Section 19jj of the Park System Resource Protection Act, 16 U.S.C. 19jj. The proposed Consent Decree resolves natural resource damage claims and park system resource damage claims of the United States and Texas against the defendants arising out of the discharge of fuel oil in the Gulf of Mexico in February 1995. Under the proposed Consent Decree, defendants will conduct specific projects at public beaches to restore some of the natural resources that were lost or injured as a result of the oil spill, pay approximately $1.6 million into a court registry account to help fund projects to restore, replace or acquire the equivalent of resources or services injured by the oil spill, and pay all assessment costs.

The Department of Justice will receive comments relating to the proposed Consent Decree for 30 days following publication of this Notice. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, United States Department of Justice, PO Box 7611, Ben Franklin Station, Washington, DC 20044–7761, and should refer to *United States and the State of Texas* v. *Bulk Transport LTD, of Bermuda and SPT Marine, Inc. et al.* The proposed Consent Decree may be examined at the Office of the United States Attorney for the Southern District of Texas, Houston, Texas, and the Region VI Office of the United States Environmental Protection Agency, 1445 Ross Avenue, Dallas, Texas, 75202. A copy of the proposed Consent Decree may be obtained by mail from the Department of Justice Consent Decree Library, PO Box 7611, Washington, DC 20044. In requesting a copy, please enclose a check for reproduction costs (at 25 cents per page) in the amount of $5.00 for the Decree, payable to the Consent Decree Library.

Joel M. Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 99–30827 Filed 11–26–99; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Degree Under Comprehensive Environmental Response, Compensation and Liability Act

In accordance with Departmental policy, 28 CFR 50.7, notice is hereby given that a proposed consent decree in *United States* v. *H.W. Wageley, Inc., et al.*, C.A. No. 3:99–CV–90, was lodged on October 28, 1999 with the United States District Court for the Northern District of West Virginia. The consent decree resolves the United States' claims for response costs, pursuant to section 107 of the Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. 9607, against defendants H.W. Wageley, Inc., Mary P. Perry, Roger Perry, and William C. Perry. These costs were incurred in connection with the cleanup of the Charles Town Coal Tar Site, located in Charles Town, West Virginia. Under the consent decree, the defendants, within thirty days after entry of the decree by the Court, will reimburse the Superfund $80,000 for response costs incurred in connection with the cleanup of the Site.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General for the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and should refer to *United States* v. *H.W. Wageley, et al.*, DOJ Reference No. 90–11–3–06366.

The proposed consent decree may be examined at the office of the United States Attorney, Suite 200, 1100 Main Street, Wheeling, West Virginia 26003; and the Region III Office of the Environmental Protection Agency, 1650 Arch Street, Philadelphia, Pennsylvania 19103–2029. A copy of the proposed decree may be obtained by mail from the Department of Justice Consent Decree Library, PO Box 7611, Washington, DC 20044. In requesting a copy, please refer to the rerferenced case and enclose a check in the amount of $22.50 (.25 center per page production costs), payable to the Consent Decree Library.

Joel M. Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 99–30828 Filed 11–26–99; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Antitrust Division

United States of America and the State of Texas v. Aetna Inc. and The Prudential Insurance Company of America; Public Comments and Response on Proposed Final Judgment

Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(c)–(h), the United States publishes below the comments received on the proposed final judgment in *United States of America and the State of Texas* v. *Aetna Inc. and The Prudential Insurance Company of America,* Civil Action No. 3–99CV1398–H, filed in the United States District Court for the Northern District of Texas (Dallas Division), together with the United States' response to those comments.

Copies of the comments and the response are available for inspection and copying at the U.S. Department of Justice, Antitrust Division, 325 7th Street, NW, Suite 400, Washington, DC 20530 (telephone: (202) 616–5933), and at the Office of the Clerk of the United States District Court for the Northern District of Texas (Dallas Division). Copies of these materials may be obtained upon request and payment of a copying fee.

Constance K. Robinson,

Director of Operations.

Response of the United States to Public Comments

Pursuant to the requirements of the Antitrust Procedures and Penalties Act (the ''APPA''), 15 U.S.C. 16(b)–(h), the United States hereby responds to public comments received regarding the proposed Revised Final Judgment in this matter.

The United States filed a civil antitrust Complaint under Section 15 of the Clayton Act, 15 U.S.C. 25, on June 21, 1999, alleging that the proposed acquisition by Aetna Inc. (''Aetna'') of The Prudential Insurance Company of America's (''Prudential'') health insurance business would violate Section 7 of the Clayton Act (''Section 7''), 15 U.S.C. 18. The State of Texas, by and through its Attorney General, joined the United States as co-plaintiff in this action. On August 4, 1999, the United States and the State of Texas filed a proposed Revised Final Judgment, a Revised Hold Separate Stipulation and Order, and a Revised Competitive Impact Statement (''CIS'').

The proposed Revised Final Judgment and CIS were published in the **Federal Register** on Wednesday, August 18, 1999 at 64 FR 44946 (1999). A summary of the terms of the proposed Revised Final Judgment and the CIS and directions for the submission of written comments were published in the *Washington Post* and the *Dallas Morning News* for seven consecutive days, from July 27 through August 2, 1999. The 60-period for comments expired on October 18, 1999.

The United States received six comments on the proposed Revised Final Judgment. Two of the comments were submitted by individuals; one was submitted on behalf of a medical group and physician contracting organization; three were submitted on behalf of

professional medical associations. All six comments are addressed below.

After careful consideration of the comments, copies of which are attached to this Response, the United States has concluded that the additional relief suggested by the comments is either not relevant to the violations investigated by the Department and alleged in the Complaint or unnecessary to remedy the harm caused by the proposed transaction. For that reason, once the comments and the Response have been published in the **Federal Register** pursuant to 15 U.S.C. 16(d), the United States will move this court for entry of the proposed Revised Final Judgment.

I. Background

At the time the Complaint was filed, Aetna was (and remains) the largest health insurance company in the United States, providing health care benefits to approximately 15.8 million people in 50 states and the District of Columbia; Prudential was the ninth largest, providing health care benefits to approximately 4.9 million people in 28 states and the District of Columbia. Aetna and Prudential each offered a wide range of managed health insurance plans, including health maintenance organization (''HMO'') plans and point of service (''POS'') plans.

As the Complaint alleges, Aetna and Prudential competed head-to-head in the sale of HMO and HMO-based POS (''HMO–POS'') plans in Houston and Dallas, Texas; such competition benefited consumers by keeping prices low and quality high; and the proposed acquisition would end such competition and give Aetna sufficient market power to increase prices or reduce quality in the sale of HMO and HMO–POS plans in those geographic areas. The Complaint also alleges that the acquisition would enable Aetna to unduly depress physicians' reimbursement rates in Houston and Dallas, resulting in a reduction of quantity or a degradation in quality of physicians' services in those areas.

With the Complaint, the parties also filed a proposed settlement that would permit Aetna to complete its acquisition of Prudential but would require the divestitures of certain assets sufficient to preserve competition in the sale of HMO and HMO–POS plans and the purchase of physicians' services in Houston and Dallas. This settlement was set forth in a proposed Final Judgment and Hold Separate Stipulation and Order. To further clarify certain aspects of the settlement, on August 4, 1999, the parties jointly moved for entry of a proposed Revised Final Judgment and a Revised Hold Separate Stipulation Order.

The proposed Revised Final Judgment requires Aetna to divest its interests in two previously acquired health plans serving the Houston and Dallas areas: the Houston-area commercial HMO and HMO–POS businesses of NYLCare Health Plans of the Gulf Coast, Inc. (''NYLCare-Gulf Coast''), and the Dallas-area commercial HMO and HMO–POS businesses of NYLCare Health Plans of the Southwest, Inc. (''NYLCare—Southwest''). The NYLCare entities were acquired by Aetna in 1998.

On September 14, 1999, Aetna executed a definitive Stock Purchase Agreement with Health Care Service Corporation (''HCSC''), the parent of Blue Cross/Blue Shield of Illinois and Blue Cross/Blue Shield of Texas. HCSC proposed to buy all of NYLCare—Gulf Coast and NYLCare—Southwest, excepting only the two entities' Medicare business, for a total purchase price of approximately $500 million. The United States and the State of Texas reviewed the proposed transaction to determine whether it satisfied the requirements of Section IV of the proposed Revised Final Judgment regarding the required divestitures. On October 27, 1999, the United States notified Aetna and HCSC that, subject to the terms of the proposed Revised Final Judgment, it did not object to the sale.

The Revised Hold Separate Stipulation and Order, entered by this Court on August 9, 1999, mandates that NYLCare-Gulf Coast and NYLCare-Southwest function as independent, economically viable, ongoing business concerns and that competition be maintained prior to the divestitures. It requires Aetna to take steps immediately to preserve, maintain, and operate NYLCare-Gulf Coast and NYLCare-Southwest as independent competitors until the completion of the divestitures ordered by the proposed Revised Final Judgment, including holding NYLCare's management, sales, service, underwriting, administration, and operations entirely separate, distinct, and apart from those of Aetna. In addition, Aetna is obligated to cause NYLCare-Gulf Coast and NYLCare-Southwest to maintain contracts or agreements for coverage of approximately 260,000 commercially insured HMO and HMO–POS plan enrollees in the Houston area and approximately 167,000 in the Dallas area through the date of signing a definitive purchase and sale agreement for the divestiture of the two NYLCare entities. Until the plaintiffs, in their sole discretion, determined that NYLCare-Gulf Coast and NYLCare-Southwest could function as effective competitors, Aetna was prohibited from taking any action to consummate the proposed acquisition of Prudential. On July 27, 1999, the United States informed Aetna that its efforts to establish and hold separate NYLCare-Gulf Coast and NYLCare-Southwest as effective competitors were sufficient to satisfy Section III of the Revised Hold Separate Stipulation and Order, and that it could close on the purchase of Prudential.

The United States, the State of Texas, and the defendants have stipulated that the proposed Revised Final Judgment may be entered after compliance with the APPA. Entry of the proposed Revised Final Judgment would terminate this action, except that the Court would retain jurisdiction to construe, modify, or enforce the provisions of the proposed Revised Final Judgment and to punish violations thereof.

II. Response to Public Comments

A. Overview

The United States received six comments in response to the proposed Revised Final Judgment. The comments consist of a general concern with the transaction and any further consolidation in the HMO industry in the U.S. (*see* Subsec. B); a concern about the failure of the proposed Revised Final Judgment to address consolidation in the Georgia HMO industry (*see* Subsec. C); a request that the proposed Revised Final Judgment be amended to enjoin Aetna's use of certain contractual provisions as anticompetitive (*see* Subsec. D); and questions regarding the adequacy of the remedial provisions in the proposed Revised Final Judgment, in particular the propriety of requiring Aetna to divest its NYLCare assets rather than its Prudential assets in Dallas and Houston (*see* Subsecs. E and F). For the reasons stated in Subsection B–F, below, the United States believes that the comments provide no basis for determining that the proposed Revised Final Judgment is not in the public interest.

B. The Judgment Adequately Protects Competition Affected by the Proposed Merger and Should Not Address Prior Mergers

Charlene L. Towers of Highland Beach, Florida, quoting a newspaper columnist, contends that the United States's approval of the transaction should be reconsidered because it furthers the on-going consolidation of the HMO industry. Ms. Towers assets that while as recently as a few years ago there were eighteen large HMO plans in

the U.S., only seven remain. Ms. Towers also suggests that the HMOs are now colluding on price and benefits and that consumer choice is suffering.

Ms. Towers argues that because Aetna's acquisition of Prudential—in conjunction with the other mergers and acquisitions in the past—will result in fewer competitors, competition will be harmed. The number of competitors by itself, especially the number of competitors nationally, is a poor indicator of competitiveness. Indeed, Ms. Towers points to no specific market where she believes that the Aetna-Prudential transaction will substantially lessen competition. Our investigation, which examined markets throughout the country, concluded—and the Complaint alleged—that Aetna's acquisition of Prudential would have substantial anticompetitive effects in the Houston and Dallas areas. The Complaint did not allege—nor did the investigation disclose—any evidence of collusion on price or product design. *See United States v. Microsoft Corp.*, 56 F.3d 1448, 1459 (D.C. Cir. 1995) (declining to reach beyond the Complaint to evaluate claims that the government did not make or to inquire as to why they were not made). Moreover, the proposed Revised Final Judgment, requiring Aetna to divest itself of the two NYLCare entities in Houston and Dallas, will ensure the maintenance of competition in those areas, and is fully adequate to address the anticompetitive effects alleged in the Complaint. Indeed, since Prudential had only approximately 172,000 HMO–POS enrollees in Houston and 171,000 in Dallas, while NYLCare covered 260,000 HMO–POS enrollees in Houston and 167,000 in Dallas, the divestiture will not only effectively restore the Houston and Dallas markets to the *status quo ante*, but will result in the creation overall of a larger and stronger competitor than if Prudential had remained independent.[1]

C. The Judgment Adequately Protects Competition Affected by the Proposed Merger and Should Not Address Potential Future Mergers

The Medical Association of Georgia (''MAG'') objects to the proposed merger for two reasons. First, it believes that the acquisition of Prudential exacerbates Aetna's bargaining power and will give it the ability to impose ''onerous contract terms'' on physicians.[2] Second, it alleges that the proposed future acquisition of Blue Cross/Blue Shield of Georgia (''Georgia Blue'') by WellPoint Health Networks, Inc. (''WellPoint'') will further reduce the number of significant competitors of HMO and HMO–POS plans in Georgia and, in conjunction with Aetna's acquisition of Prudential, produce substantial—but undefined—anticompetitive effects.

The United States investigated the likely effect of the proposed merger of Aetna and Prudential in those areas of the U.S. where Aetna and Prudential compete, including Georgia. The information obtained in the investigation led the United States to conclude that the merger was unlikely to have substantial anticompetitive effects in either the sale of HMO–POS products or the purchase of physician services in Georgia.[3]

The proposed acquisition of Georgia Blue by WellPoint, MAG's second concern, was not announced until after the parties reached agreement on the proposed Revised Final Judgment, and our review of the proposed transaction was on the basis of the market structures existing at the time. However, as MAG acknowledges, Wellpoint currently has only a minimal presence in Georgia (less than 2% of the HMO–POS market). Its acquisition of Georgia Blue is therefore unlikely to have a substantial anticompetitive effect or alter our analysis of the effects of the Aetna-Prudential transaction.[4]

In arguing that the proposed Revised Final Judgment is inadequate because it does not address the harm in Georgia from Aetna's acquisition of Prudential (or Wellpoint's acquisition of Georgia Blue), MAG is, in fact, requesting that the Court assess not the propriety of the relief in light of the allegations of the Complaint, but the propriety of the Complaint itself. This it may not do:

> In part because of the constitutional questions that would be raised if courts were to subject the government's exercise of its prosecutorial discretion to non-deferential review, we have construed the public interest inquiry narrowly. The district court must examine the decree in light of the violations charged in the complaint and should withhold approval only if any of the terms appear ambiguous, if the enforcement mechanism is inadequate, if third parties will be positively injured, or if the decree otherwise makes ''a mockery of judicial power.''

Massachusettts School of Law at Andover, Inc. v. *United States*, 118 F.3d 776, 783 9D.C. Cir. 1997) *citing Microsoft*, 56 F.3d at 1457–59, 1462).

D. Additional Relief Regarding Certain Clauses in Physician Contracts Is Not Necessary

The American Medical Association, joined by the Texas Medical Association and the Dallas and Harris County Medical Societies, submitted a comment generally supportive of the proposed revised Final Judgment but requesting that the relief be expanded to enjoin Aetna from enforcing for five years certain provisions in its contracts with participating physicians in Dallas and Houston, in particular its ''All Products'' and ''Practice Closure'' clauses.[5] The Genesis Physician Group, Inc. and Genesis Physicians Practice Association (collectively ''Genesis'') also submitted a comment requesting that Aetna's use of its ''All Products'' clause be prohibited for five years, and further expressing concern with Aetna's practice of reserving, in its contracts with physicians, ''the power unilaterally to amend * * * material terms of the contract without any requirement that Aetna notify physicians.'' The American Podiatric Medical Association, Inc. (''APMA'') also submitted a comment requesting that the proposed revised Final Judgment be modified to prevent Aetna's continued use of its ''All Products'' and ''Practice Closure'' clauses.[6]

[1] In addition to the divestitures required by the proposed Revised Final Judgment, Aetna has decided to sell all the commercial HMO–POS enrollees of NYLCare-Gulf Coast and NYLCare-Southwest outside the Houston and Dallas areas, as well as approximately 12,000 enrollees in Preferred Provider Organization (''PPO'') plans. In total, Aetna will be divesting approximately 526,000 enrollees.

[2] Specifically, MAG cites to Aetna's ''All Products'' clause (discussed in Subsec. D, below), along with contractual provisions that permit Aetna to determine ''medical necessity,'' to ''unilaterally amend'' the contract, ''to compel'' physicians to participate in plans of other insurers, to impose ''unfair penalties'' on physicians, and to ''hold Aetna harmless.''

[3] While Aetna would control roughly 26% of the HMO–POS market in the Atlanta area after acquiring Prudential, the United States concluded that Aetna would continue to face significant competition from Kaiser, which also has approximately 26% of the market, United HealthCare, with approximately 19%, and Georgia Blue, with approximately 18%. In Macon, Georgia, the only other area of the state where Aetna will have a significant share of the HMO–POS market, Aetna's share will increase only minimally (by approximately 4%) from the acquisition of Prudential, and will continue to be dwarfed by Georgia Blue, with 62% of the market.

[4] MAG's concerns with Wellpoint's ''unparalleled focus on its managed care products'' and ''pattern of abusive [but unspecified] managed care practices,'' as well as with the fact that Georgia Blue ''would no longer be a Georgia-based company, would no longer be owned primarily by Georgians and would have little if any allegiance to Georgians,'' are not related to this action and need not be addressed here.

[5] The AMA and its co-signatories also expressed concern that the divestiture of the NYLCare assets be carefully monitored to ensure that the result is a viable competitor in the HMO market. This issue is addressed in Subsec. F, below.

[6] The APMA also expressed concern that the increasing concentration of managed care companies generally will diminish the availability

Continued

Aetna's ''All Products'' clause requires physicians to participate in *all* of Aetna's current and future health plans as a precondition to participating in *any* current Aetna health plan. Thus, a physician who serves on the provider panels of two different Aetna health plans (*e.g.*, an Aetna PPO and an Aetna HMO) cannot terminate his or her participation in only one of those plans without giving up the revenue he or she earns from both. The ''All Products'' clause, as a result, enhances Aetna's bargaining power in its negotiations with physicians by ''significantly increas[ing] the volume of business that a physician would lose if he or she rejected [an Aetna contract demand].'' (Complaint, ¶31.) Aetna's ''Practice Closure'' clause, on the other hand, hinders a physician who wishes to limit his or her dependence on Aetna by requiring that a physician accept Aetna's HMO patients if he or she is accepting HMO patients from other payers, *i.e.*, a physician may not selectively close his or her practice to Aetna's HMO patients.

As alleged in the Complaint, Aetna's proposed acquisition of Prudential would have further enhanced Aetna's bargaining leverage in its contract negotiations with Houston and Dallas physicians. The acquisition would have added to the substantial proportion of a physician's total patient revenue already at stake in a physician's negotiations with Aetna (*i.e.*, all of that physician's Aetna and NYLCare business) a significant additional share of that physician's total patient revenue—his or her Prudential patients. In addition, the acquisition of Prudential would make it even more difficult for a Houston or Dallas physician to replace the lost revenue if he or she were to reject Aetna's contract demands. Post-transaction, Aetna (including NYLCare and Prudential) would account for a significantly larger share of all local health plan enrollees, thereby diminishing the pool of potential replacement patients.

The United States believes that the proposed Revised Final Judgment fully addresses the concerns raised to the extent they are a product of the proposed transaction. It requires Aetna to divest its NYLCare businesses in Houston and Dallas as a pre-condition for acquiring Prudential and, as a result, physicians in those areas will have essentially the same proportion of their revenue at stake in future negotiations with Aetna as they did before the proposed transaction. Aetna's acquisition of Prudential will not increase its bargaining power *vis-a-vis* physicians in those areas.[7]

The comments of the AMA, Genesis, and the APMA, however, were not limited to addressing the harm arising from this particular transaction. They also address the possible consequences of the ''All Products'' clause independent of any proposed transaction—in particular, its effect on physicians who currently derive a large share of their total patient revenue from an Aetna PPO health plan and who may be forced by the ''All Products'' clause to agree to participate in Aetna's HMO health plans.

The Complaint in this action is clearly limited to redressing the anticompetitive effects of Aetna's proposed acquisition of Prudential. Aetna's ''All Products'' clause was considered only in the context of that transaction. The United States did not purport to investigate—or remedy through the proposed Revised Final Judgment—all possible anticompetitive behavior by Aetna, and the proposed Revised Final Judgment is to be evaluated in that context. See Massachusetts School of Law, 118 F.3d at 783 (the proper role in determining whether the public interest would be served is to assess the adequacy of the relief obtained in light of the case brought, not to determine the appropriate relief had a different case been brought).[8]

E. The Plaintiff Is Not Required To Seek Alternative Relief That a Third Party Prefers

Robert D. Gross, M.D., of Forth Worth, Texas, suggests there is a better remedy than requiring Aetna to divest its interests in NYLCare-Gulf Coast and NYLCare-Southwest before being permitted to acquire Prudential. Dr. Gross believes that Prudential's organizations in the Houston and Dallas areas are of substantially higher quality than the former NYLCare organizations, and that Prudential had ''made an extraordinarily strong commitment to quality in the Dallas-Ft. Worth market.''[9] He suggests that it would be less disruptive to the health care markets and patient populations in those two areas if Aetna divested its Prudential assets rather than its NYLCare assets in those areas.[10]

The goal of the proposed Revised Final Judgment is to return the markets in the Houston and Dallas areas to the *status quo ante*. As discussed in Subsection B, above, the United States believes that the proposed remedy will do so. Indeed, it believes that the divestiture of NYLCare will result in an overall larger and stronger competitor than if Prudential had remained independent.[11] Dr. Gross' suggestion that there is an alternative to the proposed Revised Final Judgment that he thinks would be preferable is not sufficient reason to reject the settlement negotiated in this case. See *United States* v. *Microsoft Corp.*, 56 F.3d at 1460 (a court is not empowered to reject remedies agreed to in a consent decree merely because it believes other remedies are preferable).

F. The Judgment Adequately Protects the Viability and Independence of the NYLCare Businesses To Be Divested

The American Medical Association along with the Texas Medical Association and the Dallas and Harris County Medical Societies also expressed concern about the viability of the NYLCare businesses in Houston and Dallas to be divested, and requested that the United States closely monitor this aspect of the divestiture.

The proposed Revised Final Judgment and the Revised Hold Separate Agreement require Aetna to take ''all steps necessary to ensure that NYLCare-Gulf Coast and NYLCare-Southwest are

of podiatric services for consumers and reduce the demand for podiatrists. Our investigation did not disclose any evidence that the transaction would diminish the availability or demand for podiatric services.

[7] Similarly, the ''Practice Closure'' contract provision discussed by the American Medical Association, the Texas Medical Association and the Dallas and Harris County Medical Societies, MAG, and the APMA, the provision reserving for Aetna the right to unilaterally amend the provider contract, discussed by Genesis, and the various other provisions discussed by MAG, all involve contracting practices of Aetna which predate the transaction with Prudential. They are not the result of the proposed transaction, nor are they impacted significantly by the proposed Revised Final Judgment. They are clearly beyond the scope of the Complaint and thus beyond the scope of this proceeding.

[8] It is worth noting that nothing in the proposed Reviewed Final Judgment limits the ability of the United States or the State of Texas to look into Aetna's ''All Products'' clause or other contractual provisions in the future, nor does it restrict in any way the rights of private parties to pursue the full range of remedies available under the antitrust laws.

[9] Our investigation revealed that many other physicians as well as employers and health care consultants/brokers do not share this view.

[10] Dr. Gross is also concerned with NYLCare's viability as an effective competitor. That issue is addressed in Subsec. F, below.

[11] As noted above, Prudential had approximately 172,000 enrollees in Houston and 171,000 in Dallas in its HMO–POS plans. In contrast, Aetna is required to divest the approximately 260,000 HMO–POS enrollees in Houston and 167,000 HMO–POS enrollees in Dallas covered by NYLCare. Since Aetna has also decided to divest NYLCare's HMO–POS enrollees outside the Dallas and Houston areas, as well as approximately 12,000 enrollees in Preferred Provider Organization (''PPO'') plans, it will be selling a total of approximately 526,000 enrollees.

maintained and operated as independent, on-going, economically viable, and active competitors until completion of the divestitures ordered by this Revised Final Judgment * * *.'' (proposed Revised Final Judgment, Sec. IV H.) Those steps include, but are not be limited to, the appointment of experienced senior management and the creation of separate and independent sales, provider relations, patient management/quality management, commercial operations, network operations, and underwriting organizations for the NYLCare entities. (*Id.*) Aetna is also required to provide specified transitional services, as well as such additional services requested by the management of NYLCare as may be necessary to ensure NYLCare's viability, including the funding of service quality guarantees. (*Id.*) Aetna is also required to fund an incentive pool of at least $500,000, which will be available to management of the NYLCare entities if they meet certain membership targets as of the closing date for the sale of the NYLCare entities. (*Id.*)

In addition, the proposed Revised Final Judgment (and the Revised Hold Separate Stipulation and Order) obligate Aetna to ''cause NYLCare-Gulf Coast and NYLCare-Southwest to maintain contracts or agreements for coverage of approximately two hundred sixty thousand (260,000) commercially insured HMO and HMO-based POS plan enrollees in Houston and contracts or agreements for coverage of approximately one hundred sixty seven thousand (167,000) commercially insured HMO and HMO-based POS plan enrollees in Dallas through the date of signing the definitive purchase and sale agreement(s) for the divestiture of the two NYLCare entities.'' (*Id.* Sec. IV B; Revised Hold Separate Stipulation and Agreement at Sec. III B.)

The United States believes the procedures provided in the proposed Revised Final Judgment and the Revised Hold Separate Stipulation and Order are fully adequate to ensure that Aetna will divest its NYLCare businesses in Houston and Dallas as viable and independent competitors. No further additions or changes to the proposed Revised Final Judgment are necessary.

III. The Legal Standard Governing the Court's Public Interest Determination

Section 2(e) of the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(e), requires that the proposed Revised Final Judgment be in the public interest. The Act permits a court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's complaint, whether the decree is sufficiently clear, whether enforcement and compliance mechanisms are adequate, and whether the decree may harm third parties. See *Microsoft,* 56 F.3d at 1461–62.

Consistent with Congress' intent to use consent decrees as an effective tool of antitrust enforcement, the Court's function is ''not to determine whether the resulting array of rights and liabilities is the one that will best serve society, but only to confirm that the resulting settlement is within the reaches of the public interest.'' *Id.* at 1460 (internal quotations omitted); see also *United States* v. *Bechtel Corp.,* 648 F.2d 660, 666 (9th Cir. 1981), *cert. denied,* 454 U.S. 1083 (1981). As a result, a court should withhold approval of a proposed consent decree ''only if any of the terms appear ambiguous, if the enforcement mechanism is inadequate, if third parties will be positively injured, or if the decree otherwise makes 'a mockery of judicial power.' '' *Massachusetts School of Law at Andover, Inc.* v. *United States,* 118 F.3d 776, 783 (D.C. Cir. 1997) (quoting *Microsoft,* 56 F.3d at 1462).

None of these conditions are present here. The proposed Revised Final Judgment is closely related to the allegations of the Complaint, the terms are unambiguous, the enforcement mechanism adequate, and third parties will not be harmed by entry of this Judgment. The specific acquisition investigated—Aetna's purchase of certain health insurance-related assets from Prudential—is full remedied in the proposed Revised Final Judgment. The fact that Aetna may be acting in other ways detrimental to competition is simply not the issue here and can be addressed by means still available to the plaintiffs and others.

IV. Conclusion

The United States has concluded that the proposed Revised Final Judgment reasonably, adequately, and appropriately addresses the harm alleged in the Complaint. As required by the APPA, the United States will publish the public comments and this response in the **Federal Register**. After such publication, the United States will move this court for entry of the proposed Revised Final Judgment.

Dated: November 9, 1999.

Respectfully submitted,

Paul J. O'Donnell,
John B. Arnett, Sr.,
Steven Brodsky,
Deborah A. Brown,
Claudia H. Dulmage,
Dionne C. Lomax,
Frederick S. Young,
Attorneys, U.S. Department of Justice, Antitrust Division, Health Care Task Force, 325 Seventh St. N.W., Suite 400, Washington, D.C. 20530, Tel: (202) 616–5933, Facsimile: (202) 514–1517.

July 14, 1999.

Attn: Joel L. Klein
Asst. Attorney General
Fax: 202–514–4371
Re: Aetna Inc. acquisition of Prudential Health Care
From: Charlene L. Toews
1057 Boca Cove Lane
Highland Beach, Florida 33487
Fax: 561–278–1306

Dear Mr. Klein: Please find attached some quotes from Molly Ivans regarding the acquisition by Aetna Inc of Prudential Health Care—which I totally agree with. PLEASE reconsider your approval of this acquisition. The citizens of the United States are NOT being served by this approval.

''Late last month, the Justice Department, showing the spinelessness for which it is so noted in these matters, approved the merger of Aetna and Prudential. The merged company will provide health care for one in every eleven Americans, and that makes it big enough to downsize services, hike prices and force doctors to accept unreasonable contract provisions and reimbursement rates.''

''Just a few years ago there were 18 big HMO's; today there are seven.''

''All seven of the giants decided—independently of course—on the very same day last year to dump rural seniors on Medicare. They also decided, in perfect concert, to cut back on the prescription drug benefits and no co-pay policy that got the seniors into the HMO's in the first place.''

''And every one of the seven has substantially hiked premiums for all their patients this year. And just over a week ago, they announced they were dumping another 250,000 Medicare patients, as well as cutting benefits and raising premiums.''

''We were supposed to be able to keep HMO's in line by quitting ones that provided poor service or cost too much, but it hasn't worked out that way. Only 17 percent of employers offer workers a choice of plans. Everybody else is stuck with whatever the company chooses; and the company chooses by cost of premiums, not by quality of care. As USA Today recently noted, ''Even without consolidation in the industry, patient choice has been slowly but inexorably vanishing.''

Mr. Klein, when are the people that ''we the people'' put in place to serve going to actually SERVE ''the people'' and put OUR best interests first?

Sincerely,

Charlene L. Toews.

October 18, 1999.

Gail Kursh, JD,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, 600 E Street, NW, Room 9300, Washington, DC 20530.

Re: Proposed Acquisition of Prudential by Aetna

Dear Ms. Kursh: Please accept this letter as the written comments of the Medical Association of Georgia on the proposed acquisition (hereinafter ''the Acquisition'') by Aetna, Inc. (hereinafter ''Aetna'') of the Prudential Insurance Company of America's healthcare business (hereinafter ''Prudential'').

The Medical Association of Georgia (''MAG'') is a non-profit, voluntary professional association of Georgia physicians. MAG was founded in 1849, is a part of the American Medical Association and is the largest physicians' association in Georgia. Presently, MAG has over 8,000 members—more than 5,000 of whom are physicians actively practicing medicine in the State of Georgia.

MAG was founded to promote the art and science of medicine and the improvement of public health. With these ends in mind. MAG actively works to advocate physician and patient positions in the United States Congress, the Georgia General Assembly, the courts of this State and the United States, as well as before a variety of state and federal regulatory agencies.

The purpose of this letter is to formally OBJECT to the proposed acquisition of Prudential by Aetna. Our reasons for this objection are numerous and are presented in the following paragraphs. Additionally, we hereby adopt as our own as if stated herein, the positions and rationale proffered by the State of Texas in the civil lawsuit in which that sovereign state joined the United States of America, alleging that the acquisition would violate Section 7 of the Clayton Act and would be detrimental to patients and physicians throughout much of this country.

1. Two Primary Reasons MAG Opposes the Acquisition

A. Increased Market Strength Will Have Adverse Impact on Patient Care

The primary basis for the Medical Association of Georgia's objection to the acquisition of Prudential by Aetna lies in the fact that Aetna has shown a propensity to impose onerous contract provisions that have the effect of adversely impacting the quality of care patients receive. Historically, physicians have played the role of patient advocate. In fact, it is the public policy of the State of Georgia that physicians are encouraged to advocate on behalf of the best interests of their patients.[1] Unfortunately, physicians are unable to fully exercise this role in today's healthcare market.

In today's healthcare market, physicians have no bargaining power whatsoever when it comes to negotiating with health insurance plans regarding the obligations of the insurers, or those of the physicians, under the insurance plans. Given the current antitrust laws applicable to the contracting process between health insurers and physicians, physicians have no ability to collectively bargain on behalf of their patients or themselves. As such, they have no bargaining strength against the health insurers who are able to submit contracts to physicians virtually on a ''take it or leave it.'' basis. The Acquisition will only exacerbate that problem for Georgia physicians and patients as it will further empower Aetna to impose onerous contract provisions on physicians and other healthcare providers, eventually ''lead[ing] to a reduction in the quantity or a degradation in the quality of physician services'' provided to patients.[2]

B. The Double Whammy Effect of the Aetna/Prudential Acquisition Plus the Georgia Blue/Wellpoint Merger

The second major basis for the Medical Association of Georgia's objection to the Aetna/Prudential Acquisition is that is comes at the same time that Georgia is about to suffer the effects of a merger between the state's largest and oldest health insurer, Blue Cross/Blue Shield of Georgia (hereinafter ''Georgia Blue'') and Wellpoint Health Networks, Inc. The combination of Blue Cross/Blue Shield of Georgia and Wellpoint will place more than 32% of the Georgia health insurance market in the hands of one of the nation's largest publicly traded managed care insurance behemoths. The corporate entities that will follow the Aetna/Prudential acquisition and the Georgia Blue/Wellpoint merger will control nearly 60% of the HMO/POS markets in Georgia. The concurrence of these two transactions will dramatically reduce the competition among carriers and, therefore, the healthcare options available to all Georgians.

II. What Is There To Fear About an Enlarged Aetna?

Given the monopsony position of some insurers in some locales (such as the position Aetna would enjoy in Georgia if the acquisition were approved), many plans use this ''unlevel playing field'' to issue contracts to physicians on a ''take it or take it'' basis. The physicians are not in a position to negotiate any of the terms of the contract. For example, physicians' objections to gag clauses usually go unheeded. Reimbursement rates may not be disclosed in some contracts, much less negotiated. Yet, because of the number of patients that they have under the dominant insurer's plans, they cannot afford—financially or ethnically—to abandon their patients by rejecting the contract submitted to them by the insurer, regardless of how onerous some of the contents of the contract are. Their only option is to ''take it.'' Stated differently, when a physician's revenue from a single insurer gets to a certain point, i.e., a certain percentage of the overall revenue, that physician is ''locked in'' to the plan and has no bargaining power whatsoever. At that point, the plan's contract becomes a contract of adhesion and the physician has no ability to negotiate for his or her patients' rights and no opportunity to reject the contract.

Aetna has incorporated into their physician agreements many of the most onerous contract provisions popular among the managed care industry today. Some of the provisions that Aetna has used to control the quality and quantity of care that physicians provide to their patients include the following:

- *Aetna's Infamous ''All Products'' Clause*

Perhaps the single worst contract provision used by Aetna is its often criticized ''all products'' clause. ''All products'' clauses provide that if a physician participates in any of the carrier's plans, he or she must participate and take patients covered under all of their plans, now and in the future. These clauses, like most of the provisions discussed below, are usually non-negotiable. They are objectionable for many reasons. Health plan products differ substantially in operation. A physician may feel comfortable participating in a PPO product, but may have very valid reasons for not wanting to participate in an HMO product,

[1] O.C.G.A. § 33–20A–7(b). ''No healthcare provider may be penalized by a managed care plan for providing testimony, evidence, records, or any other assistance to an enrollee who is disputing a denial, in whole or in part, of a health care treatment or service or claim therefore.''

[2] [See, *Competitive impact Statement. U.S.A. and the State of Texas* v. *Aetna, Inc., Et al.,* USDC Northern District of Texas, CA 3–99CV1398–H (1999)].

which is a dramatically different product that requires physicians to assume certain risks. Those risks may not be viable for smaller practices with smaller patient bases because of practice size, patient mix or other valid actuarial and business concerns. Yet, these clauses require physicians to participate in products despite the existence of legitimate concerns.

Moreover, imposing these clauses on physicians (especially as a unilateral amendment to an existing contract) may sever existing patient-physician relationships. This has been seen most vividly in Texas where Aetna US Healthcare enforced its ''all products'' clause and terminated a large physician group that refused to take new patients under one of the insurer's HMO products. This resulted in thousands of patients losing access to their physicians and, for many of them, having to change doctors in mid-treatment. An additional concern with ''all products'' clauses is that where plans have significant market share (such as the 58% share WellPoint/Georgia Blue and Aetna/Prudential would have in Georgia), the non-negotiable ''all products'' clauses will operate to further limit patient choice by facilitating a conscious push of patients into HMO products and away from other options.

''All products'' clauses also harm premium-payers. An insured who selects a PPO product, usually does so in order to have access to a more attractive panel of physicians and other healthcare providers. Typically, that insured has to pay for that privilege with a higher premium than the basic HMO member will pay. Yet, if a physician agrees to be an authorized provider under Aetna's PPO plan, and is subject to the ''all products'' clause contained therein, that physician has to take Aetna HMO patients, as well as PPO patients. So, the HMO member will have the same access to that doctor as the higher premium-paying PPO member. Thus, the PPO member paid the higher premium but got nothing for the higher cost. Is this fair to patients? Is this fair to employers who purchase health insurance for their employees?

• *Aetna's Ability To Determine What Is ''Medically Necessary''*

Among the other more egregious contract provisions found in many managed care contracts, especially Aetna's, is the provision that authorizes the health plan to make the determination as to what is ''medically necessary'' for a patient. Testifying in support of managed care reform before a subcommittee of the United States House of Representatives in 1996 and again before a Georgia State Senate committee just this past March, Dr. Linda Peeno, M.D., a former medical executive for several managed care companies across the country, stated that ''the definition of 'medical necessity' is the 'smart bomb' of managed care.'' She explained that managed care companies can appear to offer all sorts of options and decision-making power to their insureds and providers but as long as they retain control over the definition of what is, and what is not, medically necessary, they have unfettered control over what medical treatment they will pay for on behalf of their insureds, despite the fact that the insured has paid to have the service covered by their plan.

Many insurance plan contracts in existence today, including most Aetna contracts, allow the insurer to supersede a treating physician's determination regarding the necessity of medical services without any consideration whatsoever of that physician's judgment or the patient's true needs. Aetna accomplishes this by retaining for itself the unfettered discretion to determine what they will, and what they will not, pay for—all under the guise of the service not being, ''medically necessary.'' For example, Aetna's contract with physicians provides as follows:

1.1 Provision of Covered Services * * * It is understood and agreed that Company, or when applicable, the Payor, shall have final authority to determine whether any services provided by Provider were Covered Services * * *

12.4 Covered Services. Those Medically Necessary Services which a Member is entitled to receive under the terms and conditions of the Plan.

12.7 Medically Necessary Services. * * * Health care services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards and which are likely are result in demonstratable [sic] medical benefits, and which are the least costly of alternative supplies or levels of service which can be safely and efficiently provided to the patient.

• *Hold Harmless Clauses*

Aetna has unfairly shifted the legal liability associated with its policies to physicians through hold harmless clauses, clauses limiting their liability and clauses shortening the applicable statue of limitations. Aetna has insulated itself from liability by inserting hold harmless clauses in its contracts with physicians in blatant disregard of statutory prohibitions contained in some state's laws. Certainly, health plans should not be allowed to shift their own legal liabilities onto the physician while simultaneously deciding how and under what circumstances physicians can provide care. That is exactly what Aetna does when they have the right to decide what is, and what is not, ''medically necessary.'' Is there any reason to believe that Aetna will adhere to Georgia's newly enacted statutory prohibition against hold harmless clauses.[31]

• *Clauses Which Allow Aetna To Amend Unilaterally the Contract Without the Physician's Consent and Sometimes Knowledge*

Another onerous provision found in managed care plan contracts today is the clause that allows a plan to amend the contract entirely on its own and exclusively within its unfettered discretion. While traditionally such clauses have been utilized by insures to alter very minor features of an insurance contract—*e.g.*, changing the address where claim forms are to be sent, changing the payment dates, and other elements of a clerical nature—managed care plans have more recently been using these unilateral amendments to make major changes in the fundamental, core obligations of the parties which constitute the very essence of the contractual agreement between the insurer and the physicians. These fundamental obligations include the nature of the services that the physicians are to provide under the contract, the physician services that are to be paid for and the method by which reimbursements are to be calculated.

Moreover, the unilateral changes being made today by insurance plans, including those of Aetna, involve not only fees, but also utilization review/case management policies, which, in essence, dictate whether and under what circumstances patients are able to obtain medically necessary services.

• *Requirements That Force Physicians To Participate in Other Insurers' Plans About Which the Physicians Know Noting*

In light of the fact that physicians have no bargaining power whosoever with respect to contracting with health insurers about the contents of their plans, fairness certainly seems to require that the physicians at least be allowed to know with which plans they are contracting. Aetna's contracts have provisions that retain for Aetna the right to require that their physicians also

[3] See O.C.G.A. § 51–1–48(b).

participate with a network of plan ''affiliates'' or otherwise participate in other insurers' plans. Under such contractual provisions, physicians are not permitted to review the additional contracts to know or understand their terms and conditions. Physicians are not authorized to accept or reject these other insurers' contracts. When patients who are insured under the affiliate plans come to the physician's office for treatment, the physician must provide covered medical treatment to the patient and can only expect to be paid at the same discounted rates Aetna has imposed upon them in their contract. Further, physicians are required to accept payment not from Aetna, but from the ''affiliate'' insurer. If the affiliate insurer does not pay the physician, the only remedy is to seek payment from the patient. Moreover, when the physician treats the insured patient under the affiliate plan, the physician must follow that plan's definition of what is medically necessary.

• *Provisions Which Impose Unfair Penalties Upon Physicians*

Aetna, like many managed care health plans, reserves the right to punish physicians who do not follow certain plan rules and regulations. These contractual ''punishments'' often bear no relationship to alleged wrongdoing, run the potential of jeopardizing quality care, and are of questionable legality. Under the Aetna contract, if a physician fails to obtain appropriate prior authorization, he or she shall have their reimbursement reduced for all medical services provided to all patients that they treat after notification by Aetna. This provision is often referred to as a ''contamination'' clause—the theory being that if one patient goes out of plan, a physician's payment for all patients will be ''contaminated,'' *i.e.*, reduced

Sometimes physicians do not comply with utilization review requirements (such as prior approval rules) because they are not in a patient's best interest. Sometimes the noncompliance is inadvertent. In many cases, there was no mistake at all. Given the proliferation of managed care throughout Georgia and given the fact that physicians contract with numerous health plans, all with different procedures and requirements, billing for medical services has become cumbersome, complex and confusing. This scenario has placed an incredible burden on physicians (and their office staffs). So, it is understandable that some physicians' offices may fail on an isolated occasion to meet each and every billing, utilization review, or other procedure imposed by each and every one of the myriad health plans with which they have contracted. Healthcare insurance company acquisitions and mergers that further empower insurers to impose sanctions against physicians in this manner should not be allowed to occur. This type of disproportionate punishment provision should not be tolerated.

Further, penalizing physicians for failing to comply with a plan's utilization review program in order to advocate for medically necessary treatment or care is contrary to Georgia law. Is there any reason to believe that Aetna will abide by this newly enacted provision of Georgia law? Other managed care companies have continued to enforce such provisions against physicians in direct violation of some states' laws. Is this what Georgia patients and physicians deserve?

The Georgia General Assembly has spoken unequivocally (and nearly unanimously) on this point. With the passage of O.C.G.A. § 33–30A–7(b), the legislature made it clear that it is the public policy of the State of Georgia that a physician should be allowed, in fact encouraged, to advocate for medically appropriate health care for his or her patients. If Aetna is allowed to violate state law by penalizing physicians for such advocacy, as other companies have done (e.g., the way Wellpoint Health Networks, Inc. has done in violation of California law), then such important patient advocacy will be severely chilled and could result in a dangerous threat to patient care in Georgia.

III. The Double Whammy Effect Of Aetna/Prudential and Georgia Blue/ Wellpoint

The second major reason for our objecting to the Acquisition is the fact that it comes at the same time that Georgia's largest and oldest health insurer, Blue Cross/Blue Shield of Georgia, is merging with WellPoint Health Networks, Inc., one of the nation's largest publicly traded managed care insurance behemoths. The combination of Blue Cross/Blue Shield of Georgia and WellPoint Health will control more than 32% of the health insurance market in Georgia [1.8 million persons]. The consequences of having one of the largest managed care networks in the country, which is not Georgia-based, take over one-third of the Georgia healthcare insurance market would be troubling enough for Georgia patients, Georgia physicians and other healthcare providers interested in providing the best quality of healthcare to their patients. However, the ill effects of that merger will be compounded by the fact that it will occur at the same time that Aetna and Prudential, the third and fourth largest health insurers in Georgia are dissolved into one. The concurrence of these two transactions will dramatically reduce the competition among carriers and, therefore, the healthcare options available to all Georgians. It will directly affect nearly 59% of the HMO/ POS market in Georgia and more than 52% of that same market in the Metropolitan Atlanta area.[4] Because of the unfair market share that the two resulting insurance carriers will have, however, the effects will be hard felt throughout the entire state's health insurance market. The following market share chart shows how these two consolidating transactions will affect the health insurance market share landscape in Georgia.

[In percent]

HMO/POS market	Market share as of 07/01/99 for Aetna Inc.	Market share as of 07/01/99 for Prudential	Market share for Aetna/Prud following the acquisition	Market share affected by combination of Aetna/ Prud acquisition and merger of BC/ BS of GA with WellPoint
Market Share for all of Georgia	10.08	15.95	26.03	58.62
Market Share for Metropolitan Atlanta Area	9.35	18.13	27.48	52.34

[4] All statistics are based on information contained in the latest update of Harkey & Associates' 1999 report on managed care insurers operating in Georgia.

The merger of Georgia Blue with WellPoint would increase WellPoint's market share in Georgia from less than 2% of the market [100,000 persons insured currently under Wellpoint's subsidiary, UNICARE] to nearly 32% of the private health insurance market [1.8 million persons]. While the market share increase for Georgia Blue following the merger would appear to be fairly minimal, the dynamics of having one of the largest managed care networks in the country, which is California-based, take over one-third of the Georgia market will be extremely consequential for Georgia insureds and Georgia physicians and other healthcare providers interested in providing the best quality of healthcare to their patients.

The merger between Georgia Blue and WellPoint is worrisome in several respects. First, Georgia Blue would no longer be a Georgia-based company, would no longer be owned primarily by Georgians and would have little, if any, allegiance to Georgians. The influence and presence of California-based WellPoint, as a dominant managed care player, would be significant. WellPoint would immediately assume a dominant position in the Georgia health care insurance market. With this advantage, WellPoint would be expected to rapidly increase its market share in Georgia.

Furthermore, considering WellPoint's unparalleled focus on its managed care products and its dominant power in the managed care industry, it is reasonable to expect that the managed care portion of Georgia Blue will grow at an even faster rate in Georgia than it otherwise would have and with a concomitant decrease in their attention to the traditional indemnity market needs of Georgians. Patients will be faced with a marketplace that is less competitive and that offers far less choice.

If the merger is approved, Georgia Blue, in a period of less than 5 years, will have transformed from a Georgia-based, not-for-profit insurer that was loyal to its insured patients and that was accountable to the people and State of Georgia, into an indivisible piece of one of the nation's largest publicly traded managed care behemoths.

While the corporate entity that would follow the merger of Georgia Blue and WellPoint would not be an illegal monopoly in Georgia, it most certainly would constitute a monopsony with significant market share dominance. Given WellPoint's history of using abusive tactics in California and the significant market share that they would acquire from Georgia Blue, the merger between the two can only spell trouble for Georgia patients and their health care providers. The combination of market share dominance and a pattern of abusive managed care practices could be a lethal dose of bad medicine for Georgians.

Although the Medical Association of Georgia and its members acknowledge that managed care is here to stay, the amount of abuse that is already present in the managed care industry—even in Georgia—presents a significant concern. Thus, it is our obligation, by whatever means are appropriate, to raise the issues and concerns of our members and their patients whenever quality care is threatened by the managed care industry. We strongly feel that allowing the state's third and fourth largest healthcare insurers to merge at the same time the state's largest healthcare insurer is being taken over by one of the nation's largest managed care companies certainly constitutes just such a threat to Georgia patients.

Conclusion

In summary, Aetna, through the use of numerous onerous contract provisions, already constitutes a threat to quality care in Georgia and elsewhere. Allowing it to consume an even larger segment of the healthcare insurance market will only further empower Aetna to drive the delivery of healthcare in any direction that its financial incentives may dictate, regardless of the needs of patients. Aetna has shown in many ways (E.g., by its unrepentant use of its definition of ''medical necessity''), that its primary, if not singular, emphasis is in producing returns for its shareholders' investments—all to the detriment of their insureds and without regard for same. The larger they are allowed to become, the greater their dominance over the healthcare market will be and the less physicians and other healthcare providers will be able to determine what care patients can receive.

The concurrence of this Acquisition at the same time that Georgia's largest healthcare insurer and its tremendous market share are being turned over to one of the nation's largest managed care companies can only spell trouble for Georgia patients and physicians. Together, the two resulting corporate giants will control more than 58% of the Georgia HMO/POS markets. With that combined ability, the two insurers will dictate what care is provided throughout all of Georgia and they will lower the standard of healthcare services to that which is ''the least costly,'' just as Aetna says in its definition of ''medically necessary.'' Is this really the single criterion that should control the quality and quantity of healthcare that will be made available in Georgia or anywhere else in the United States? The Medical Association of Georgia arduously submits that it should not be.

Accordingly, and for the many reasons articulated above, the Medical Association of Georgia and its 8,000 Georgia physicians respectfully request that the proposed acquisition by Aetna of Prudential Insurance Company's healthcare insurance business be *disapproved*.

Thank you for your consideration in this matter that is of great importance to all Georgians.

Sincerely,

David A. Cook,

General Counsel.

William T. Clark,

Associate General Counsel.

September 7, 1999.

Gail Kursh, JD,

Chief, Professions and Intellectual Property Section, Health Care Task Force, Department of Justice, 600 E. Street, NW, Room 9300, Washington, DC 20530.

Re: Comments of the American Medical Association, Texas Medical Association, Dallas County Medical Society, and Harris County (Houston) Medical Society to the Proposed Revised Final Judgment pending in *United States* v. *Aetna, Inc.*, Civil Action no. 3–99CV 1398–H

Dear Ms. Kursh: The American Medical Association (AMA), along with the Texas Medical Association (TMA), the Dallas County Medical Society, and the Harris County (Houston) Medical Society (collectively, ''the Texas medical societies'') submit these comments regarding the proposed consent decree (''consent decree'') entered into by the United States Department of Justice, the Texas Attorney General (collectively, ''the Government''), and Aetna/U.S. Healthcare (''Aetna'') and Prudential Insurance Company of America (''Prudential'') in a complaint and final judgment submitted to the United States District Court for the Northern District of Texas on June 22, 1999.

Our organizations submit these comments in order to state to the Government our desire for a fair and balanced healthcare marketplace, including access by patients to the physicians our organizations represent. Our organizations have a first-hand familiarity will marketplace realities and the potential impact of this proposed merger on physicians and patients. During the course of the investigation of this proposed merger,

the AMA and the Texas medical societies have worked in partnership to respond to requests from the United States Department of Justice (DOJ) for information on the impact of this merger on physicians and patients in the Dallas and Houston area.

The AMA is a not-for-profit association of approximately 275,000 physicians in all areas of specialization throughout the United States and is the largest medical society in the United States. The Texas Medical Association (TMA) is a not-for-profit association of 36,000 physicians and medical students practicing in all areas of specialization in the State of Texas. TMA represents more than 83% of all licensed physicians in Texas. The Harris County Medical Society represents 8500 physicians, 80% of all physicians practicing in all areas of specialization in Harris County. The Dallas County Medical Society represents 6000 physicians practicing in Dallas County, 80% of all physicians practicing in all areas of specialization in the county. The foundation of all our organizations is the promotion of the science and art of medicine (including quality of care) and the betterment of public health. We also advocate on behalf of our physicians and their patients at all levels of state and federal government and in the private sector.

The underlying focus of our joint effort is our commitment to the preservation of quality medical care and the patient-physician relationship. The AMA and the Texas medical societies believe that in a well-balanced marketplace, patients and physicians will have the best opportunity to make informed decisions as to the appropriateness of care.

We are filing these comments because we believe there is a strong factual basis for the action taken by the Government to require Aetna to divest its NYLCare business in the Houston and Dallas markets. However, we also believe the consent decree should be broadened to address Aetna/U.S. Healthcare's contracting practices that directly impact and lessen competition in the Dallas and Houston marketplaces. Moreover, we are concerned that the Government continue to closely oversee the divestiture of NYLCare to ensure that there is a viable competitive alternative for patients and physicians in Dallas and Houston.

We also fully support the Government's allegations that the merger of Aetna and Prudential, if unchallenged, would lead to violations of the antitrust law because (1) it would substantially lessen competition in the fully-funded Health Maintenance Organization (HMO) and HMO Point of Service (POS) markets in Dallas and Houston resulting in increased price or decreased quality, thereby increasing prices for or decreasing the quality of services; and (2) it would result in consolidation over purchasing of physician services in Dallas and Houston, giving Aetna the ability to depress physicians' reimbursement rates, and allow Aetna to dictate all terms and conditions in its contracts, which is likely to result in a reduction in the quality or degradation in the quality of those services.

I. The AMA and the Texas medical societies believe that there is a strong factual basis for the Government's findings regarding the anticompetitive impact of the proposed merger in the Dallas and Houston HMO and HMO Point of Service markets

The AMA and the Texas medical societies believe there is a strong factual basis for the allegations that in the Houston and Dallas markets, the HMO and HMO–POS plans are an appropriate relevant product market and that an unchallenged merger would result in a reduction in competition in the sale of HMO and HMO–POS plans in Dallas and Houston. This is a significant shift from a number of litigated cases where the courts refused to recognize a separate market for HMO products and instead defined the relevant product market as all health care plans. A more flexible case-by-case approach that evaluates the actual dynamics of an individual marketplace is necessary to assure that a given marketplace remains competitive in a time of rapid market consolidation.

II. The AMA and the Texas medical societies support the Government's findings regarding the anticompetitive impact of the merger in the market for the purchase of physician services in Dallas and Houston and the potential impact on quality and/or quantity of care

The AMA and the Texas medical societies agree that the Government correctly identified the relevance of and the anticompetitive impact of Aetna's post-merger purchasing power over physician services in Dallas and Houston. There is a strong factual basis for the Government's allegations that physician services constitute a relevant product market within which to assess the likely effects of the proposed acquisition of Prudential by Aetna.

There is a strong factual basis to support the Government's contention that without divestiture. Aetna's consolidated purchasing power over physicians' services will enable the merged entity to unduly reduce the rates paid for those services. This will likely lead to a reduction in quantity and/or degradation in quality of physician services. The Government's recognition of the unique aspects of physician services (compares to other tangible services) that make it very difficult for physicians to replace lost business quickly are consistent with our experience of market realities.

Consistent with that, the Government correctly alleges that the contract terms a physician can negotiate with a health plan depend on the physician's ability to terminate his or her contract if the company demands unfavorable terms. In other words, if a physician cannot ''walk away'' from a contract, he or she has no ability to reject unfavorable terms—including those with clear patient care implications.

We believe there is a strong factual basis for the Government's allegation that in the Dallas and Houston markets, physicians' limited ability to encourage patient switching and consequent inability to reject Aetna's contracts post-merger will result in a violation of the Section 7 of the Clayton Act by giving Aetna the ability to reduce physician reimbursement rates, which will have a negative impact on the quality and/or quantity of physicians services.

In response to requests from the Department of Justice relating to the investigation of this proposed merger, the Texas Medical Association (TMA) developed a physician practice cost model that simulates the effects of the loss or termination of a family practice physician's managed care contract. Based on this model, should a physician terminate a managed care contract that accounts for 20 percent of total practice revenue, the physician would experience a loss of approximately $40,000 of net medical income. Where a plan accounts for a significant percentage of a physician's practice revenue, the prospect of severe financial repercussions greatly reduces—if not eliminates—the physician's ability to walk away from an unreasonable contract with that plan.

At the request of the Department of Justice (DOJ), the Harris County (Houston) and Dallas County Medical Societies went further and performed a survey to collect practice revenue data to determine the actual impact of the merger at the practice level. The results of the survey showed the impact would create tremendous market imbalance. Before the proposed acquisition of Prudential, 62% of Dallas County physicians limited their exposure to the combined Aetna/NYLCare entity to

under 20% of total practice revenue. However, after the acquisition, if NYLCare were not spun off, only 43% of Dallas physicians would be able to limit their exposure to the merged Aetna/Prudential entity to under 20% of total practice revenue.

In Houston, the results are more dramatic. Prior to Aetna's acquisition of NYLCare, 91% of Houston physicians were able to limit contract exposure to Aetna to under 20%. Subsequent to Aetna's acquisition of NYLCare and Prudential and without the spin-off of NYLCare, only 27% of Houston physicians could still limit exposure to the Aetna entity to under 20%.

Given the substantial financial damage to a physicians' practice that would result from declining an Aetna contract in these circumstances, it is reasonable to conclude that the 57% of Dallas physicians and 73% of Houston physicians with 20% or more practice revenues dependent on the merged Aetna/Prudential entity could not walk away from the Aetna contract.

III. The AMA and the Texas medical societies believe that additional relief is needed to guard against Aetna's ability to exercise anticompetitive power in the purchase of physician services in Dallas and Houston

The AMA and the Texas medical societies believe that the proposed divestiture is an appropriate first step to ward off the anticompetitive impact of the proposed merger in the combined HMO and HMO–POS market. However, we do not believe that the remedy adequately guards against Aetna's ability to exercise anticompetitive power in its purchase of physician services in the relevant geographic markets.

This is because Aetna's contracts include provisions that operate to ''lock-in'' physicians making it extremely difficult if not impossible to walk away from an Aetna contract that is disadvantageous to them or to their patients. The continuing threat that these provisions will enable Aetna to exert monopsonistic power in spite of the divestiture warrants modification of the Revised Final Judgment to include further relief.

The ''all products'' policy is the first and most obvious of these provisions. Under this ''take-it-or-leave-it'' policy, Aetna requires a physician to participate in all of Aetna's current and future health plans as a condition of participating to any current Aetna plan. Aetna has publicly stated that this provision is non-negotiable.

The consent decree recognizes the anticompetitive nature of this policy by noting that in Dallas and Houston, the policy ''significantly increases the volume of business that a physician would lose if he or she rejected (an Aetna Contract). Terminating the provider relationship thus would mean that a physician not only would lose his or her own patients who participate in the plan, but also access to other patients in that plan.'' Although the ''all products'' policy played a significant role in the Government's finding that the merger would result in an antitrust violation in the market for purchase of physician services, it is not addressed in the Revised Final Judgment.

Based on market realities, the AMA and Texas medical societies believe that the ''all products'' policy enhances Aetna's market power, operates to ''lock-in'' physicians to Aetna contracts, and therefore raises serious anticompetitive concerns in the Dallas and Houston markets for purchase of physician services. The ''all products'' policy enhances Aetna's market power by ensuring that physicians are funneled through the HMO product to have access to Aetna's patient populations within other products such as a PPO.

From a physician's perspective, Aetna's HMO product therefore serves as a ''gateway'' to Aetna's patient populations enrolled in other products. The provision ensures that Aetna becomes a sizable percentage of a physician's business even if a physician wishes to participate in only one of Aetna's products for legitimate business reasons (such as lack of access to information systems needed to manage risk contracts) or quality of care concerns. The ''all products'' policy seriously undercuts the ability of Houston and Dallas physicians to walk away from an Aetna contract, a key concern set forth in the Complaint.

Moreover, Aetna's ability to force this provision on Dallas and Houston physicians is further evidence of its anticompetitive market share. The substantial differences between HMO and PPO products from the Physicians' standpoint are poorly understood by most Americans. However, it is critical to understand this difference in order to fully grasp the pernicious nature of Aetna's ''all products'' policy, particularly as it would operate in Dallas and Houston.

A shorthand explanation is that under an HMO contract, physicians are compensated in a variety of ways. While many are paid using a substantially discounted fee schedule, some are paid on a ''capitated'' basis which means that the financial risk of insuring HMO members is passed from the insurer—in this case Aetna—to the treating physician. While risk-bearing by physicians in some settings may result in the provision of cost-effective quality medical care, managing insurance risk is a highly complex task that involves equally complex actuarial assumptions that are generally undertaken by large entities.

Entering into risk contracts is inadvisable for physicians without, among other things, (1) Access to the underlying acturial data on which the capitaton rate is based, (2) data to match costs related to patients with reimbursement received from them under a capitated contract; and (3) a large enough patient base to ''spread the risk.'' It is indisputable that entering into an HMO risk contract without a careful evaluation can have severe financial repercussions for a physician's practice, and potentially adversely impact the care that a physician can provide his or her patients.

Our organizations (as well as many other organizations) have developed educational information to assist physicians in deciding whether entering into an HMO risk contract is advisable for their practice and in evaluating capitation rates. Attached are *Capitation: The Physician's Guide:* (American Medical Association 1997) and *The Law of Managed Care, Chapter 5,* ''Risk Contracting'' (Texas Medical Association, 1997) which provide a more in-depth discussion of the many variables that physicians must consider.

Moreover, in 1997, the AMA Council on Ethical and Judicial Affairs (CEJA) issued a report on Financial Incentives and the Practice of Medicine (attached) which has been adopted by the AMA House of Delegates and Incorporated into the AMA Code of Ethics (see especially Section E–8.051, ''The Ethical Implications of Capitation,'' adopted June 1997) (attached). The Code of Medical Ethics unambiguously states that physicians have an ethical obligation to ''evaluate a health plan's capitation payments prior to contracting with the plan to assure that the quality of patient care is not threatened by inadequate rates.'' It also recommends, for example, that financial incentives be applied across broad physician groups so that an individual physician's incentive to inappropriately limit care is minimized.

The Aetna ''all products'' policy prohibits physicians from making any of these necessary evaluations. Instead, they are forced to blindly accept risk contracts (without even knowing what they are accepting as capitated risk) that they may be ill-equipped to manage. There is no opportunity for any type of

evaluation. Any physician who wishes to participate in any Aetna contract—including a PPO contract which does not involve sharing financial risk—must accept HMO risk contracts under terms set unilaterally by Aetna (which may be changed by Aetna unilaterally) with absolutely no opportunity to make the critical analysis outlined in the above-referenced document. Even worse, physicians' must agree to participate in future products—which may subject physicians to higher levels of insurance risk—under whatever conditions Aetna sets. Any reasonable attorney, business consultant, or ethicist would advise a client against agreeing to this type of blind risk-sharing contract, particularly a solo or small group practice for whom this kind of arrangement is even riskier.

In addition, another aspect of the Aetna contract works in concert with the ''all products'' policy to further ''lock-in'' the physician and significantly undercuts, if not eliminates any real ability of physicians to withdraw from an Aetna contract. This provision states that:

- ''To prevent discrimination against Company or its Members for such time as Provider declines to accept new Members as patients, Provider shall not accept as new patients additional members from any other health maintenance organization.''

This bar on closing a practice to new Aetna patients prevents a physician from being able to ameliorate the harsh effects of any Aetna policy by accepting patients in other plans or being available to see patients covered by a new entrant. Under this provision, a physician has no ability to limit exposure or reduce exposure to Aetna by increasing his or her participation level with another plan. It undercuts the ability of physicians to manage their ''book of business'' and thus establish an effective balance between revenue sources. This further exacerbates their dependence on Aetna.[1]

Because the divestiture does not limit Aetna's ability to impose both of these contract provisions on physicians, the Final Judgment does not provide a sufficient remedy to the monopsonistic power that Aetna will wield in the Dallas and Houston markets for physicians post-merger. To better address the anticompetitive effects of these contract provisions, the AMA and the Texas medical societies propose that the Government modify the Final Judgment to enjoin the use or enforcement of these provisions in any Aetna physician contract with a physician practicing in the Dallas and Houston markets for a period of five years following the proposed divestiture. This remedy is addressed toward the type of future injury to competition that Section 2 of the Clayton Act is designed to prevent.

An injunction would preserve a physician's ability to terminate or credibly threaten to terminate his or her relationship with Aetna if Aetna should seek to reduce the prices it pays to physicians in a manner likely to lead to a reduction in the quantity or a degradation in the quality of physician services in those geographic markets. The injunctive relief that the AMA and the Texas medical societies propose is consistent with prior injunctions that courts have issued to prevent enforcement of contract provisions in unlawful restraint of trade or to prevent the maintenance of a monopoly. See, e.g., Cass Student Advertising Inc. v. National Educational Advertising Services, Inc. 537 F. 2d 282 (7th Cir. 1976) (affirming injunction that prohibited defendant from enforcing a provision in its contracts that gave the defendant exclusive rights to represent college newspapers in student advertising).

It should also be noted that the ''all-products'' and ''practice-closure'' provisions also serve as substantial barriers to entry in light of Aetna's still significant position in the Dallas and Houston health care markets. The provision of managed care in a particular market is heavily dependent on maintaining a quality physician network. To justify the expense of developing and maintaining the network, there must be potential for competitors to generate some critical level of market penetration.

By using the ''all-products'' policy and barring participating physicians from reducing the amount of Aetna business in favor of another plan, Aetna's market share is self-perpetuating, and these policies operate to bar the entry of other plans in the Dallas and Houston markets. It is simply too difficult to put together the requisite provider network to compete in this situation. In the future, this may enable Aetna to extract monopoly prices or reduce quality of care to the detriment of consumers.

IV. It is critical that the Government closely monitor the divestiture of NYLCare.

The AMA and the Texas medical societies have serious concerns about the potential viability of a divested NYLCare entry. Prior to the divestiture agreement, Aetna representatives had informed us that they were well underway in their efforts to fully integrate NYLCare's Texas operations into their primary organization. It is our understanding that they had substantially dismantled NYLCare's separate administration, data processing, and claims processing and payment functions.

Although the Hold Separate Provisions require Aetna to recreate separate administrative, sales, provider relations, quality management, operations and underwriting departments for the NYLCare entity, the magnitude of this task is such that it would be very difficult to complete within the time frame specified in the Revised Final Judgment. Furthermore, Aetna will be subject to serious conflicts of interest in regard to its efforts to reassign appropriate staff and resources to NYLCare.

It will be extremely difficult for the Government to determine whether the recreated administration and operations will function effectively enough to preserve NYLCare's viability as a market competitor. Because of the inherent conflict of interest, the plans' assurances in that regard might not be sufficient evidence. We urge the Government to require NYLCare to demonstrate its viability over some reasonable period of time before it allows Aetna to consolidate the merger with Prudential.

We support the Government's action in the Revised Final Judgment to define the number of covered lives that must be divested with the NYLCare business. We are concerned, however, about what appears from Texas Department of Insurance figures to be a 10% decline in NYLCare covered lives in the Houston Market since the fourth quarter of 1998. A decline of this size is material and could be a signal of some ongoing deterioration of NYLCare's market position. Such deterioration could

[1] Another aspect of Aetna's business conduct recently brought to the attention of the AMA is worth noting in this respect. At least in some parts of the country (if not nationally) Aetna is requiring physicians groups and independent practice associations to enter into a two-tiered contract. The group of IPA must agree to secure individual contracts between Aetna and each individual physician member of the group or network that will bind the individual physician to Aetna if there is a termination between Aetna and the group or IPA. We believe that this practice is designed to defeat any leverage physicians have gained by forming legitimate groups and networks, and also in part due to the highly publicized contract disputes Aetna has encountered over the ''all products'' policies in at least three states—including Texas—with IPAs. When linked with the ''two tiered'' contracting approach, the all products policy becomes even more onerous because, as noted, it is much more difficult for a solo or small group practice to take on risk or capitated contracts for under any circumstances for obvious actuarial reason, particularly when Aetna requires the group to do so without ever stating the price it is willing to pay for risk or capitated contracts.

signal the beginning of an ongoing decline in market position caused by Aetna's actions prior to the divestiture agreement.

If that is the case, the ongoing loss of market share might continue into the fall reenrollment period, in spite of any current reparative actions undertaken by the new NYLCare administration. For example, we do not know to what extent Aetna may have already (prior to the divestiture agreement) encouraged providers and customers to sign agreements with Aetna in lieu of their former agreements with NYLCare. We urge the Government to monitor NYLCare's covered lives through the fall enrollment period in order to assure that the divested NYLCare business will include the requisite number of covered lives in the Houston market.

We consider the viability of NYLCare's provider network to be essential to NYLCare's overall viability as a competitor in the Houston and Dallas markets. We urge the Government to closely monitor this aspect of the divestiture because of many unknown factors relating to the current Aetna/NYLCare provider network. If the divestiture is to be meaningful, the provider networks that were previously in place for NYLCare business will need to be preserved or, if necessary, re-assembled.

We support the Government's requirements that a buyer for the NYLCare business must be capable of competing effectively and be substantially independent of Aetna. We would further advocate that the buyer be capable of assuming all support services for NYLCare, so that the divested entity would not be dependent on Aetna for critical operations. For example, the Revised Final Judgment allows Aetna to continue to provide ''support services'' to NYLCare until the divestiture, including software and computer operations support. To the extent that NYLCare continues to rely on Aetna for crucial business functions such as processing, pricing, and paying claims, it will not function as a separate entity and will not b e capable of standing alone as a viable entity. Any potential buyer should be capable of providing NYLCare with these support services without reliance on Aetna. Furthermore, a buyer should be required to have the demonstrated ability to comply with all state laws including those concerning reserves and timely claims payment, and offer a credible plan to continue to comply after absorbing the NYLCare business.

We would advocate that the Government carefully monitor the NYLCare divestiture process in order to assure that the divested plan has a viable administration and operating structure, and that it maintains its provider networks and customer base. Until the new NYLCare administration and operations have been shown to be effective and independent, acquisition of Prudential should not be allowed to proceed. We also suggest that the Final Judgment give this Court the power to evaluate the effectiveness of the divestiture one year from its conclusion.

V. Conclusion

The Proposed Consent Decree and Proposed Revised Final Judgment take a significant and needed step towards addressing the anticompetitive impact of the proposed acquisition of Prudential Health Insurance by Aetna/U.S. Healthcare. However, failure to address the contracting practices that play a key role in the alleged violations of the antitrust laws will undercut the effectiveness of the Consent Decree. Moreover, a commitment by the Government to carefully monitor the divestiture of NYLCare is also essential to achieving the purposes of the proposed settlement.

Sincerely,

Thomas R. Reardon, MD,

President, American Medical Association.

Gordon Green, MD,

President, Dallas County Medical Society.

Alan C. Baum, MD,

President, Texas Medical Association.

Carlos R. Hamilton, Jr., MD,

President, Harris County Medical Society.

September 21, 1999.

Steve Brodsky,

Antitrust Division, Department of Justice, 950 Pennsylvania Ave, NW, Suite 3101, Washington, D.C. 20530.

Re: AetnaUS Healthcare/Prudential Merger.

Dear Mr. Brodsky: This letter is written on behalf of Genesis Physicians Group, Inc. and Genesis Physicians Practice Association (collectively, ''Genesis'') and is a supplement to our earlier letters on the above matter. GPG believes that some of the current contracting activities related to the merger of AetnaUS Healthcare (''Aetna'') and Prudential HealthCare (''Prudential'') are anti-competitive and hopes that the information presented below will be helpful to you in your review of these post-merger activities.

Physician Office Practice

Earlier submissions to the Department of Justice have suggested that, once a payor becomes 20% of a physician's practice, the physician is unable to resist the unfair pressures of that payor. This is known as the ''lock-in'' percentage for physicians and, for primary care physicians (''PCPs''), Genesis believes that this figure is correct. As for specialist physicians (''SPCs''), Genesis believes that the ''lock-in'' figure is more like 10% because of the different referral patterns between PCPs and SPCs, particularly in the HMO contracts which Aetna has stated is its growth product. This lock-in percentage is important because, when it is reached, physicians are not able to resist the unfair contracting and operational activities of Aetna, some of which are described below.

Aetna/Prudential Contracting Activities

It is important to note that Prudential is requesting all physicians to sign individual contracts, even if they are in a group practice. This request is clearly aimed at isolating individual physicians from their lawfully constituted groups and utilizing the unequal bargaining power of a large insuror against an individual physician. Thus, as Genesis predicted, the size of Aetna/Prudential has led to coercive marketing and contracting activities. Although Aetna and Prudential are offering different contracts to physicians, the terms are very coercive and both result in threats to patient care. Genesis will summarize only two of those terms in this submission, i.e. the all products clause and the unilateral right to change the basic terms of the contract.

All Products Clause

This is the clause that requires physicians to participate in all products of Aetna in order to participate in any Aetna product. Because the contracts that Aetna is presenting to physicians contain a provision for unilateral imposition of a capitation (''risk'') reimbursement methodology, physicians may be forced into operational and financial constraints that will adversely affect patient care. Capitation payments shift the cost and administrative risk to the physician, generally with a lower reimbursement to the physicians. Under ''risk'' products, physicians have higher overhead costs because of the increased medical management and other administrative burdens by the payors. Increased physician overhead is, for example, due to more detailed medical management protocols, longer waiting times for payor pre-certification and referral procedures and more personnel to handle the increased administrative burden. Common sense dictates that physicians would not want to sign a contract that gives such unilateral rights to Aetna.

Coupled with the lack of full disclosure about the financial risks of capitation payment methodology, it is clear that the ''all products'' clause is a deceptive practice that could adversely affect patients, as well as physicians.

Aetna has libelled physicians by stating that their opposition to this clause is based on a desire to avoid treating poor patients that Aetna claims is the primary user of HMOs. Aetna has no evidence that Dallas-area physicians discriminate on the basis of HMO participation nor that only poor people use HMO products. The truth is that the all products clause (with its imposition of capitation reimbursement methdology) is a mechanism to shift costs and risks to the physicians without proper disclosure of the material aspects of the ''risk'' products offered by Aetna. Such cost and risk shifting is done to enhance shareholder value, not patient care.

Unilateral Right To Change Contract Terms

Under its proposed contract with physicians, Aetna has the power unilaterally to amend certain material terms of the contract without any requirement that Aetna notify physicians. In addition, the contract lacks a price term, which in a contract for services is an essential term. The power to unilaterally amend has major potential impact on patients. By reserving the right to unilaterally amend all terms, including clinical protocols, the contract gives Aetna very real power to impose barriers to care and to decrease medical expenses, especially if it is under financial pressure to meet shareholder expectations. These barriers can result in delays and denial of care to patients.

Aetna's National Focus on HMO Growth

Aetna has stated publicly that its growth will be in HMO contracts and that it is actively pursuing this aspect of their business. With this product's added burdens of onerous medical management, random reimbursement changes and other interference in the patient/physician relationship, the 20% lock-in threshold becomes even more important. Physicians believe that there must be a balance between insuror's rules and regulations and the objective decisions made by a physician for his/her patient's best interest. At the 20% level, that becomes problematic from the standpoint of the physician being able to say no to an onerous contract.

Aetna seeks to use its market position to require physicians who may wish to participate in a PPO product, to participate in an HMO—a substantially different product. This pressure occurs despite the fact that the physician may have ethical, operational or clinical objections to capitated HMO plans, and even if the practice is not in a position to accept the substantial amount of insurance risk involved in such HMO products.

Conclusion

The pressure on employers to offer HMO plans means more pressure on primary care physicians since they are a necessary element of any successful HMO strategy by Aetna. Because of the current method of financing premiums, either through Medicare or employer payments, there is a limit to the physicians' ability to influence payors and patients. Thus, patients—the true consumer of health care—have very little control over choice of plan. Physicians have an ethical and legal obligation to their patients and the clinical decisions made in the course of the patient-physician relationship, not the insurer/insured relationship. Consequently, physicians will always play a critical role as patient advocate in an increasingly financially-driven health care system. This role can be easily undermined when a physician has no leverage in the face of an antagonistic and monopsonistic health plan.

Because Aetna has exhibited such anti-patient and anti-physician behavior, it is obvious that their market power in selected markets will lead to increased use of their anti-competitive contractual provisions. Genesis requests that the Department of Justice prohibit the use of the ''all products'' clause for 5 years and to require more balanced contractual provisions, all in an effort to protect patients, physicians and employers, particularly small business owners, from the power of Aetna.

Sincerely,

J. Scott Chase.

October 8, 1999.

Gail Kursh,

Chief, Health Care Task Force, Antitrust Division, U.S. Department of Justice, 325 Seventh Street, N.W., Suite 400, Washington, D.C. 20530.

Re: Comment of the American Podiatric Medical Association to the Proposed Revised Final Judgment in *United States, et al.* v. *Aetna, Inc., et al.* (No. 3–99 CV 1398–H).

Dear Ms. Kursh: This comment is being submitted by the American Podiatric Medical Association (APMA), the oldest and largest association representing podiatrists in the United States. These comments are submitted regarding the proposed Revised Final Judgment entered into by the plaintiffs, the United States of America and the State of Texas, and the defendants, Aetna, Inc. and The Prudential Insurance Company of America. Notification of the 60-day comment period regarding the consent decree and Revised Final Judgment was published in the **Federal Register** on August 18, 1999.

Podiatric medicine is the profession of the health sciences concerned with the diagnosis and treatment of conditions affecting the human foot and ankle. The podiatric medical education is based upon accepted principles of allopathic medicine. Podiatrists may employ both surgical and non-surgical modalities in the treatment of the ailments of the human foot and ankle. Since the late 1960s, foot and ankle services provided by doctors of podiatric medicine have been covered by Medicare. Podiatrists are recognized as physicians by Medicare and under many state licensure acts.[1]

The APMA is a non-profit organization representing over 10,000 licensed doctors of podiatric medicine in the United States; this number represents more than 80% of those licensed to practice podiatry. There are component state organizations for each of the 50 states, District of Columbia and Puerto Rico, and for those podiatrists employed by the federal government. The APMA is in a unique position in the field of podiatry to comment upon the subject matter of this litigation.

The general concern raised by the APMA is that a concentration of market power by insurance companies in general, and in this case by Aetna through its acquisition of The Prudential Life Insurance Company, is harmful to the provision of quality podiatric medical care. Patient care and the welfare of the patient is paramount in the practice of podiatry, as in other health care professions. The corporate interests of Aetna, in its accountability to its shareholders, is not necessarily compatible with the provision of the highest quality of care and the broadest availability of services to the public-at-large. The concentration of too much economic power in any one market reduces, rather than enhances, health care options and may lead to distortions to, and even interference in, the physician/patient relationship. The APMA has serious concerns when third parties, whose interests may not coincide with that of the patient, are

[1] Unless otherwise made plain by the context, the term ''podiatrist'' and ''physician'' are used interchangeably.

making financial decisions which ultimately impact on the availability and quality of care.

In addition, podiatrists are often confronted with other problems which are exacerbated when there is a concentration of power in the hands of third-party payors. As noted above, there are more than 10,000 podiatrists who are members of the APMA throughout the United States. By way of comparison, there are over 14,000 allopathic physicians practicing in Harris County and Dallas County alone; there are 145 podiatrists in the Houston area and 128 podiatrists in the Dallas area. Because of the relatively small number of podiatrists, as compared with the allopathic/osteopathic physicians, podiatrists have had the added burden of fighting for access to managed health care plans. The concern among podiatrists is that a concentration of power would restrict rather than enhance the ability of podiatrists to provide quality, cost-effective care to its patients within managed care plans. When HMO and HMO–POS plans prevent podiatrists from participating in their programs, it limits the choices of the patient in the health care market with the potential of harm to the patient's well-being and care. It is for those reasons that the APMA, on behalf of its members, files these comments with the Department of Justice.

I. The Complaint of the Department of Justice and the State of Texas is Justified Regarding the Potential Anti-Competitive Effects of the Merger of the Aetna and Prudential HMO and HMO–POS Plans

The concerns of the Antitrust Division of the U.S. Department of Justice and the State of Texas were well-founded regarding the anti-competitive effects of the proposed merger. As alleged by the Department of Justice and the State of Texas, the proposed transaction is part of a clear trend towards the increasing consolidation among health insurance companies. Managed care companies are clearly engaged in a separate market from fee-for-service-based plans. While all facets of the health care industry are concerned regarding rising health care costs, managed care programs (such as HMOs), which place limits on treatment options, restrict access to out-of-network providers, and use primary physicians as gatekeepers, are in a greater position to affect the physician/patient relationship. The concern that the insurance companies are making decisions that may interfere in the course of treatment and the management of patient care is real. Any aggregation of power which would reduce the competition among HMO and HMO–POS plans or consolidate the purchasing power of a managed care plan over podiatric services, would be inimical to the well-being of the patient consumer and, ultimately, contrary to the provision of the lowest, cost-effective provision of health care services to the public.

The Justice Department complaint amply demonstrates the economic power that Aetna would acquire in the Houston and Dallas markets if corrective action were not taken. In Houston, Aetna presently has 44% and Prudential has 19% of the HMO and HMO–POS enrollees. After the merger, without divestiture, almost two-thirds of the enrollees in the Houston metropolitan area would be enrolled under the Aetna HMO-controlled plans. In Dallas, while not as large, the numbers are nonetheless quite substantial. The combination of Aetna's current 26% of the HMO and HMO–POS enrollees with the 16% now controlled by Prudential totals 42% in the Dallas metropolitan area. These numbers, in and of themselves, represent significant market penetration by one insurer.

The experience of podiatrists in the Houston and Dallas area, as well as elsewhere, indicate that the concerns regarding a potential reduction in the quantity or in the degradation in the quality of physician services provided to patients are genuine. Due to a number of factors, most health insurance is provided to consumers by employers. In an effort to reduce costs, as more and more employers move to managed care programs, podiatrists are finding that their patients are not able to maintain their relationships with their chosen podiatrists because of the limitations in the managed care plans. As the number of fee-for-service programs shrink, there is not a readily available pool of other patients waiting to fill the slots of those patients who have been restricted in their access to podiatrists.

Further, as will be discussed more fully later, the experiences of podiatrists are that the managed care programs, where they utilize podiatric services, engage closed panels to perform such services. Fewer and fewer podiatrists are performing more and more services. The natural effect is to ultimately reduce the availability of podiatric services to the public-at-large. This is the very degradation in both the quantity and quality of services which the Justice Department was rightly concerned. The divestitures of NYLCare, and the maintenance of a separate plan until NYLCare is sold, is clearly warranted in the Houston and Dallas markets.

II. The Concentration of Economic Power in the Hands of a Few Managed Care Companies Creates the Potential for Greater Exclusion of Podiatrists in the Health Care Market Place

One of the principal concerns of podiatrists throughout the country, as well as in the affected markets in this case, is the propensity of managed care organizations to prohibit access to podiatrists or to offer podiatric services through such a small number of podiatrists that it acts as a barrier to the participation of podiatrists in the HMO and HMO–POS markets.

Large scale participation of podiatrists on hospital staffs is a relatively recent phenomenon, having principally occurred since the 1960s within the United States. With the development of managed care programs, podiatrists have found that in a number of plans, again particularly initially, podiatric services were not included within the benefits offered by the plans. With the passage of time, podiatric participation in managed health care plans, including HMOs and HMO–POS plans, has increased. Nonetheless, there are numbers of plans which do not include podiatric services or so limit the number of podiatrists included in the panel as to effectively foreclose large numbers of podiatrists from participating in the managed care plans.

The APMA undertook a nationwide survey of its members to determine what participation barriers exist in the managed care market. The most recent data available, from the 1993 survey, provided that 60% of those podiatric physicians who responded indicated that major HMO and PPO organizations had prevented, limited, or attempted to prevent or limit, them from participating in such plans. Aetna, U.S. Health Care, and Prudential were all prominently mentioned in the survey. Of those who responded, 73% found that there were closed panels of podiatrists (a small number of podiatrists who could exclusively handle the foot care needs under the plan) or that the plans were closed to podiatrists entirely. In a 1998 survey, of those podiatrists who reported that there net income decreased from the prior year, 44.7% indicated it was because of the impact on managed care.

To the extent that there is a concentration of ownership and operation of these managed care plans in any one area, such as in Dallas or Houston, it necessarily follows that the number of options available to consumers (either employers or individual patients) will be limited. The more limited the options within the

HMO and HMO–POS plans, such limitations may lead to a further reduction in the number of podiatrists participating in such plans.

While podiatrists provide many services which may be classified as primary care, podiatrists frequently receive referrals because of the specialist nature that they provide for the treatment of the human foot. Many general practitioners, whether allopathic or osteopathic, make referrals to podiatrists to handle specific foot ailments which require certain treatment (including surgeries) that the general practitioner believes in the best interest of a patient should be treated by a specialist. To the extent that an HMO neither permits podiatric participation or so limits the number of podiatrists on its panel, such limitation reduces the availability of podiatric services and may prevent the referring physician from making the referral to the podiatrist best-suited to handle the particular condition.

Again, it is for these reasons that the APMA believes that divestiture, as set forth in the Revised Final Judgment, and for the purpose of maintaining competition, is the minimum condition to be imposed in order to permit the merger to proceed.

III. Anti-Competitive Provisions of the Aetna Contracts, Which Operate to Lock in Physicians and Reduce the Ability of Physicians to Provide Quality Health Care Should Be Purged

While highlighted by the U.S. Department of Justice and the State of Texas in their complaint, the proposed remedy of divestiture does nothing as it relates to certain onerous contract provisions incorporated in the Aetna contracts. The APMA joins the American Medical Association and others in urging that these provisions be stricken as a further condition of approval for the merger.

Certain of Aetna's contract provisions have the effect of binding a physician, whether or not a podiatrist, to the Aetna plans, whether or not such continued participation is in the physician's best interest. Aetna includes an ''all products'' policy which requires that if you are a member of one plan you must participate in all of Aetna's plans. In the Dallas and Houston area, Aetna does permit podiatric participation in its plans. Like other physicians, once a podiatrist is included in the plan, the podiatrist must participate in all of the Aetna plans.

The result of this is that in a number of the Aetna plans, there are circumstances and conditions which make the provision of care unprofitable and there are certain requirements which arguably interfere in the physician/patient relationship. Without this all-products policy, podiatrists might choose not to treat patients under such circumstances. However, because that policy is in place, podiatrists are required to provide services at times for less than cost and to go through procedures which may not necessarily be in the best interest of the patient. A provision such as the all-products policy is not in the best interest of the consumer or the physician, particularly if the Aetna line of business represents a very significant portion of the podiatrist's practice.

Further, while a relatively innocuous anti-discrimination provision is included in the contract, its effects is likewise to restrict choices by podiatrists. The anti-discrimination provision provides that if a physician declines to accept new Aetna patients under the HMO or HMO–POS plans, that podiatrist ''shall not'' accept as new patients additional members from any other health maintenance organization. That is, regardless of the unprofitability or the concerns that a provider may have as it relates to the strictures on treatment as imposed by certain plans, if the podiatrist refuses to accept any new Aetna enrollees, podiatrists cannot provide services to members of any other HMOs. In conjunction with the ''all products'' policy, once a podiatrist is in the plan, if that podiatrist desires to treat participants of any other HMO program, that podiatrist must always be willing to accept participants under any Aetna HMO or HMO–POS program.

These ''lock-in'' provisions do nothing to enhance quality of care or to enhance or to further the physician/patient relationship. There effect is to virtually eliminate any of the bargaining power that providers, whether or not podiatrists, need when dealing with these plans. In addition to the requirement of divestiture, the Justice Department should require that these clauses be stricken from the Aetna contracts.

IV. Conclusion

The Revised Final Judgment, with the requirements of the maintenance of the NYL–HMO and HMO–POS plans with the specified number of enrollees, addresses the anti-competitive impact posed by the original Aetna/Prudential merger. It is requested that the clauses highlighted above be deleted as well in order to further reduce the anti-competitive effect of this merger.

Sincerely,

Ronald S. Lepow, DPW,

President, American Podiatric Medical Association.

Glenn B. Gastwirth, DPM,

Executive Director, American Podiatric Medical Association.

June 25, 1999.

Ms. Gail Kursh,

Chief, Healthcare Task Force, Antitrust Division, U.S. Department of Justice, 325 Seventh Street, NW—Suite 400, Washington, DC 20530.

Re: Proposed consent decree allowing acquisition of Prudential Healthcare by Aetna in the Dallas-Fort Worth market.

Dear Ms. Kursh: I wish to express my disappointment in and opposition to the proposed consent decree requiring Aetna to divest NYLCare in the Dallas-Fort Worth and Houston markets.

As you are aware, NYLCare has already been absorbed by Aetna. As is usually the case when Aetna absorbs another company, all of the best management staff within the absorbed organization, such as NYLCare, are not kept with the new entity. This destroys all of the previous relationship that the absorbed entity had established in the marketplace and replaces them with less desirable Aetna relationships. This has led to contract terminations and disruption of care for countless NYLCare members, both in terms of their access to physicians and in terms of their access to hospitals.

On the other hand, it just so happens that Prudential Healthcare has made an extraordinarily strong commitment to quality in the Dallas-Fort Worth market. The medical director and associate medical directors of the Dallas-Forth Worth Prudential operation represents the ''who's who'' among medical directors in our region. They are individuals of the highest ethical and professional caliber. Their approach to managing care runs counter to Aetna's previous track record.

It makes no sense to dissemble a high quality operation which is serving its members well and then have Aetna divest a now disemboweled shell of a former HMO devoid of its experienced leadership. There is no rational basis for allowing Aetna to take over another HMO and give up one that has already taken over. The membership in question is approximately the same and Aetna should be allowed to retain its ownership of NYLCare in Dallas-Fort Worth and should be prohibited from absorbing Prudential Healthcare in this market.

In many consent decrees organized by your division it is not uncommon for

corporations to take over another corporation and then be required to sell that corporations holdings in only specific markets. It is my premise that the Department of Justice would be serving the healthcare needs of the patient population in the Dallas-Fort Worth market in a much better way and with much less disruption by simply allowing Aetna to continue business as it has been with NYLCare and require them to divest the Dallas-Forth Worth Prudential Healthcare portion of their new acquisition with the requirement that they make no changes in its management or business prior to sale.

In my view, this would create a much more level playing field and provide for significantly improved quality and continuity of care for managed care patients in the Dallas-Fort Worth market.

Your consideration of these comments is appreciated.

With best regards,

Sincerely yours,

Robert D. Gross, MD

Certificate of Service

I hereby certify that on this 9th day of November, 1999, I caused a copy of the Response of the United States to Public Comments to be served on counsel for all parties by U.S. First Class Mail, at the following addresses:

Mark Tobey, Esq.

Assistant Attorney General, Chief, Antitrust Section, State Bar No. 20082960, Office of the Attorney General, P.O. Box 12548, Austin, Texas 78711–2548.

Robert E. Bloch, Esq.,

Mayer, Brown & Platt, 1909 K Street, N.W., Washington, DC 20006.

Michael L. Weiner, Esq.,

Skadden, Arps, Slate, Meagher & Flom LLP, 919 Third Avenue, New York, NY 10022.

Paul J. O'Donnell.

[FR Doc. 99–30832 Filed 11–26–99; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

U.S. v. *Morgan Drive Away, Inc., et al.*, Civ. Action No. 74–1781 (TAF) (D. D.C. 1976); United States Notice of Defendant's Motion To Terminate Final Judgment

Notice is hereby given that Morgan Drive Away, Inc. (''Morgan''), the only remaining defendant in the captioned matter, has moved to terminate the Final Judgment entered by the United States District Court for the District of Columbia on June 30, 1976. In a stipulation also filed with the Court, the Department of Justice (''Department'') has tentatively consented to termination of the Judgment, but has reserved the right to withdraw its consent pending receipt of public comments.

On December 5, 1974, the United States filed its complaint in this case. The complaint charged the defendants with conspiracy in restraint of trade, conspiracy to monopolize and monopolization of the for-hire transportation of mobile homes in the United States in violation of Sections 1 and 2 of the Sherman Act. Among the violations alleged in the complaint were that the defendants deprived applicants to state and federal regulatory agencies for mobile home transportation authority of meaningful access to and fair hearings before those agencies. This was done by various means including (1) protesting virtually all applications regardless of the merits, (2) including others to protest such applications, (3) jointly financing the protests and providing personnel to aid in the protests, (4) using tactics to deter, delay and increase the costs of the applications, and (5) providing, procuring, and relying on testimony in agency application proceedings that they knew to be false and misleading. The suit also charged that the companies conspired to coerce competitors to charge the same rates as they charged and to fix rates without authorization of federal or state law.

The Final Judgment, filed January 21, 1976 and entered by the Court on June 30, 1976 after a Tunney Act review, prohibited the defendants from using litigation before administrative agencies to exclude competition in the interstate transportation of mobile homes. The Judgment also enjoined the defendants from joint activities in connection with regulatory applications, from fixing interstate, intrastate, or military rates without proper legal authorization, from mutual stabilization of driver compensation, and from agreements to refrain from hiring one another's personnel.

In the period between 1976 and 1999 substantial changes have been made in the regulation of motor carriers, including transporters of mobile homes, effectively eliminating the opportunity for firms to manipulate the regulatory process to exclude competitors, to limit their growth, or to fix rates.

The Department and Morgan have filed memoranda with the Court setting forth the reasons they believe termination of the Final Judgment would serve the public interest. Copies of Morgan's motion to terminate, the stipulation containing the Department's consent, the supporting memoranda, and all additional papers field with the Court in connection with this motion will be available for inspection at the Antitrust Documents Group of the Antitrust Division, U.S. Department of Justice, Room 215, North, Liberty Place Building, 325 Seventh Street, NW., Washington, DC 20004, and at the Office of the Clerk of the United States District Court for the District of Columbia. Copies of these materials may be obtained from the Antitrust Division upon request and payment of the duplicating fee set out in Department of Justice regulations.

Interested persons may submit comments regarding the proposed termination to the Department. Such comments must be received by the Antitrust Division within sixty (60) days and will be filed with the Court by the Department. Comments should be addressed to Roger W. Fones, Chief, Transportation, Energy and Agriculture Section, Antitrust Division, U.S. Department of Justice, 325 Seventh St. NW., Suite 500, Washington, DC 20530, telephone: 202–307–6456.

Rebecca P. Dick,

Director of Civil Non-Merger Enforcement.

[FR Doc. 99–30831 Filed 11–26–99; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

Agency Information Collection Activities: Proposed Collection; Comment Request.

ACTION: Notice of Information Collection under Review: Study of Employment Eligibility.

The Department of Justice, Immigration and Naturalization Service (INS) has submitted the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection was previously published in the Federal Register on August 17, 1999 at 64 FR 44747. The notice allowed for a 60-day public review and comment period. No public comment was received by the INS on this proposed information collection.

The purpose of this notice is to allow an additional 30 days for public comments. Comments are encouraged and will be accepted until December 29, 1999. This process is conducted in accordance with 5 CFR 1320.10.

Written comments and/or suggestions regarding the items contained in this notice, especially regarding the