as an indicator of the effect of this proposed merger on competition. Here we have a merger of two non-exclusive physician networks. HHI analysis breaks down in this case, for two reasons.

First, the physician members of both THA and LPO are, and would remain after the merger, independent contractors, free to compete with each other for payer contracts outside of the network. The presence of competition among the physicians within a network lessens the reliability of that network's "market share" figure.

Second, non-exclusive physician networks are not really distinct competitors with each other, because they often share physicians. Indeed, twelve physician members of THA are also members of LPO. Six members of THA are also members of Northeastern Pennsylvania Physicians Organization ("NEPPO"), a network that "competes" with THA. The HHI figures would be skewed in one direction or another depending on which network is assigned these physicians. For these reasons, we have not done HHI calculations for this analysis.

There are 236 PCPs in Lackawanna County. THA/LPO would have 55 PCPs based in Lackawanna County.[12] This is a market share of 23%. There are several other physician networks in Lackawanna County. The largest is NEPPO, which has

[12] The total obtained by adding the combined figures for THA and LPO is 67, but 12 physicians are members of both networks.

approximately 45 PCPs in Lackawanna County. Other physician networks include Physicians Health Alliance (approximately 20 PCPs in the county), InterMountain Health Group MSO (9 PCPs), Penn State Geisinger physician group (15 PCPs), and Lackawanna Medical Group (4 PCPs).

There is an adequate supply, if not an oversupply, of PCPs in Lackawanna County now, and the proposed merger would have very little effect on competition because of the availability of so many alternatives in the market.

In each PCP specialty as well, there would be many alternatives available in Lackawanna County after the merger. In all four PCP specialties, THA/LPO would have less than 30% of the market, the "safety zone" threshold for non-exclusive networks under the Statements. The post-merger market share of THA/LPO would look like this:

PCP Specialty	THA/LPO	Lack. County	Market Share
Family Practice	13	62	21%
General Practice	2	14	14%
Internal Medicine	33	131	25%
Pediatrics	7	29	24%
TOTAL	**55**	**236**	**23%**

As in an overall PCP market, there would be many alternatives in each of the PCP specialties after the merger.

Thus, in both a PCP market and in the specialty PCP markets, analysis of the combined market share of THA/LPO indicates that the proposed merger is unlikely to significantly lessen competition in Lackawanna County.

D. Competitive Effects

The post-merger marketplace would have many competitors, making coordinated interaction that lessens competition difficult. There is, as far as we know, no history of collusion among physicians in Lackawanna County. Nor would THA/LPO have unilateral market power, because of the number of PCPs in the county.

Moreover, the buyers of health care services in northeastern Pennsylvania are becoming larger and more sophisticated as managed care penetration increases. HMO enrollment in Lackawanna County has increased significantly in the last three years. New HMOs have entered the market in recent years, including Aetna US Healthcare, Health America, Physicians Care, and QualMed. These payers have the size and sophistication to prevent any anticompetitive behavior by physicians. Indeed, it is partly because of the increased size and sophistication of the payers in this market that the physicians are seeking alliances to be able to compete on a more level playing field.

The proposed merger may even have a pro-competitive effect. NEPPO is now the largest physician network in the county. NEPPO has to this point pursued exclusivity as a market strategy, particularly with Blue Cross/Blue Shield of Northeastern Pennsylvania. The proposed merger would give THA a network of specialists it does not have, and would give LPO a large number of PCPs it does not have. In simple terms, the proposed merger may cause THA/LPO to be a stronger competitor to NEPPO than either THA or LPO could be on their own. Because THA/LPO would be non-exclusive, this effect would be pro-competitive.

E. Entry

There are no apparent barriers to entry into a PCP practice in Lackawanna County. A physician must have the necessary education and credentialing, like any other professional, and the ability to set up a practice, either alone or with other physicians.

The major hospitals in Lackawanna County are open to new entrants, and routinely grant privileges to recent medical school graduates. Temple University Medical School has a Scranton residency program which supplies the hospitals with newly-graduated physicians on a routine basis. Moses Taylor Hospital, one of the three major hospitals in Scranton, saw seven new PCPs join its staff so far in 1997. There is no indication that this trend is likely to decrease in the near future. Nor has there been any activity by the hospitals, physician networks, or managed care plans to close their panels or limit in any other way the entry of new physicians into this market.

As we point out above, however, there is currently an adequate supply, if not an oversupply, of PCPs in Lackawanna County. This condition would seem to make entry by a new PCP into the county difficult, as he or she must either displace existing PCPs or rely on new patients moving into the county. So far this condition has not appeared to limit entry. It should also be noted that entry as a sole practitioner is becoming increasingly difficult. The expansion of managed care in Lackawanna County and the increasing formation of physican networks offering payers a broad array of choices make entry by a sole practitioner PCP increasingly difficult in this market.

All of these factors together suggest that entry into the PCP market in Lackawanna County is likely to be timely and sufficient to counteract any anticompetitive effect of the proposed merger.

F. Efficiencies

The revised efficiency standard in the Merger Guidelines states that "mergers have the potential to generate significant efficiencies by permitting a better utilization of existing assets, enabling the combined firm to achieve lower costs in producing a given quantity and quality than either firm could have achieved without the proposed transaction. Indeed, the primary benefit of mergers to the economy is their potential to generate such efficiencies." Such efficiencies would result from this merger.

THA/LPO would integrate the practices of the member physicians in several specific ways, leading to significant efficiencies. THA/LPO, through the MSO, would have a coordinated MIS system; joint purchasing of medical malpractice insurance, office supplies, and other necessities; joint marketing opportunities for member physicians; and joint contracting. There would be an Operations Management and Information Systems Committee, which would advise the Board of Directors regarding the selection of information systems to assist physicians in becoming more productive and efficient, and for the purpose of collecting and charting data on the operational management of the network, and the clinical performance, outcome, and utilization for each sponsored arrangement.[13] Significant cost savings would inevitably result from such integration.

[13] These data would include, but not be limited to: (1) total number of physician visits and visits per enrolled person per year; (2) total number of hospital admissions and admissions per enrolled person per year; (3) total number of hospital days and days per enrolled person per year; (4) average length of stay per hospital confinement; (5) total number and type of consultations outside of THA/LPO's systems and consultations per enrolled person per year; (6) total number of emergency room visits and emergency visits per enrolled person per year; (7) total number of laboratory procedures and procedures per enrolled person per year: (8) total number of x-ray and other radiological procedures and procedures per enrolled person per year; and (9) total number of enrolled persons in each sponsored arrangement at the end of the year, persons enrolled during the year, and terminating persons during the year.

Moreover, a Credentialing Committee would carefully select physicians to participate in THA/LPO based upon a screening process of the physician's credentials, professional history, professional liability claims history, disclosure information, office and/or hospital practice and sanction status. Only physicians who are likely to further the efficiency goals of the network would be selected.

Current plans include a $5 million capitalization plan in order to pay for the infrastructure that would be required to accomplish these efficiency goals.

The revised efficiency statement in the Guidelines specifically points to such marginal cost savings as having the potential to reduce the merged firm's incentive to raise prices above competitive levels. These efficiencies, in addition to reducing the incentive to raise price, would improve the quality of the medical care provided by the physicians by allowing them to spend more time and effort practicing medicine and less time on administrative details, which would be handled by the MSO staff.

The efficiencies to be generated by the proposed merger are merger-specific. Neither THA nor LPO could achieve such cost savings without the merger. Each would be spreading their costs over a dramatically larger number of physicians. Only by consolidating staff, office equipment, MIS systems, and other overhead could they realize such cost reductions.

G. Conclusion

The proposed merger of THA and LPO is not likely to substantially lessen competition for PCP services in Lackawanna County, Pennsylvania. The existence of numerous other PCPs in the county and the presence of increasingly large and sophisticated payers indicate that the proposed merger does not pose a threat to competition. The proposed merger would be complementary for both THA and LPO, adding specialist physicians to THA's strong network of PCPs, and providing LPO with additional PCPs and a broader geographic reach. Entry is not difficult in this market, and the proposed merger presents the opportunity for specific efficiencies that could not be achieved absent the merger. The proposed merger does not violate Section 7 of the Clayton Act. We respectfully submit that the Agencies should not initiate any enforcement action concerning the proposed merger.

Because the revised Statements shed new light on the Agencies' treatment of physician network joint ventures, we now provide information to assist the Agencies in analyzing the legality of the network that would survive the proposed merger.

II. JOINT VENTURE INFORMATION

Related to the question of the legality of the proposed merger of THA and LPO is the question of the legality of the structure of THA/LPO. This question should, it seems, be governed by the Statements, specifically Statement 8 concerning "physician network joint ventures." Statement 8 defines a physician network joint venture as "a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services" (p. 62). It appears that THA/LPO, under current plans, would fit within this definition.

Adhering to the Commission staff's suggestions on information to be submitted with requests for advisory opinion letters concerning joint ventures,[14] we provide each of the suggested items of information below.

A. Name, address, legal form and ownership structure of the venture

1. **Name**: To be determined. For purposes of this letter, we use THA/LPO.
2. **Address**: 212 East Drinker Street, Dunmore, Pennsylvania 18512.
3. **Legal Form**: Corporation formed under Pennsylvania law.
4. **Ownership Structure**: Shares in the new venture will be sold to investors.

B. Participants in the venture and the nature of their business and contributions to the venture

Participants in the venture include the 82 PCPs currently in THA and the 164 SCPs and 26 PCPs currently in LPO (12 physicians are members of both networks). Each of the physicians provides medical care to patients.

The nature of the business of PCPs is discussed in the service market analysis, *supra* Section I.B.1.

[14] *See* Moreland, Judith A., "Overview of the Advisory Opinion Process at the Federal Trade Commission," presented at the National Health Lawyers Association, Antitrust in the Health Care Field, Washington, D.C., February 13 and 14, 1997.

The specialist physicians in LPO offer specialized healthcare services not normally offered by PCPs. They may treat all patients that the PCPs treat, but only for particular types of care, such as cardiology, hematology, etc.

The physicians may be required to make an initial capital contribution to the new entity. In addition, each would contribute their time and energy towards making THA/LPO work. In addition, there would be a full-time staff for the network made up of current employees of THA and LPO, and possibly employees not yet named.

C. Purpose and objectives of the venture and any limitations on its activities

1. Purpose and Objectives

The purpose of the combined network is to create a fully integrated, multi-specialty based physician network that would be efficient, and therefore beneficial to patients, payers, physicians and other health care providers. The objectives of THA/LPO are:

(a) forming a regional approach to organizing and delivering health care which responds to market needs;
(b) developing a true economic partnership between physicans, hospitals, health systems and purchasers in which risk is shared and incentives are aligned;
(c) integrating delivery and financing to encourage cost-effective use of services;
(d) performing primary and preventive care;
(e) providing a comprehensive continuum of health care services across settings and levels of care;

(f) implementing a plan of outcome-focused care appropriately incorporating education, science and information technology; and

(g) satisfying member needs and maintaining the health and well-being of patients.

2. Limitations on THA/LPO's activities

THA/LPO would be "non-exclusive," *i.e.*, the network would not prevent a member physician from joining another physician network, physician hospital organization, or managed care plan, or from entering into payer contracts outside of those entered into by THA/LPO.

In addition, THA/LPO and its member physicians would be independent legal entities whose relationship to each other would be that of independent contractor. The relationship between THA/LPO and the member physicians would not be considered that of employer and employee, partnership, joint venture,[15] or any relationship other than that of independent contractor.

Another limitation on THA/LPO's activities is that, despite physician participation in Quality Assurance and Utilization Review programs to be set up by THA/LPO, the network would not interfere with or in any way affect the physician's obligation to exercise independent medical judgement in rendering health care services to patients. THA/LPO would not force the physician to accept additional patients if the physician does not have adequate resources to treat the additional patients or other appropriate reason, provided the payer contract does not specifically prohibit such

[15] Notwithstanding this provision in the contemplated physician participation agreement between THA/LPO and the physician participants, Statement 8 would still seem to apply, as THA/LPO would fall within the definition of "physician network joint venture" set forth in the Statements.

closing. Physicians would retain ownership of assets, including the building in which they practice, equity and supplies specific to their practice.

D. All products and services to be offered by the venture

THA/LPO would offer primary care and specialty care physician services to health care payers. The preferred basis of THA/LPO's agreements with payers is a full medical capitation to manage total healthcare services for those enrollees who choose a THA/LPO physician. THA/LPO would provide to payers a quality control program that would include reports on the quality of services delivered by THA/LPO providers. In addition, THA/LPO would provide an integrated delivery system that would be overseen by the physicians themselves and managed by THA/LPO.

For physician members, THA/LPO would offer opportunities for joint marketing, purchasing, and contracting. Through the MSO, THA/LPO would manage payer contracts, provide utilization review and quality assurance services, and manage risk pools to ensure that the network is meeting cost-containment targets. THA/LPO would put into place risk management programs during 1998, and would begin managing risk in 1999.

E. Extent to which participants already produce the products or services to be offered by the venture

Both THA and LPO currently offer medical services to health care payers. THA currently offers only PCP services, while LPO offers both SCP and PCP services. Both also offer practice support, and joint marketing and contracting to their respective physician members. Although both THA and LPO are attempting to establish risk management plans, neither has accepted any risk to this point.

F. Identity and significance of competitors to the venture

There are approximately 600 physicians in Lackawanna County, many of whom now compete with THA and LPO physicians, and would continue to so compete after the proposed merger. Some physicians in the county have formed competing networks. The most significant by far is NEPPO, which has 45 PCPs in the county. NEPPO's member physicians include most of the physicians employed by Community Medical Center, one of the three major hospitals in the county. As discussed in Section I.D. *supra*, NEPPO has had an exclusive contract with Blue Cross/Blue Shield of Northeastern Pennsylvania, which has the largest HMO in Lackawanna County. Other physician networks in Lackawanna County are discussed in Section I.C. *supra*.

The Wyoming Valley Health Care System ("WVHCS"), a hospital in Wilkes-Barre, owns a physician group with approximately 150 employed physicians. WVHCS is the dominant player in the Wilkes-Barre area (Luzerne County), which, as explained in Section I.B.2 *supra*, should be considered a separate geographic market from Lackawanna County.

G. Any restrictions on the ability of the participants to compete with the venture

THA/LPO would be non-exclusive. The physician participation agreement used by THA, which would be used by THA/LPO, states: "Physician's participation in Network will not be deemed in any manner to be exclusive and Physician will be free to participate in or become a member of any other independent practice association, physician hospital organization, or managed care plan."

However, as part of the physician participation agreement, each physician would agree not to enter into any contract, other than the THA/LPO contract, with respect to a

product of a payer if THA/LPO has a contract with respect to such product and/or negotiated a contract with respect to such product on physician's behalf, and the physician has elected to participate in such product pursuant to the provisions of the participation agreement. Upon notice by the network that it is negotiating with a payer, the physician would agree not to enter into any negotiation or execute any agreement with said payer. If no agreement is reached, or the physician elects not to participate in the network's agreement with the payer, the physician agrees not to negotiate with said payer for ninety days after receipt of notice from the network that negotiations have either terminated or physician has elected not to participate.

An amendment to the participation agreement concerning a separate contract between THA and Aetna US Healthcare ("USHC") contains a non-competition clause stating that during the term of the participation agreement and for a period of one year thereafter, the physician "agrees not to compete with the Network or USHC in owning, operating or managing a competing licensed HMO, licensed point of service (POS) plan or licensed risk bearing preferred provider organization (PPO) in Pennsylvania."

H. Any restrictions on the exchange of information among the participants

There would be no restrictions on the exchange of information among the participants, except with respect to "confidential information" considered the property of THA/LPO. "Confidential information" is defined in the participation agreement as follows: "the information made available to or developed by Network, including but not limited to compensation schedules, payer contract terms, mailing lists, patient lists, employer lists, utilization management procedures, quality assurance policies and programs, internal risk management programs and policies, programmatical information

and structure and related information and documents concerning the planning, structure and operation of Network or a particular product."

Medical records would be considered confidential, and member physicians would agree to comply with all state and federal laws regarding their confidentiality.

I. The projected ten largest customers for products or services to be offered by the venture and the projected volume of their purchases

THA/LPO would assume the current payer contracts of THA, which include the following payers: USHC, Pennsylvania Healthmate, Inc. (Medicaid product), Pennsylvania Physician Healthcare Plan, Inc., and Three Rivers Health Plans, Inc. (Medicaid product).[16] THA is currently in discussions to sign contracts with First Priority HMO and First Point PPO (Blue Cross of Northeastern Pennsylvania), QualMed HMO, and HealthAmerica HMO.

THA has forecasted the anticipated revenue to THA/LPO from the four payers with which THA currently holds contracts. Approximately 59% of the projected contractual revenues for 1998 would be from USHC. In terms of covered lives, the projection is 17,500 by the end of 1998: 11,000 from USHC, 3,000 each from Healthmate and Three Rivers, and 500 from Physicians Care. If THA/LPO is able to secure contracts with First Priority, HealthAmerica, and QualMed, the projection is a total of 25,000 covered lives by the end of 1998. By the end of 1999, projected covered lives total 25,500: 14,500 from USHC, 5,000 each from Healthmate and Three Rivers, and 1,000 from Physicians Care. The projection for the end of 2002 is a total of 44,000 covered lives, or 50,000 with First Priority, HealthAmerica, and QualMed contracts.

[16] LPO has contracts with Healthmate and Three Rivers.

J. Entry conditions in the market in which the venture will operate

See discussion of entry, *supra* Section I.E.

K. The efficiencies to be achieved through the venture

See discussion of efficiencies, *supra* Section I.F.

L. Documents relating to the legal structure of the venture or its competitive and legal implications, and business plans of the venture and its participants

See Exhibits B-D, attached to this letter.

III. APPLYING STATEMENT 8 ON PHYSICIAN NETWORK JOINT VENTURES TO THA/LPO

A. Relevant Service and Geographic Markets

When analyzing the legality of a physician network joint venture, the Statements say that the Agencies will define the relevant product (or service) and geographic markets in which to analyze the network. Here we must look not only to the overlap markets (see Sections I.B.1 and 2, *supra*) but the non-overlap markets as well. For the relevant service market analysis, this means determining the relevant service market in which SCPs compete; for geographic market analysis, it means determining the relevant geographic market for SCP services, and determining the relevant geographic market for those PCPs currently in THA whose offices are in counties outside Lackawanna.

1. Service Market

Each of the specialty areas in which LPO physicians currently practice should be considered a separate service market. This was the Commission staff's determination in the Yellowstone Physicians matter,[17] and seems the only logical way to analyze the service market. A simple example illustrates the point: a patient who has serious heart trouble needs to see a cardiologist, and would not switch to a PCP or another SCP in response to a 5-10% increase in the price of all cardiologists' services.

2. Geographic market

It is said that SCP markets may in certain circumstances be less localized that PCP markets,[18] presumably on the theory that people will travel further for specialist services. This does not appear to be the case in this market. The executive director of LPO believes that Lackawanna County defines the boundaries of the market for all SCP services. While Wilkes Barre does offer many SCPs, they are generally not viewed as alternatives for Lackawanna County patients, for reasons of distance, both actual and psychological, discussed above (see Section I.B.2, *supra*). Consequently, managed care plans could not substitute Luzerne County SCPs for Lackawanna County SCPs in response to a 5-10% price increase by all Lackawanna County SCPs.

There are Lackawanna County patients who will travel to Philadelphia (approximately 130 miles from Scranton) to obtain the services of a particular hospital or

[17] In a recent business review letter concerning a proposed merger of three gastroenterology groups, DOJ held that gastroenterology services define a relevant service market in Allentown, Pennsylvania (approximately 70 miles south of Scranton). *See* Letter from Joel I. Klein, Acting Assistant Attorney General, to Donald H. Lipson, Esq., July 7, 1997 ("Lipson letter").

[18] *See* Lipson letter, *supra* note 17.

SCP, especially in serious or life-threatening situations. However, these patients are usually choosing that Philadelphia physician or hospital based on reputation and quality, and not on price. Thus, Philadelphia SCP services cannot be considered part of this market.

We therefore believe that Lackawanna County is the relevant geographic market in which to analyze the legality of the THA/LPO network.

THA/LPO would also have the following PCPs, all current members of THA, in counties surrounding Lackawanna:

Luzerne County	25 family practice
	4 internal medicine
	5 pediatrics
Wayne County	2 internal medicine
Wyoming County	2 family practice
Susquehanna County	1 internal medicine
	1 family practice
Monroe County	1 family practice

Of these five counties, the only county in which THA/LPO could possibly be anticompetitive is Luzerne County. THA/LPO's presence in the other four counties is so minimal as to make it unlikely to have any effect on those markets. For all the reasons discussed above for Lackawanna County, Luzerne County would seem to define a relevant geographic market. Luzerne County has many of the same characteristics that led us to conclude that Lackawanna County defines a relevant geographic market for PCP services (*See* Section I.B.2 *supra*). Thus, we will consider the effect of THA/LPO on a Luzerne County geographic market.

B. Competitive Effects of the Venture

1. "Safety Zones"

In analyzing the competitive effects of THA/LPO, we first determine whether any of the markets qualify for "safety zone" treatment. The Statements set out "safety zones" for non-exclusive joint ventures in which "physician participants share substantial financial risk and constitute 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant market."

a) Lackawanna County

i) PCP market

In an overall PCP market in Lackawanna County, THA/LPO would qualify for the safety zone, assuming it is found that the physician participants share substantial financial risk. As discussed in Section I.C. *supra*, THA/LPO would have 23% of the PCPs in Lackawanna County, well within the safety zone for non-exclusive joint ventures.

ii) SCP markets

There is no county-wide listing of physicians by specialty. In lieu of such a list, we cross-checked several lists, including the Lackawanna Medical Society list of members (approximately two-thirds of the physicians in the county), lists of physicians provided by four of the five hospitals, and the Yellow Pages.

The following table represents our best estimate of the relevant percentages in the specialties:

Specialty	THA/LPO	Lack. County	Percentage
Allergy & Immunology	1	5	20%
Anesthesiology	8	25	32%
Cardio Diseases	7	35	20%
Cardio Surgery	2	4	50%
Dermatology	3	7	43%
Endocrinology	1	5	20%
Family Practice[19]	13	62	21%
Gastroenterology	7	12	58%
General Practice	2	14	14%
General Surgery	20	40	50%
Gynecology	1	1	100%
Hematology/Oncology	8	9	89%
Internal Medicine[20]	33	131	25%
Neurology	5	12	42%
Neurosurgery	4	8	50%
Obstetrics/Gynecology	12	28	43%
Ophthalmology	11	17	65%
Orthopedic Surgery	14	22	64%
Otolaryngology	3	8	38%
Pathology	4	15	27%

[19] The total obtained by adding the THA and LPO family practice figures is 14, but one family practice physician is a member of both networks.

Specialty	THA/LPO	Lack. County	Percentage
Pediatrics[21]	7	29	24%
Phys. Med. & Rehab.	6	11	55%
Plastic Surgery	2	8	25%
Podiatry	4	38	11%
Psychiatry	1	24	4%
Pulmonary Disease	2	10	20%
Radiation Therapy	3	9	33%
Radiology	27	38	71%
Rheumatology	1	5	20%
Thoracic Surgery	1	11	9%
Urology	6	8	75%

Using these figures, fourteen of the THA/LPO specialties would qualify for the safety zone for non-exclusive networks (assuming the physicians share substantial financial risk). These are allergy and immunology, cardio diseases, endocrinology, family practice, general practice, internal medicine, pathology, pediatrics, plastic surgery, podiatry, psychiatry, pulmonary disease, rheumatology, and thoracic surgery. Nine specialties are in the 30-50% range: anesthesiology, cardio surgery, dermatology, general surgery, neurology, neurosurgery, obstetrics/gynecology, otolaryngology, and radiation oncology. In eight specialties the percentage is greater than 50%.

Because of the pro-competitive aspects of the combined network, such as risk sharing and efficiency-enhancing integration that are discussed in Sections III.C.-G. *infra*, we believe that the venture qualifies for "rule of reason" treatment. We recognize,

[20] The total obtained by adding the THA and LPO internal medicine figures is 39, but 6 internal medicine physicians are members of both networks.

however, that the high percentage of physicians in THA/LPO in these eight specialties could be a cause for concern. There are, however, business reasons for inclusion of such percentages of SCPs in the network.

In some specialties, one or several practice groups constitute a majority of the specialists in the county. In order to make the panel of specialists attractive to payers and enrollees, it is necessary to include these practice groups in the network.[22] It would be impractical to offer membership in the network to some physicans in the practice group but not to others.

Moreover, the incentive structure that would be put in place by the MSO -- including risk pools, utilization review, and withholds from physician compensation until cost-containment targets are reached -- would ensure that the physicians in these specialties with high percentages do not attempt to raise prices above competitive levels. As we explain in more detail in Sections III.C.-G. *infra*, THA/LPO would be non-exclusive, there would be substantial financial risk sharing, and there would be physician integration producing significant efficiencies. There would be no sharing of competitively significant terms such as price among the physicians in these specialties, so there would be little risk of anticompetitive "spillover" effects on non-network contracts.

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[21] The total obtained by adding the THA and LPO pediatrics figures is 12, but 5 pediatricians are members of both networks.

[22] For example, one practice group, Hematology Oncology Associates of Northeast PA, includes 8 of the 9 hematologists in the county. A similar situation exists in ophthalmalogy (Northeastern Eye Institute has 10 of the 17 ophthalmalogists in the county as members); physical medicine and rehabilitation (Northeast Rehab Associates PC has 7 of the county's 11 specialists); orthopedic surgery (three practice groups, Cesare Metzger Coyle PC (4 physicians), Professional Orthopedic Associates (4 physicians), and Steindel Malloy Cronkey Chiavacci (5 physicians), together make up 13 of the 22 orthopedic surgeons in the county); radiology (three groups, M Radiological Associates Inc., Radiological Consultants Inc., and Radiological Group Inc., together make up 28 of the 38 radiologists in the county); and urology (Delta Medix PC has 5 of the 8 urologists in the county) .

Thus, the fact that a high percentage of physicians in one specialty would be members of the same non-exclusive network should not, by itself, lead to an Agency challenge to this network. Consideration of the incentive structure to be implemented should, we believe, tip the scales in favor of approving the THA/LPO network even in the markets where percentages would be high.

b) Luzerne County

The other geographic area of potential concern is Luzerne County, where THA/LPO would have 25 family practice physicians, 4 internal medicine physicians and 5 pediatricians. There are at least 59 family practice physicians in Luzerne County,[23] making THA/LPO's percentage in that market 42%. While this is too high to qualify for safety zone treatment, it should be analyzed under the rule of reason. Because of the incentive structure, the non-exclusivity, the financial risk sharing and the physician integration contemplated for THA/LPO, the percentage of THA/LPO physicians in the family practice market in Luzerne County should not warrant a challenge from the Agencies.

In internal medicine in Luzerne County, THA/LPO would be in a safety zone. There are at least 28 internal medicine physicians in the county, making the percentage 14%. The same is true of the pediatrics market. There are at least 20 pediatricians in Luzerne County pediatrics, so THA/LPO would qualify for the safety zone in that market at 25%.

[23] Unlike in Lackawanna County, we were unable to put together a comprehensive list of Luzerne County physicians. Those names we were able to locate, however, indicate that there is sufficient competition in all of the primary care specialties in Luzerne County.

C. Non-Exclusivity

THA/LPO would be non-exclusive, both on paper, *i.e.*, in the participation agreement, and in actual practice. Both LPO and THA are now non-exclusive on paper and in practice. There are 12 physicians who are members of both THA and LPO. Several physicans who are members of THA are also members of the InterMountain Health Group MSO. Six physician members of THA are also members of NEPPO. Non-exclusivity is also a current reality in payer contracts. Most of the contracts entered into by physician members of LPO and THA are formed with non-network payers. THA estimates that up to 90% of the revenue generated by its physicians is from non-network contracts. There has been no evidence of "de-participation" by any THA or LPO physicans from networks or managed care contracts outside THA or LPO.

Despite the fact that THA and LPO have practiced non-exclusivity, others in this market have not. As mentioned, NEPPO has had an exclusive relationship with Blue Cross/Blue Shield of Northeastern Pennsylvania. In addition, Physicians Health Alliance has had an exclusive relationship with Geisinger Health Plans. These exclusive relationships have thus far made it impossible for THA to obtain a contract with either Blue Cross or Geisinger. There are some indications that Blue Cross may in the near future open up to new networks, but to this point it has been unavailable to networks other than NEPPO.

D. Sharing Substantial Financial Risk

The MSO would have a utilization review (UR) committee that would meet at least monthly to set specific utilization targets and to monitor THA/LPO's success in meeting those targets. The UR committee would also set targets based upon performance and the quality of the health care services provided by member physicians. To provide

financial incentives for the member physicians to meet the utililization targets set by the committee, the MSO would set up and manage "risk pools," or separate pools of funds, with partial withholds on physician compensation; full compensation would be withheld until the targets are met. These pools would be set up to insure that the MSO and THA/LPO have adequate funds to pay expenses before paying the physicians. There would be several risk pools – one for the PCPs, one for the SCPs, one for hospital care and related costs. There may be other risk pools.

Among the five payer contracts that THA/LPO would hold at formation (*i.e.*, by September 30, 1998), four of them would be capitated contracts with managed care plans. The fifth would be a fee-for-service contract with a PPO.[24] The UR requirements for the managed care contracts would apply as well to the PPO contract, with partial withholds tied to specific cost-containment goals. In each case, the insurer would assume the risk of the contracts until January 1, 1999, when the contracts would be converted to full-risk capitation. In addition, THA is now in discussions with Blue Cross of Northeastern Pennsylvania to enter into a contract for Blue Cross's HMO and PPO products.

E. Physician Integration Creating Significant Efficiencies

As we discussed in Section I.F. *supra*, THA/LPO would integrate the practices of the member physicians in several specific ways, leading to significant efficiencies.

[24] This contract, currently held by THA, is with Physicians Care PPO, Inc. Physicians Care hopes to offer an HMO product by January 1, 1998. If it does, the MSO would at that time begin negotiations to enter into a risk contract with Physicians Care.

F. "Spillover" Effects

There is little risk of anticompetitive "spillover effects" from the network. Neither LPO nor THA has seen any evidence of coordination on price among their physician members on non-network business. There would be no pricing information shared among the physician members, except the price of services proposed by the payers to the Contract Committee, which would include four physician members. These four would be the only physicians in THA/LPO who would have access to any pricing information, and they would be precluded from sharing that information with other physicians.

To the extent that THA/LPO would have available to it pricing information from the individual physicians in THA/LPO, this information would be "confidential information" and thus the property of THA/LPO. If there were pricing information from the individual physician members, non-physician employees of the MSO would collect and analyze those data; the only physicians who would have access to the data would be the members of the Contract Committee, who would be precluded from sharing it with other physicians.

Thus, procedures would be put in place to prevent the sharing of competitively significant information such as pricing that might lead to anticompetitive effects outside the network.

G. Collateral Agreements

There are not, and would not be, any anticompetitive collateral agreements involving THA/LPO.

H. Conclusion

THA/LPO does not present a threat to competition for either PCP services or SCP services in northeastern Pennsylvania, under the guidelines set forth in Statement 8.

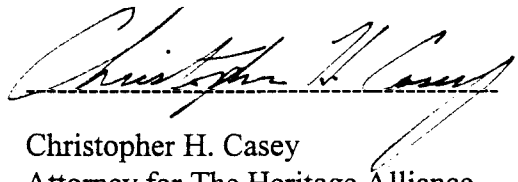
IV. FINAL CONCLUSION AND REQUEST

We submit that the proposed merger of THA and LPO does not present a threat to competition in the health care industry in northeastern Pennsylvania.

We respectfully request a response from the Commission or DOJ staff within 90 days of the date that staff determines that it has enough information to analyze the competitive effects of the merger and/or the competitive significance of the combined physician network. I hope that the information in this letter and the attached documents are helpful to the staff in its analysis.

I look forward to a response to this letter. Please feel free to have anyone on staff call me if additional documentation or factual support is needed, or if there are any questions with regard to anything in this letter.

Sincerely,



Christopher H. Casey
Attorney for The Heritage Alliance

Enc. Exhibits A-D
cc. Judith A. Moreland, Esq. (w/enclosures)