IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

IN RE CAREMARK INTERNATIONAL INC. DERIVATIVE LITIGATION	)))	Cons. C.A. No. 13670

DEFENDANTS' REPLY BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS THE THIRD AMENDED COMPLAINT

Of Counsel:

Howard M. Pearl
Timothy J. Rivelli
Julie A. Bauer
Winston & Strawn
35 West Wacker Drive
Chicago, IL 60601
(312) 558-5600

Kevin G. Abrams
Thomas A. Beck
Richard I.G. Jones, Jr.
Richards, Layton & Finger
One Rodney Square
P.O. Box 551
Wilmington, DE 19899
(302) 658-6541
Attorneys for Caremark International Inc.

Of Counsel:

William J. Linklater
Baker & McKenzie
One Prudential Plaza
130 East Randolph Drive
Chicago, IL 60601
(312) 861-8000

Kenneth J. Nachbar
Morris, Nichols, Arsht & Tunnell
1201 N. Market Street
P.O. Box 1347
Wilmington, DE 19899
(302) 658-9200
Attorneys for the Individual Defendants

Date: May 26, 1995

TABLE OF CONTENTS

TABLE OF AUTHORITIES

OTHER AUTHORITIES

PRELIMINARY STATEMENT

Defendants filed their opening brief in support of their motion to dismiss plaintiffs' Second Amended Complaint on January 25, 1995. (Dkt. 15, 20).[1] Defendants demonstrated in their opening brief that plaintiffs' claims are barred under the Section 102(b)(7) provision in the Caremark Charter and that plaintiffs failed yet again to comply with the demand excusal pleading requirements of Chancery Court Rule 23.1. Continuing their practice of seeking to amend their complaint in an attempt to overcome the defendants' dismissal arguments, plaintiffs filed on April 11, 1995 both their answering brief in opposition to defendants' motion to dismiss and a motion for leave to file their Third Amended and Supplemental Derivative Complaint ("Third Amended Complaint"). (Dkt. 22, 23). Plaintiffs' fourth attempt at pleading a legally cognizable derivative claim adds no particularized factual support to their previous claims against the thirteen Director Defendants.[2]

---

[1]Unless otherwise defined herein, all defined terms have the same meaning as set forth in defendants' opening brief in support of their motion to dismiss the Second Amended Complaint (Dkt. 20; "DOB ___"). The parties' pleadings and prior submissions are identified by reference to their docket number as "Dkt ___." References to plaintiffs' answering brief in opposition to defendants' motion to dismiss the Second Amended Complaint are identified as "PAB ___." A copy of each unreported opinion cited herein is contained in the compendium filed contemporaneously herewith.

[2]In order to bring the briefing to a close, the parties have agreed as follows: (i) the arguments in defendants' opening brief to dismiss the Second Amended Complaint (Dkt. 20) apply to defendants' arguments regarding the legal insufficiency of the Third Amended Complaint; (ii) plaintiffs' answering brief (Dkt. 23) will be the only brief filed by plaintiffs in support of their contention that the Third Amended Complaint states a viable cause of action; (iii) defendants' reply brief will be the only brief filed by defendants in support of their contention that the Third Amended Complaint fails to state a claim under Chancery Court Rule 12(b)(6) and fails to comply with the pleading requirements of Chancery Court Rule 23.1; and (iv) plaintiffs will stand on the Third Amended Complaint.

In an effort to cure the obvious deficiencies of the Second Amended Complaint (see Dkt. 20), plaintiffs essentially made three changes in the Third Amended Complaint. First, the Third Amended Complaint attempts to add particularity to plaintiffs' discussion of the purported "Atlanta Overbilling and Kickback Scheme" by incorporating charges against Caremark and certain of its employees aired on the February 23, 1995 edition of PrimeTime Live. (See 3d Amend. Comp. ¶¶ 2, 62-66, 84). Second, in a new section on the purported "fall-out" from the alleged kickback scheme, plaintiffs discuss Caremark's recent sale of its home infusion business at a purported "fire sale" price. (3d Amend. Comp. ¶¶ 85-86). Third, employing the adjective "intentionally" without any particularized supporting allegations, plaintiffs now claim that the Director Defendants "intentionally or recklessly" breached their duty to oversee the actions of Caremark employees. (3d Amend. Comp. ¶¶ 90(a), 90(e), 91(a)-(c), 93, 94).

Like its three predecessors, the Third Amended Complaint completely (and fatally) fails to link the challenged conduct of certain Caremark employees with any action or disqualifying interest on the part of the Director Defendants. Plaintiffs still do not allege anything tying any of the thirteen members of the Caremark Board to any of the alleged wrongdoing. Similarly, plaintiffs continue their failure to offer any particularized basis for their prior allegations of the Director Defendants' conscious or intentional participation in the purported wrongdoing. Plaintiffs' argument appears to be that, when wrongdoing is alleged against corporate employees, demand is excused even where, as here, (i) plaintiffs cannot allege that any employee has been found to have committed any illegal act, (ii) there are no particularized allegations linking any, much less a majority,

of the directors to the challenged conduct, and (iii) plaintiffs cannot identify a disqualifying personal interest of the directors. Because plaintiffs have now failed in four complaints to set forth a claim which survives under Section 102(b)(7) and which complies with the demand excusal pleading requirements of Rule 23.1, the Court should dismiss with prejudice plaintiffs' Third Amended Complaint.

STATEMENT OF FACTS[3]

A. The Parties.

Caremark operates in two business segments: (i) patient care -- which includes Caremark's home infusion therapy services, pharmaceutical service alliance programs, hemophilia and immune deficiency therapies, and physical therapy and rehabilitation services, and (ii) managed care -- which includes prescription drug benefit services, a preferred provider organization and multi-specialty physician practice management. (3d Amend. Comp. ¶ 8). Plaintiffs allege that the home infusion therapy business, which was only one of many operations in one of Caremark's two business segments, was "the division most directly involved in the kickback scheme." (3d Amend. Comp. ¶¶ 8-9, 85). Although Caremark had 1994 fiscal year revenues of approximately $2.4 billion (see 3d Amend. Comp. ¶ 16), plaintiffs do not disclose that during that period Caremark's infusion business generated only 18.2% of Caremark's revenues and had a net loss before taxes exceeding $6 million. (Ex. A -- Caremark 1994 10-K, p. 4 and Ex. No. 13.1 (Caremark's 1994 Annual Report), p. 30).[4]

---

[3]Attached hereto as Exhibit A is a copy of the Third Amended Complaint which has been marked by plaintiffs to show changes from the Second Amended Complaint. In view of defendants' summary of the allegations of the Second Amended Complaint in their opening brief (Dkt. 20, pp. 8-18), this Statement of Facts will discuss only the allegations in the Third Amended Complaint not contained in the Second Amended Complaint.

[4]For the reasons set forth in defendants' opening brief (Dkt. 20, p. 8 n. 3), defendants are entitled to support their motion to dismiss by referring to the contents of the documents incorporated by plaintiffs into the Third Amended Complaint. Plaintiffs raised no objection in their answering brief to such references by defendants in their opening brief. Copies of the pertinent documents are attached hereto and identified herein by reference to ("Ex. __").

B. Plaintiffs' Allegations Of Wrongdoing By Caremark, Its Employees And Third Parties.

In support of their liability allegations against the Director Defendants, plaintiffs continue to rely on the same seven examples of supposedly illegal conduct set forth in the Second Amended Complaint. Plaintiffs attempt in the Third Amended Complaint to supplement two of those examples with additional factual allegations. Critically, plaintiffs still do not allege with particularity that any of the Director Defendants were involved in, approved of, knew of or acquiesced to any of the alleged misconduct.

1. The OIG Investigation.

As in the Second Amended Complaint, plaintiffs continue to rely on public statements by the Company's officers and statements in the Company's SEC filings during 1992-1994 regarding the potential adverse effect of potential adverse findings from the OIG Investigation into Caremark's payment practices. The Third Amended Complaint supplements the prior allegations by referring the OIG's August 9, 1991 subpoenas to Caremark and subsequent scrutiny of Caremark's contractual relations with various doctors and hospitals. (3d Amend. Comp. ¶ 27). Plaintiffs continue their failure to allege any particularized facts demonstrating that the Director Defendants knew that Caremark's practices were illegal.

Plaintiffs' allegations concerning the OIG Investigation principally are derived from September 6, 1991 Caremark press release and a September 16, 1991 article in Modern Healthcare. (3d Amend. Comp. ¶ 23; see Ex. B). Plaintiffs fail to apprise the Court that, in the same article, Caremark specifically denied any wrongdoing and stated its intention to "seek clear regulations" from the government. (Ex. B, at 2). In that press

release and in subsequent public statements, Caremark and its representatives stated that the Company was discontinuing reimbursements to doctors supplying home care services to Medicare and Medicaid patients until the issue could be resolved under new federal regulations. (3d Amend. Comp. ¶¶ 24-25). While plaintiffs also cite a September 9, 1991 Chicago Tribune article noting Caremark's discontinuance of consulting arrangements with doctors for Medicare and Medicaid home-care patients (3d Amend. Comp. ¶ 24), they omit Caremark's denial of any wrongdoing and explanation that the discontinuance merely reflected Caremark's conservative position. (Ex. D). Caremark's denials of any improper activities relating to the OIG Investigation also were reported in the Business Week article, dated October 7, 1991 (Ex. E), in which (as plaintiffs acknowledge) Caremark's president stated that the Company's payments to doctors fell within a "gray area" of the regulations and were not prohibited by the Federal anti-kickback law. (2d Amend. Comp. ¶ 25).[5]

The Third Amended Complaint concedes that Caremark's consistent response to the OIG Investigation was that the Company's payment practices were entirely proper. (See 3d Amend. Comp. ¶¶ 24-25). Nevertheless, plaintiffs assert that the Director Defendants knew or should have known by November 1992 about supposedly illegal payment practices by Caremark employees as a result of the OIG Investigation. (3d Amend. Comp. ¶ 27). This allegation stands in contrast to the undisputed facts that,

---

[5]It is not surprising that, in the Third Amended Complaint, plaintiffs have continued to delete the references in the First Amended Complaint to repeated public statements by Caremark's president during October-December 1991 that the Company's payment practices were not in violation of federal Medicare and Medicaid rules. (See Dkt. 14, ¶ 23-25, 27; Exs. C, E).

throughout 1991, Caremark denied any wrongdoing relating to the OIG Investigation and at least eight of the thirteen Director Defendants had no association with Caremark before they became directors prior to the November 1992 spin-off by Baxter. (See 3d Amend. Comp. ¶¶ 12, 24-25; Exs. B, C, D, E).

2. The Minnesota Joint Venture Investigation.

Plaintiffs have added the allegation that The Wall Street Journal reported on March 2, 1995 that a University of Minnesota audit report concluded that the Minnesota Joint Venture was not within federal safe harbor rules and that it was accordingly uncertain whether the challenged conduct would be legally defensible. (3d Amend. Comp. ¶ 42). Plaintiffs fail to note that the audit report specified that activities which do not fit within a safe harbor are "not presumed to be unlawful." (Ex. G). They further ignore Caremark's vice president who stated in the same article that the auditors "didn't come across any areas with which they were uncomfortable." (Ex. G).

Although plaintiffs characterize the Minnesota Joint Venture as an "illegal referral arrangement," the Third Amended Complaint fails to report that the newspaper articles do not assert that the questioned payments were illegal. Revealingly, plaintiffs also omit to mention in the Third Amended Complaint that one of the Minneapolis Star Tribune articles refers to the eleven page response by the University of Minnesota which stated that the formation and operation of the Minnesota Joint Venture complied with applicable law, and that procedures currently are in place to assure continued compliance. (See Ex. H). Most importantly, plaintiffs continue their failure to allege that the Director

Defendants were in any way involved in or aware of what plaintiffs repeatedly refer to (with curious certainty) as an "illegal" scheme. (See 3d Amend. Comp. ¶¶ 36-42).

3. The Minneapolis Indictment.

The Third Amended Complaint adds no new facts regarding the Minneapolis indictment other than to recharacterize The Wall Street Journal's description of that indictment and the related investigation. (3d Amend. Comp. ¶ 50). As before, no allegations connect any of the Director Defendants with the Minneapolis indictment or any of the persons named in that indictment. (See 3d Amend. Comp. ¶¶ 43-52).

4. The Ohio Investigation and Indictment.

Plaintiffs' allegations concerning the Ohio investigation and indictment are substantially unchanged. (3d Amend. Comp. ¶ 53-55). While plaintiffs cite articles speculating that the unnamed "home infusion company" is Caremark (3d Amend. Comp. ¶ 53, 55), they omit both the critical fact that the unnamed company was not charged in the indictment and Caremark's specific denial of wrongdoing. (Exs. I, J). As before, no allegations connect any of the Director Defendants with the Ohio investigation and indictment or any of the persons involved in the Ohio proceedings.

5. The Atlanta Lawsuit.

Plaintiffs supplement their allegations regarding the Atlanta Lawsuit by referring to reports from the February 23, 1995 edition of PrimeTime Live. (3d Amend. Comp. ¶ 62-66). In the PrimeTime segment, a physician's office manager and two unidentified former Caremark employees essentially stated that an unidentified number of unnamed doctors in Atlanta received a percentage of Caremark's insurance billings as a form of

referral fees. (3d Amend. Comp. ¶ 64). Of course, plaintiffs fail to mention that portion of the Primetime Live episode where Caremark asserts that its arrangements were structured to better serve patients and complied with all applicable federal and state laws. (Ex. K). Plaintiffs further do not allege that the Director Defendants participated in, approved of, or even had knowledge of the alleged wrongdoing in Atlanta. In fact, plaintiffs acknowledge that the Atlanta lawsuit was settled and that the plaintiff in that proceeding signed "an exculpatory affidavit." (3d Amend. Comp. ¶ 60). In that affidavit the Atlanta plaintiff stated under oath that "he had no personal knowledge of any kickbacks to doctors." (Ex. K).

6. The Detroit Investigation.

Plaintiffs have supplemented their prior assertions regarding the Detroit Investigation by adding allegations relating to the profitability of the purported scheme involving Dr. Margulis, as well as raising allegations that certain unnamed former Caremark employees allegedly stated that the Company supposedly charges $250 per patient for a regimen of intravenous nutrients which costs the Company only about $6. (3d Amend. Comp. ¶¶ 70, 72).

Although plaintiffs rely exclusively on an article in the November 11, 1994 Wall Street Journal (the "November WSJ Article") to contend that two former Caremark employees in Detroit believed that Caremark's payment practices were intended to induce patient referrals (3d Amend. Comp. ¶¶ 67-71), plaintiffs once again failed to include in their complaint a host of significant facts from the November WSJ Article. (Ex. L). First, the November WSJ Article clearly states that Caremark terminated its joint venture

with Margulis in December 1992 -- the fourth month after nine out of ten of the Outside Directors joined the Caremark board, and less than one month after plaintiffs possibly could have become stockholders of the Company following the Spin-Off. Second, none of the wrongs alleged in the November WSJ Article are reported to have occurred after 1992. Third, the November WSJ Article makes the following statements about Caremark's response to the Detroit Investigation:

> Caremark denies any impropriety, saying that "compliance with the law has always been a high priority."
>
> * * *
>
> Caremark had contracts with doctors spelling out what patient-monitoring services were expected and forswearing any effort to induce referral of patients. A Caremark attorney, Howard M. Pearl, says any doctor failing to perform patient monitoring "would have violated Caremark's clearly stated policies."

(Ex. L). Finally, as with every other allegation in the Third Amended Complaint, there are no factual allegations suggesting that any of the Director Defendants are implicated in the alleged wrongdoings, are the subjects of the reported investigations, or had any knowledge of the allegedly wrongful activity in Detroit. (See 3d Amend. Comp. ¶¶ 67-72).

Plaintiffs further note that, in articles appearing on November 17-18, 1994, the Wall Street Journal, New York Times and Chicago Tribune reported that the federal investigation of Caremark had been expanded to focus on Caremark's office in Detroit. (3d Amend. Comp. ¶ 76-77). In characteristic fashion, plaintiffs once again omit to mention that all three articles refer to Caremark's denial of any wrongdoing. (Exs. M, N, O).

7. The FTC Investigation.

Plaintiffs continue to assert that the FTC is investigating whether relationships between the Company's prescription drug division and various drug companies violate the Clayton Act or the FTC Act. (3d Amend. Comp. ¶ 82). The FTC investigation appears to be entirely separate from the proceedings relating to Caremark's infusion business. Consistent with the deficiencies throughout the Third Amended Complaint, no allegations link any decision by the Director Defendants to the FTC investigation. (Id.)

8. Caremark's Sale Of Its Home Infusion Business.

On January 29, 1995, Caremark entered into an agreement to sell its home infusion business for $310 million to James Sweeney, Caremark's founder and the current CEO of Coram Healthcare Corp. (See 3d Amend. Comp. ¶¶ 5, 85). Baxter International, which owned Caremark until the 1992 spin-off, had purchased the home infusion business from Sweeney in 1987 for $586 million. (3d Amend. Comp. ¶¶ 7, 85). Plaintiffs allege no facts comparing (i) the business Baxter purchased from Sweeney in 1987 with the division Caremark sold in 1995, (ii) the competitive environment for a home infusion business in 1987 and in 1995, or (iii) any of the multiple external factors which would affect the value of a home infusion business in 1987 and 1995.[6]

---

[6]Plaintiffs' allegation that Caremark received only a "fire sale" price for its infusion business from Sweeney is inconsistent with other allegations of the Third Amended Complaint. The sale price presumably would have been diminished if the acquiror assumed all of that division's actual and contingent liabilities, including the potential exposure resulting from the pending investigations and lawsuits. However, plaintiffs acknowledge that Caremark's agreement with Sweeney specifies that Caremark bears sole responsibility for any liabilities which might result from government or civil proceedings relating to the home infusion business. Notably, plaintiffs do not allege that the Director (continued...)

Plaintiffs assert that the sale of Caremark's home infusion business was occasioned by the pendency of stockholder class actions in Illinois and Minnesota as well as negative publicity occasioned by the PrimeTime Live story. (3d Amend. Comp. ¶ 83-84). Plaintiffs allege that the sale of the Company's home infusion division will not relieve Caremark of liability for the class action lawsuits, which plaintiffs further allege that the Company is attempting to settle. (3d Amend. Comp. ¶ 86). According to plaintiffs, a CNBC reporter has estimated that Caremark could be required to pay $400 - $700 million to settle all of the pending state and federal investigations and proceedings. (3d Amend. Comp. ¶ 87).

C. **Plaintiffs' Allegations Of Wrongdoing By The Director Defendants.**

Despite the fact that plaintiffs' supplemental allegations in the Third Amended Complaint utterly fail to link the Director Defendants with any of the purported wrongdoing, plaintiffs have amended the charging paragraphs of their complaint to allege that the Director Defendants acted "intentionally or recklessly" in allowing Caremark "to enter into and continue arrangements . . . which violated federal and state anti-kickback laws for Medicare and Medicaid patients." (E.g., 3d Amend. Comp. ¶¶ 2, 90-91, 93-94).

---

[6](...continued)
Defendants breached any legal duties in approving the sale of the Company's infusion business to Sweeney. In the absence of any logically consistent or specific allegations regarding the supposed injury to Caremark relating to the sale of its home infusion business, plaintiffs cannot overcome the presumption that Caremark received the best available price. (See 3d Amend. Com. ¶¶ 85-86).

The fatal defect in plaintiffs' "intentionally or recklessly" charge is that Caremark consistently has denied any wrongdoing in connection with its payment practices in the seven examples identified in the Third Amended Complaint. Caremark responded to the commencement of the OIG Investigation in 1991 by asserting that the Company had complied with the law and would continue to do so. (See Amend. Comp. ¶¶ 24-25; Exs. B, C, D).[7] Plaintiffs also acknowledge the September 26, 1994 statement by Caremark that the Company will not enter into or continue any financial relationship with a physician unless it is "fully consistent" with a "new" federal law. (3d Amend. Comp. ¶ 79). Plaintiffs only rebuttal to Caremark's compliance statement is to point to the several investigations and a supposedly critical observation by an assistant in a regional office of HHS that Caremark made similar statements in 1991. (3d Amend. Com. ¶ 81). Of course, despite the commencement of the OIG Investigation in August 1991 -- nearly four years ago, neither Caremark nor any of its employees have been found guilty of criminal conduct or subject to civil liability for any of the matters identified in the Third Amended Complaint. Thus, it is impossible to understand how plaintiffs can assert that the Director Defendants "intentionally or recklessly" allowed the continuation of illegal activities. (See, e.g., 3d Amend. Comp. ¶ 91(a)).

---

[7]Plaintiffs exceed the boundaries of proper pleading by deliberately mischaracterizing Caremark's statements in 1991 to suggest that Caremark's management "acknowledged . . . the questionable propriety" of certain payment practices and that the Company "committed to discontinue such [questionable] arrangements." (3d Amend Comp. ¶¶ 26-27). In fact, the misleading conclusions drawn by plaintiffs are completely inconsistent with the relevant statements.

Plaintiffs' assertion that the Director Defendants consciously acquiesced to illegal activities (3d Amend. Comp. ¶ 91(b)) is undercut fatally by plaintiffs' admission that Caremark consistently has asserted the propriety of its payment practices involving doctors and hospitals which use Caremark's infusion therapy services. (See 3d Amend. Comp. ¶¶ 24, 25; Exs. B, C, D). As to the Minnesota Joint Venture, the eleven-page rebuttal by the University of Minnesota Hospital speaks for itself. (Ex. H). Caremark was not named as a defendant in the Ohio Indictment, and the Atlanta Lawsuit was settled after the individual plaintiff executed an affidavit which denied any wrongdoing by Caremark. Furthermore, as Caremark has stated consistently and as plaintiffs concede, the Company has policies and practices to prohibit wrongdoing by its employees. (See Ex. L). The statements and documents set forth and incorporated by reference in the Third Amended Complaint demonstrate that Caremark has denied any misconduct and plaintiffs fail to allege that the Board had a basis to conclude that the Company's compliance policies were not being followed. Accordingly, the Third Amended Complaint fails to allege with particularity that the Director Defendants "intentionally or recklessly" allowed the Company to engage in illegal conduct.

The Director Defendants' supposed knowing acquiescence of illegal activities also is inconsistent with the status and nature of the proceedings cited in the Third Amended Complaint. Plaintiffs themselves allege that Caremark's payments to doctors fell into a "gray area" and were not "prohibited by the Federal anti-kickback law." (3d Amend. Comp. ¶25). Furthermore, plaintiffs refer to past and ongoing investigations as determining whether Caremark's practices were illegal. (3d Amend. Comp. ¶ 27;

emphasis added). Plaintiffs acknowledge that (i) Caremark has disclosed that the nature, scope, timing and outcome of the OIG Investigation "are not currently determinable," (ii) neither Caremark nor any of its employees has been indicted or subjected to restitution claims in connection with the Minneapolis Joint Venture, the Detroit Investigation, the FTC Investigation or the Ohio Indictment; (iii) the Minneapolis Indictment has not resulted in a determination of wrongdoing by Caremark or any of its employees; and (iv) the Atlanta Lawsuit has been settled. Thus, plaintiffs only assert that the Director Defendants supposedly acquiesced to "risky" practices which "could result" in the loss by Caremark of some unspecified amount of revenues. (3d Amend. Comp. ¶ 27; emphasis added). Having conceded that Caremark has denied any wrongdoing and that the Company has never been found to have engaged in any illegal practices, plaintiffs have failed to satisfy Rule 23.1 by alleging with particularity that the Director Defendants "intentionally or recklessly" allowed Caremark or its employees to engage in improper conduct.

ARGUMENT

I. THE THIRD AMENDED COMPLAINT MUST BE DISMISSED FOR FAILURE TO COMPLY WITH RULE 23.1.

A. Plaintiffs' Demand Excusal Allegations Are Governed By Rales.

Recognizing the inadequacy of their demand excusal allegations under Rales v. Blasband, Del. Supr., 634 A.2d 927 (1993), plaintiffs contend that their compliance with the strict pleading requirements of Rule 23.1 should be evaluated under the two-part test articulated in Aronson v. Lewis, Del. Supr., 473 A.2d 805 (1984). (PAB 18-21). The parties agree that, because the business judgment rule "operates only in the context of director action", Aronson, 473 A.2d at 813, the Aronson test for determining demand futility does not apply "where the board that would be considering the demand did not make a business decision which is being challenged in the derivative suit." Rales, 634 A.2d at 933-34. (See DOB 24-28; PAB 19). However, plaintiffs assert that Aronson, rather than Rales, applies because the Court should infer that the Caremark directors made a "conscious decision" to ignore the supposed warning signs of improper practices and to refrain from taking action to ensure the termination of the challenged activities. Plaintiffs' argument simply ignores the clear standards set forth in Aronson and Rales for determining the legal test to apply under Rule 23.1 to assess the sufficiency of demand futility allegations.

It is certainly true that, in the absence of a formal vote or resolution of the directors, Aronson might apply because the board made an informal decision or reached a consensus in deliberations to refrain from addressing a particular matter. Nevertheless, as the Delaware Supreme Court explained unequivocally in Rales and Aronson, the

application of the second prong of Aronson test is predicated on the existence of a business decision which is subject to evaluation under the business judgment rule. See Rales, 634 A.2d at 933 (Aronson applies to a "conscious decision by directors to act or refrain from acting") (emphasis added); Aronson, 473 A.2d at 813 ("the business judgment rule operates only in the context of director action"). Absent a specific "business decision of the board" (which must be made consciously) or "board action," it is "impossible to perform the essential inquiry contemplated by Aronson -- whether the directors have acted in conformity with the business judgment rule in approving the challenged transaction." Rales, 634 A.2d at 933. Thus, "a court should not apply the Aronson test for demand futility where the board that would be considering the demand did not make a business decision which is being challenged in the derivative suit." Rales, 634 A.2d at 933-34 (emphasis added).

The inapplicability of the two-prong Aronson test to situations such as this, where no specific board decision is challenged, was recently confirmed by this Court in Seminaris v. Landa, Del. Ch., C.A. No. 12579, Chandler, V.C. (May 2, 1995). In Seminaris, plaintiff alleged that the directors of Fidelity Medical, Inc. breached their fiduciary duties by conspiring with or failing to oversee the company's CEO and other employees, who allegedly misstated the company's expected performance in public statements, thereby subjecting the company to several securities fraud lawsuits and an SEC investigation. Upon observing that "plaintiff does not challenge a specific board action that approved or ratified these alleged wrongdoings," the Court determined that the Rales test applied rather than the Aronson test. Seminaris, slip op. at 8. As in

Seminaris, plaintiffs here identify no specific board action that was approved or ratified by the Director Defendants. Accordingly, the Rales test applies.

Plaintiffs' four complaints consistently have failed to identify any specific business decision or other action by the Caremark directors. At best, plaintiffs plead that the various Caremark directors knew or must have known the alleged wrongs and failed to take action. (See 3d Amend. Comp. ¶ 88-90). However, there are no particularized allegations that the Board or any of the Director Defendants actually knew of the alleged misconduct. Nor are there any well-pleaded allegations that the Director Defendants knew that the alleged misconduct was illegal.[8] Indeed, there is no allegation in the Third Amended Complaint that any of the alleged misconduct has ever been determined to be illegal.

The Third Amended Complaint presents the prototypical example of directors who are sued derivatively "because they have failed to do something (such as a failure to oversee subordinates)." Rales, 634 A.2d at 934 n.9. Accordingly, Rales dictates that the sole inquiry for the Court is whether the Caremark board could have properly exercised

---

[8]The alleged improprieties occurred within a discrete business group which, as noted above, generated only 18.2% of the Company's revenues and posted a $6 million pre-tax loss in fiscal 1994. Plaintiffs' allegations should be considered in that context. See Levine v. Smith, Del. Ch., C.A. No. 8833, slip op. at 22, Jacobs, V.C. (Nov. 27, 1989), aff'd, Del. Supr., 591 A.2d 194 (1991) ("Corporate directors normally have only limited available time to deliberate, and a determination of what matters will (and will not) be considered must necessarily fall within the board's discretion"); see also Manning, The Business Judgment Rule And The Directors' Duty Of Attention: A Time For Reality, 39 Bus. Law. 1477, 1485 (1984).

its independent and disinterested business judgment in responding to a demand by plaintiffs.

B. Plaintiffs Fail To Allege Particularized Facts Creating A Reasonable Doubt That A Majority Of The Director Defendants Have A Disqualifying Interest Regarding The Matters Alleged In The Third Amended Complaint.

Rales essentially requires application of the first prong of the Aronson test by inquiring whether the complaint demonstrates through particularized allegations that a pre-suit demand would have been futile due to the disqualifying interests or lack of independence of a majority of the directors at the time the suit was filed. (See DOB 27 & n. 10). Under established precedent, a director is "interested" where he or she receives a personal financial benefit not shared equally with the stockholders or where the decision will detrimentally impact the directors but not the corporation and its stockholders. See, e.g., Rales, 634 A.2d at 936; Pogostin v. Rice, Del. Supr., 480 A.2d 619, 626 (1984); Aronson, 473 A.2d at 812.

Plaintiffs' demand excusal allegations in the Third Amended Complaint fall into three general categories: (i) that the Director Defendants affirmatively facilitated or approved of the alleged wrongs, (ii) that the Director Defendants permitted the underlying wrongs to continue and failed to take remedial action, and (iii) that the Director Defendants would be required to sue themselves and face the substantial likelihood of liability.[9] While plaintiffs attempt in their brief to distinguish the defendants' authorities

[9]The Third Amended Complaint resuscitates an allegation contained in the original complaint (but deleted from the Second Amended Complaint) that each of the Director Defendants receives from Caremark an annual retainer of $33,000 which may be paid in (continued...)

rejecting the "approval" and "failure to take action" allegations as a basis to excuse demand, the plaintiffs do not affirmatively argue that such allegations excuse demand. (PAB 29-32). Instead, plaintiffs' sole argument is that, because the Director Defendants "intentionally or recklessly" allowed the alleged wrongs to continue and consciously failed to take corrective action (3d Amend. Comp. ¶ 91), the Director Defendants' inaction "is sufficiently egregious to establish a substantial likelihood that [the Director Defendants] could be held liable for their conduct." (PAB 24).

The parties agree that, under Graham v. Allis-Chalmers Mfg. Co., Del. Supr., 188 A.2d 125, 130 (1963), directors may be liable for losses to the corporation if they ignore "either willfully or through inattention obvious danger signs of employee wrongdoing." (See PAB 22-23). Furthermore, plaintiffs do not dispute the specification in Rales that, in order to excuse demand for a "failure of oversight" allegation, plaintiffs must set forth particularized allegations demonstrating a "substantial likelihood" of director liability. Accord Seminaris, slip op. at 10. Thus, as the Court recognized in Baxter Int'l, Inc. Shareholders Litig., Del. Ch., 654 A.2d 1268 (1995), demand will be

---

[9](...continued)
the form of options to purchase Caremark stock. (3d Amend. Comp. ¶ 15). The ten non-officer Director Defendants have elected through the 1998 annual meeting of the Caremark stockholders to receive their directors' fees in the form of Caremark stock options. (Id.) Plaintiffs allege that these options give the Director Defendants "a strong incentive to encourage short-term earnings from the illegal conduct". (Id.) For the reasons set forth in defendants' opening brief in support of their motion to dismiss the first amended complaint, the receipt by the Director Defendants from Caremark of ordinary compensation for their services as directors does not establish a disqualifying interest. (See Dkt. 8, pp. 28-29). Plaintiffs effectively concede the point by failing to address the issue in their answering brief in opposition to defendants' motion to dismiss the Second Amended Complaint.

excused in a "lack of oversight" case only if the complaint pleads "... with particularity what obvious danger signs were ignored or what additional measures the directors should have taken." 654 A.2d at 1271. Accord Seminaris, slip op. at 10 (demand will be excused in a director oversight case only if plaintiffs allege with particularity that the director defendants were grossly negligent in failing to supervise their subordinates).

1. Plaintiffs Have Failed To Specify Any Warning Signs Which Should Have Alerted The Caremark Directors To Illegal Activities By The Company's Employees.

Plaintiffs rely upon the ultimate bootstrap argument to allege that the commencement of the OIG Investigation in 1991, the Minnesota Indictment in 1994, the Ohio Indictment in 1994, several civil lawsuits in 1994 and the totally unrelated FTC Investigation in 1994 demonstrate that the Director Defendants "intentionally or recklessly" permitted Caremark to engage in "illegal activities on a nationwide basis after the November 1992 spin-off until at least 1994." (3d Amend. Comp. ¶ 35). Plaintiffs' core allegation is a non sequitur because the mere commencement of these proceedings certainly does not demonstrate that any illegal conduct ever occurred, that the Director Defendants even knew about any of the supposedly illegal practices, or that the activities occurred "on a nationwide basis." Furthermore, the commencement of these proceedings is entirely irrelevant to the pending question: whether the Third Amended Complaint identifies specific facts which should have placed the Director Defendants on notice that Caremark employees had engaged in improper activities. The allegations of the Third Amended Complaint demonstrate that the answer to this question is no.

Plaintiffs' latest complaint fails to identify any "red flags" which should have alerted the Director Defendants to the Company's supposedly illegal payment practices. Following the commencement of the OIG Investigation in August 1991, Caremark issued a series of statements by the Company's president and other representatives that the Company's payment practices complied with the law. (See 3d Amend. Comp. ¶¶ 24-25; Exs. B, C, D). The October 1993 disclosure by Caremark's CEO that the government investigations were continuing confirms that no finding of civil or criminal misconduct had been made in the more than two years following the commencement of the OIG Investigation. The acknowledgement by Caremark in its SEC filings since November 1992 of the existence and potentially adverse consequences of the OIG Investigation was mandated by the federal securities laws and certainly cannot be deemed, as plaintiffs suggest, to demonstrate that the Director Defendants were "fully aware" that the Company had engaged in "widespread illegal practices." (3d Amend. Comp. ¶¶ 28-30, 32-34).[10] Contrary to plaintiffs' allegation that the Director Defendants consciously allowed illegal payment practices to continue, the record demonstrates that the Caremark Board had no basis whatsoever to conclude, on the basis of the commencement and continuation of the OIG Investigation, that "illegal kickback arrangements were the 'modus operandi' of Caremark." (See 3d Amend. Comp. ¶ 2).

---

[10]Curiously, plaintiffs now assert that Caremark's supposedly illegal payment practices ended by no later than "late-1994." (3d Amend. Comp. ¶ 35). Plaintiffs naturally fail to specify in their latest complaint how, when or why the supposed "illegal activities" were stopped.

Plaintiffs assert that a "red flag" was raised by the October 1993 public disclosure of the payments by Caremark to certain doctors at the University of Minnesota Hospital. (3d Amend. Comp. ¶¶ 36-41). Plaintiffs conveniently failed to inform the Court of the contemporaneous, eleven-page statement by the University of Minnesota regarding the compliance by the joint venture with all applicable laws. (Ex. H). Furthermore, plaintiffs acknowledge that a recently completed audit by the University of Minnesota failed to determine that Caremark's payment practices were improper. (3d Amend. Comp. ¶ 42). Thus, it is impossible to understand how the Director Defendants should have concluded in October 1993, on the basis of a press report regarding the Minnesota Joint Venture, that Caremark was involved in an "illegal kickback scheme" at the University of Minnesota Hospital. (See 3d Amend. Comp. ¶ 40).

Plaintiffs further assert that the Director Defendants should have viewed as a "red flag" the 1993 alleged expansion of the OIG Investigation in 1993 to address the Company's marketing practices for a drug manufactured by Genentech, Inc. (3d Amend. Comp. ¶ 43). Plaintiffs offer no allegation as to when the Caremark or the Director Defendants supposedly learned about the expansion of the OIG Investigation. Once again, therefore, plaintiffs offer nothing to support their conclusion that, standing alone, the alleged expansion of the OIG Investigation somehow shows that the Director Defendants "consciously allowed and facilitated the continuation of Caremark's widespread illegal practices...." (3d Amend. Comp. ¶ 44).

Plaintiffs also suggest that a "red flag" should have been evident to the Director Defendants by virtue of the commencement in April 1994 of the Atlanta Lawsuit by an

AIDS patient. As usual, plaintiffs have not alleged that the Director Defendants were informed about the Atlanta Lawsuit. Furthermore, the mere filing of a lawsuit (and particularly one of this nature) provides no basis for the directors of a $2 billion company to conclude that its employees were engaged in a nationwide scheme of criminal conduct. (See 3d Amend. Comp. ¶ 59). Plaintiffs also defy logic by suggesting that an April 1994 lawsuit somehow is evidence of the Director Defendants' failure to observe warning signals in 1992 or 1993 of improper activities by Caremark employees.

The Minnesota Indictment and the Ohio Indictment, which respectively were disclosed on August 4, 1994 and September 20, 1994, certainly cannot be viewed as "red flags" which demonstrate that the Director Defendants deliberately ignored misconduct by Caremark employees. The Company's immediate response to the Minnesota Indictment was to deny liability (Ex. F), and neither Caremark nor any of its employees were named in the Ohio Indictment. (3d Amend. Comp. ¶¶ 54-56). In any event, the simple commencement in August and September 1994 of criminal proceedings obviously does not support the contention that the Director Defendants deliberately ignored misconduct at an earlier time.

Finally, plaintiffs certainly cannot rely upon the November 18, 1994 disclosure of the Detroit Investigation, the November 26, 1994 disclosure of the (unrelated) FTC Investigation or the February 23, 1995 story on "PrimeTime Live" to suggest that the Director Defendants should have realized in 1992 or 1993 that Caremark was engaged in illegal practices. Since plaintiffs state that Caremark ceased its supposedly improper activities by no later than "late-1994" (3d Amend. Comp. ¶ 35), all three of these

disclosures are simply irrelevant to plaintiffs' contention that the Director Defendants consciously determined in prior years to allow improper activities to continue.

2. Prior Decisions Demonstrate That Plaintiffs' Demand Excused Allegations Are Inadequate.

Plaintiffs' bare allegations fall woefully short of demonstrating with particularity that this is the rare case in which the asserted failure of the directors to oversee the actions of the Company's employees is so egregious that a "substantial likelihood" of director liability exists. Here, of course, plaintiffs only point to investigations and the commencement of legal proceedings against a handful of Caremark employees which do not involve any of the Director Defendants. Not surprisingly, plaintiffs fail completely to address the cases in which demand was required despite the existence of actual criminal conduct by employees, one or more of the directors or the corporation itself.

In In re E. F. Hutton Banking Practices Litigation, 634 F. Supp. 265, 267 (S.D.N.Y. 1986), demand was not excused on the directors of E. F. Hutton even though the company pled guilty to over 2,000 counts of mail and wire fraud resulting in a $2 million fine and the requirement that E. F. Hutton establish an $8,750,000 fund to pay for related costs (including the cost of government prosecution). As here, plaintiffs in E. F. Hutton filed a derivative action claiming that the directors "knew or should have known" of the existence of the overdrafting schemes which gave rise to the mail and wire fraud charges. In rejecting their demand excusal claim, the Court stated that plaintiffs "must go further than alleging passive acquiescence in the challenged conduct and potential liability on behalf of some directors." Rather, a complaint "must contain specific allegations of self-dealing or bias on the part of a majority of the board":

> No doubt there has been considerable wrongdoing at E. F. Hutton. No doubt plaintiffs have alleged that certain defendants probably encouraged and participated in such wrongdoing. However, they have failed to allege sufficient involvement on the part of a majority of Hutton's board to overcome the 'strong policy and practical advantages favoring exhaustion of intracorporate remedies'.

634 F. Supp. 272 (citation omitted). In contrast to E. F. Hutton, none of Caremark's employees have been found guilty of anything and, even if they had been, there is no suggestion in the Third Amended Complaint that even one of the Director Defendants was involved in any way in the purported wrongdoing.

Similarly, in Mozes v. Welch, 638 F. Supp. 215 (D. Conn. 1986), plaintiffs filed a derivative action against the directors of General Electric Corporation ("GE") after GE pled guilty to 104 counts of making false statements to a government agency and 4 counts of presenting false labor claims. As here, plaintiffs alleged that the GE directors had been aware of, participated in, acquiesced in and approved of the wrongs which occasioned the guilty pleas. The Court held that demand was not excused:

> Nowhere has [plaintiff] made sufficiently particular allegations of participation, self-dealing, bias, bad faith, corrupt motive or the like in reference to a board majority. She has alleged no facts from which the court could conclude that a majority of individual defendants have any interest adverse or antagonistic to G.E.

638 F. Supp. 220. Since the claims against the Caremark directors pale in comparison to the allegations against the GE directors, the Court should conclude that plaintiffs have failed to raise particularized allegations showing that Director Defendants have any interest adverse or antagonistic to Caremark.

Lewis v. Fites, Del. Ch., C.A. No. 12566, Berger, V.C. (Feb. 18, 1993), is directly applicable. In Fites, the Court rejected plaintiff's claim that a heightened threat

of personal liability created a reasonable doubt as to the disinterestedness of Caterpillar's directors, even though Caterpillar had admitted that certain of the company's public statements had violated the disclosure requirements of the Securities Exchange Act of 1934. Slip op. at 4, 6. Recognizing that the Consent Order admitting Caterpillar's wrongdoing did not contain any admission of wrongdoing or findings concerning the activities of the Caterpillar directors in the false public statements, the Court found that demand was required and dismissed the complaint. Since the Caremark directors are in the same position as the Caterpillar directors, there is no reason to deviate from the recognition in Fites that plaintiffs' "lack of oversight" allegations require a pre-suit demand.

In Allison v. General Motors, 604 F. Supp. 1106 (D. Del.), aff'd, 782 F.2d 1026 (3rd Cir. 1985), plaintiffs' derivative action was based on alleged breach of duties by the GM board arising from their permitting the production and sale of defective X-cars in 1979 and 1980 which allegedly resulted in numerous accidents, over fifty lawsuits against GM (one of which resulted in a verdict against GM in excess of $5 million), two recalls of thousands of cars and a suit by the National Highway Transportation Safety Administration to force the recall of 1.1 million X-cars, and the payment by GM to the federal government of a civil penalty in excess of $4 million. 604 F. Supp. at 1111. The District Court, per Judge Schwartz, held that demand was not excused because the plaintiff had failed to explain why the GM board would be disabled from assuming control of the litigation. Id. at 1113. The District Court specifically held that the GM directors' participation in an administrative investigation and defense of a government

agency lawsuit is insufficient to establish futility of demand. Id.[11] The Caremark directors are in no different position than the GM directors regarding plaintiffs' abdication allegations.

Finally, in Seminaris, plaintiff alleged that a pre-suit demand was excused due to the alleged failure of the defendant directors to oversee the public disclosures by its company's former CEO and other employees regarding the company's financial prospects. Applying Rales, the Court rejected plaintiff's conclusory claim that the director defendants faced a "substantial likelihood of liability" since plaintiff had failed to plead particularized facts demonstrating that the defendant directors had been grossly negligent in failing to supervise subordinates. Seminaris, slip op. at 10. Although plaintiff alleged that the directors "looked the other way" and failed to prevent the employees' conspiracy to inflate the company's stock price, the Court found that pre-suit demand was not excused because the allegations did not describe such "egregious conduct" that the directors faced a substantial risk of liability due to their failure to prevent the CEO's misrepresentations. Furthermore, despite the directors' role as defendants in federal securities litigation and as targets of a criminal investigation, the Court found that plaintiff's "substantial likelihood of liability" argument was simply "a slightly altered version of the discredited refrain -- 'you can't expect directors to sue themselves.'" Slip op. at 10-11.

---

[11]Plaintiffs assert that Allison is inapposite because plaintiff there brought suit against only four of GM's twenty-six directors. (PB 30). Of course, the relevant inquiry is not who plaintiff chooses to name as defendants, but rather whether the particularized facts alleged create a reasonable doubt that a majority of the board is interested or not independent.

Ignoring the foregoing authorities, plaintiffs assert that Miller v. Loucks, No. 91 C 6539, 1992 WL 329313 (N.D. Ill. Nov. 5, 1992), supports their claim that this is the rare case where the directors' alleged conduct is so egregious that director interest exists. (PAB 25-26). Plaintiffs invite the Court to compare the facts of Miller, in which demand was excused as futile, with the facts of In re Baxter Int'l., Inc. Shareholder Litig., 654 A.2d 1268, in which demand was held to be required and the complaint dismissed. (PAB 26). Defendants agree. The critical fact present in Miller -- and absent in Baxter and the instant case -- is that the Miller complaint accused a majority of the directors of being the "principal wrongdoers and beneficiaries of the wrongful acts at issue." WL 329313 at *24. Indeed, plaintiff in Miller alleged the following "litany of the directors' wrongful acts": affiliation with alleged Syrian terrorists and anti-semites, complicity and encouragement of a terrorist country, attempted construction of Syrian intravenous fluid factory with chemical warfare capabilities, and bribery of Syrian officials to remove Baxter from the blacklist. Id. at 8 (emphasis supplied). The District Court found that demand was excused on the basis of the particular allegations against the individual directors:

> This Court assumes the veracity of these particular facts in the context of a motion to dismiss. As a result, this Court finds that the alleged conduct is so egregious on its face that it created a substantial fear of criminal or civil liability in the board during pending Grand Jury investigations and, thereby, rendered the entire 18-member board of directors incapable of exercising valid business judgment at the time suit was filed.

Id.

The Third Amended Complaint is obviously distinguishable from the complaint in Miller because, in this case, plaintiffs have failed to allege any affirmative wrongful

acts by any of the Director Defendants. Indeed, contrary to the complaint in Miller, the Third Amended Complaint fails to allege that any of the Director Defendants were involved in any aspect of the purported wrongdoing. Plaintiffs in this case, as in Baxter and Seminaris, only charge the directors with failing to oversee the practices of employees who allegedly were violating government regulations. 654 A.2d at 1268. In Baxter, the Court rejected plaintiffs' claim that their allegations suggested a substantial likelihood of director liability:

> The claim of director culpability in this case is conclusory. The complaint does not include anything specific about the alleged scheme suggesting that the directors must have known of it. Assuming that the directors were aware of the VA's investigation, without a specific allegation to that effect, the last event alleged before the proposed suspension was the letter of April 1991 stating that corrective measures had been taken. Assuming, further, that the improper practice continued, without an allegation that wrongdoing was admitted or proven, the complaint does not plead with particularity what obvious danger signs were ignored or what additional measures the directors should have taken.

654 A.2d at 1271.

Plaintiffs purport to distinguish Baxter based upon their allegations "that the Director Defendants knew about (i) the massive investigation targeting Caremark; (ii) the existence of admittedly questionable arrangements with doctors that the Board admitted were potentially illegal; and (iii) management's publicly announced commitment to change Caremark's corporate policy" demonstrate a "substantial likelihood" that the Director Defendants will be held liable for breaching their obligations to Caremark. (PB 28). However, the Third Amended Complaint makes no claim that any of the Director Defendants has been indicted or is even under investigation in connection with the alleged payment of illegal kickbacks. Moreover, plaintiffs offer no particularized allegations

demonstrating that the Director Defendants were aware of the existence of any actual wrongdoing.

Plaintiffs do not explain why the Director Defendants could not have relied from 1991-1994 on the consistent statements by the Company's employees that Caremark's practices complied with applicable regulations. (E.g., 3d Amend. Comp. ¶¶ 24-26, 79-80). In light of these public announcements, plaintiffs fall short of their obligations under Rule 23.1 by continuing -- for the fourth time -- their failure to plead with particularity what the Director Defendants knew or what obvious danger signs the Director Defendants purportedly ignored. Moreover, as in Baxter and Seminaris, no wrongdoing has been admitted or proven and plaintiffs' complaint fails to specify what additional measures (if any) the Director Defendants should have taken. In these circumstances, the decisions by this Court in Baxter and Seminaris, rather than the Illinois Court's decision in Miller, constitute the guiding precedent.

C. Plaintiffs' Argument That Defendants' Conduct Was Not The Product Of A Valid Business Judgment Is Inappropriate And Meritless.

In an effort to evade their failure to comply with the stringent pleading requirements under Rales where there is no director decision under attack, plaintiffs assert that the Director Defendants' reckless or intentional disregard of the purported wrongdoing "could not have been the product of a valid business judgment." (See PB 22-24). Plaintiffs seek to justify demand excusal under the second prong of Aronson, which recognizes:

> [I]n rare cases a transaction may be so egregious on its face that board approval cannot meet the test of business judgment, and a substantial likelihood of director liability therefore exists.

Aronson, 473 A.2d at 815 (citations omitted). However, even were the Court to accept plaintiffs' hypothetical by assuming that the Director Defendants made a business decision which could be reviewed under Aronson, nothing in the Third Amended Complaint suggests that the Court would disregard the judgment of the disinterested Director Defendants.

Even plaintiffs' authority indicates that the second prong of Aronson is directed to "extreme cases" and that the test employed by the Court "is thus necessarily high, similar to the legal test for waste." Kahn v. Tremont Corp., Del. Ch., C.A. No. 12339, slip op. at 16, Allen, C. (Apr.21, 1994, revised Apr. 22, 1994). Waste exists only when the benefit received by the corporation is so inadequate that no person of ordinary, sound business judgment would deem it worth what the corporation has paid. Id. quoting Saxe v. Brady, Del. Ch., 184 A.2d 602, 610 (1962). Thus, plaintiffs ask the Court (i) to assume (without any specific supporting allegations) that the Director Defendants made a conscious decision to refrain from initiating steps to correct the illegal activities of certain Caremark employees, and (ii) to predict that, based on the threadbare allegations of the Third Amended Complaint, no person of ordinary, sound business judgment would have made that decision based upon the facts known to the Director Defendants. Plaintiffs do not come close to meeting this standard.[12]

---

[12]As plaintiffs recognize, the business judgment rule is a presumption that directors act in good faith and on an informed basis. (PAB 21-22). If the facts alleged in the Third Amended Complaint, though presumed true, allow the reasonable possibility that the Director Defendants' (assumed) decisions were made in good faith and on an informed basis, the Court should conclude that plaintiffs' allegations fail the second-prong of the Aronson test for demand excusal. Plaintiffs have the obligation of alleging (continued...)

The Third Amended Complaint completely fails to particularize what the Director Defendants knew in respect of the purported misconduct. The only allegations regarding the Director Defendants' knowledge of any of the purported wrongdoing involve (i) the August 9, 1991 OIG subpoenas and notification to Caremark of the OIG investigation, (ii) public statements by the Company and its officers denying any wrongdoing in connection with the OIG investigation, and (iii) the Company's public statements during 1992-1994 regarding the potentially adverse effect of any findings of illegal conduct, the Company's guidelines against illegal conduct, and the corrective measures undertaken by the Company's management. (See 3d Amend. Comp. ¶¶ 21-34 and, supra, pp. 13-15). There are no allegations that the Director Defendants were aware of any of the other instances of purported misconduct cited by plaintiffs. At best, therefore, the issue is reduced to whether no person of ordinary, sound business judgment would have done what the Director Defendants are charged with doing.

There are, of course, many plausible business explanations for not taking any additional action in response to the OIG investigation. For one, there has never been any

---

[12](...continued)
particularized facts inconsistent with the presumably proper exercise of business judgment by the Director Defendants. See, e.g., Grobow v. Perot, Del. Supr., 539 A.2d 180, 191 (1988) (listing factors which plaintiffs had failed to allege in support of due care allegations); Caruana v. Saligman, Del. Ch., C.A. No. 11135, slip op. at 8-9, Chandler, V.C. (Dec. 21, 1990) (explaining that plaintiffs' allegations were conclusory "in light of the allegations that had not been made"); see also Cottle v. Standard Brands Paint Co., Del. Ch., C.A. Nos. 9342, 9405, slip op. at 20, Berger, V.C. (Mar. 22, 1990) (Court assumes valid corporate purpose over competing entrenchment claim); Lewis v. Honeywell Inc., Del. Ch., C.A. No. 8651, slip op. at 10, Jacobs, V.C. (July 28, 1987) (dismissing due care claim where well-pleaded facts left open possibility that directors had been informed).

determination by the OIG or anyone else that Caremark's business practices were illegal. Certainly, a rational director could act within the realm of business judgment by authorizing the company to continue to operate, in an apparently lawful manner, under the clouded regulatory environment created by the government's failure to articulate precise standards for payments to doctors delivering medical services to infusion patients. Any such determination by the Director Defendants certainly would have been entirely justifiable based upon their apparent understanding from public statements by Caremark's senior officer that the Company's activities complied with the law. Even assuming that certain Caremark employees were engaged in wrongdoing, the Board reasonably could have determined that the adverse publicity and costs of instituting legal actions against the wrongdoers would outweigh the benefits of such an action, particularly inasmuch as the Company had announced in 1991 that it had terminated the practices which had occasioned the OIG investigation. (3d Amend. Comp. ¶¶ 25-26).

This same reasoning applies even if the Court assumes the existence of particularized allegations demonstrating that the Director Defendants were intimately familiar with the details of each of the instances of purported misconduct cited by plaintiffs. Since there has been no finding that any Caremark employee committed any illegal act, a disinterested board legitimately could conclude that the course of action Caremark allegedly followed (not instituting suit, announcing compliance with applicable regulations and selling the home infusion business) would be preferable from a business standpoint to initiating costly, time consuming and distracting litigation against Caremark's employees and third parties. Furthermore, even if the plaintiff specified in

the Third Amended Complaint that the Director Defendants had actual knowledge of the acts by certain Caremark employees and that the Director Defendants had actual knowledge that those acts were illegal, demand still would not be excused. See E. F. Hutton, 634 F. Supp. at 271 (explaining that demand would have been excused "even if we assume that the board had formally ratified the challenged conduct" where the "challenged conduct" resulted in a guilty plea to 2,000 counts of mail and wire fraud).

Plaintiffs merely have asserted conclusions of wrongful behavior by the Director Defendants based upon plaintiffs' assumptions about the still-unproven charges against certain Caremark employees. This is insufficient in a business judgment rule analysis because, as noted above, if there are two possible bases for the alleged actions, one constituting a breach of duty and one constituting a proper exercise of business judgment, the latter is presumed. See Cottle v. Standard Brands Paint Co., slip op. at 20. Plaintiffs here have failed to plead particularized facts sufficient to overcome the presumption of the business judgment rule by pleading facts which would eliminate the possibility that the Board properly exercised its business judgment.

Plaintiffs cite two cases in support of their "egregious business judgment" argument: Graham v. Allis-Chalmers Manuf. Co., Del. Supr., 188 A.2d 125 (1963) and Freedman v. Braddock, N.Y. Supr. Ct., Nos. 24708/92, 25968/92, Sherman, J. (May 17, 1993) (ORDER), aff'd, N.Y.A.D., 609 N.Y.S.2d 777 (1994). Allis-Chalmers was a decision after trial absolving the Allis-Chalmers directors of any liability for the activities of certain employees which violated the federal antitrust laws. As here, plaintiffs in Allis-Chalmers alleged that the directors knew or should have known of the

illegal activities by a handful of employees in a company with $500 million in annual sales. In rejecting plaintiffs' claims, the Delaware Supreme Court stated:

> The duties of the Allis-Chalmers Directors were fixed by the nature of the enterprise which employed in excess of 30,000 persons, and extended over a large geographical area. By force of necessity, the company's Directors could not know personally all the company's employees. The very magnitude of the enterprise required them to confine their control to the broad policy decisions.

188 A.2d at 130. Like Allis-Chalmers, Caremark is a large, far-flung enterprise, with annual sales exceeding $2.4 billion and over 9,000 employees scattered throughout the fifty states, Puerto Rico and six foreign countries. (3d Amend. Comp. ¶ 16; Caremark 1994 Form 10-K, p. 8). The size of Caremark's operations and the paucity of particularized allegations demonstrating any knowledge by the Director Defendants of the purported wrongdoing refute any notion that the business judgment rule (had a business decision been made) would be inapplicable.

Plaintiffs' other authority, Freedman v. Braddock, is completely uninstructive. The opinion by a New York trial court presents no analysis of the particularized allegations of the complaint at issue and ignores well-known Delaware precedent rejecting many of the conclusory allegations of demand futility advanced by the Freedman plaintiffs. See slip op. at 3-4.

In sum, attempting to apply a business judgment analysis to the facts of the Third Amended Complaint demonstrates the inapplicability of the second prong of Aronson to the present case. The factual predicate for plaintiffs' egregious business judgment claim -- "that the Director Defendants intentionally or recklessly 'shut their eyes' to widespread misconduct, even though they knew that such misconduct could lead to materially adverse

consequences to Caremark's business" (PB 24) -- is completely unsupported by any particularized facts. Just as there is no "substantial likelihood" under Rales that the Director Defendants face personal liability exposure, plaintiffs have failed to create any question -- must less the requisite reasonable doubt -- as to the application of the business judgment rule to any (assumed) decision by the Caremark Board.

II. THE THIRD AMENDED COMPLAINT FAILS TO STATE A CLAIM IN VIEW OF CAREMARK'S SECTION 102(b)(7) CHARTER PROVISION.

Plaintiffs do not dispute that Caremark's Section 102(b)(7) charter provision eliminates monetary damages for any breach of fiduciary duty by the Director Defendants unless expressly excepted from coverage. The dispute here concerns the exception "for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law." 8 Del. C. § 102(b)(7). Plaintiffs claim that Section 102(b)(7) does not exempt directors from liability for "acts which are intentional or reckless" (PAB 33; emphasis added). None of the cases cited by plaintiffs support their proposed revision of Section 102(b)(7) to subject directors to personal liability for reckless conduct.[13]

Plaintiffs' motive for excluding reckless conduct from Section 102(b)(7) protection is obvious. While plaintiffs state in their brief that the Third Amended Complaint details "defendants' bad faith, and intentional and knowing conduct" (PAB 34), their actual pleading is much more circumspect. Plaintiffs are willing to plead only that the Director Defendants acted "intentionally or recklessly." Perhaps mindful of their Rule 11 obligations, plaintiffs are unwilling to allege flatly in the Third Amended Complaint either

---

[13]The cases cited by plaintiffs, Kahn v. Roberts, Del. Ch., C.A. No. 12324, slip op. at 19, Hartnett, V.C. (Feb. 28, 1994); Baxter Int'l Inc. Shareholders Litig., 654 A.2d at 1270 and Bell Atlantic Corp. v. Bolger, 2 F.3d 1304, 1312 (3d Cir. 1993), all confine their Section 102(b)(7) analysis to the exceptions specifically enumerated in the statute. Plaintiffs' other authority, Freedman v. Braddock, slip op. at 8, is inconsistent with Dataproducts in that the New York court declined to dismiss the complaint, despite the presence of a Section 102(b)(7) provision, because of (unspecified) alleged conduct "which arguably fall [sic] within the exception" of the subject charter provision.

that the Director Defendants engaged in intentional misconduct or were acting in bad faith.

This Court has rejected a similar effort by a plaintiff to use a "pleading in the alternative" strategy to escape the claim preclusive effect of a Section 102(b)(7) charter provision. In In re Dataproducts Corp. Shareholders Litig., Del. Ch., C.A. No. 11164, Jacobs, V.C. (Aug. 22, 1991), defendants sought to dismiss, pursuant to Chancery Court Rule 12(b)(6), a claim that the Dataproducts directors improperly timed the announcement of a proposed merger to occur before favorable third and fourth quarter financial results were disclosed. Slip op. at 9. Like plaintiffs here, plaintiffs in Dataproducts alleged that the Dataproducts directors knew that management was manipulating the timing of the disclosures yet acquiesced in their actions. (Id. at 10). The Court held that plaintiffs' "abdication" claim against the directors was barred in light of the Section 102(b)(7) provision in the Dataproducts charter:

> The plaintiffs contend that the directors' abdication of their oversight obligations in favor of Mr. Davis were acts that were 'not in good faith' and that constituted "intentional misconduct" within the meaning of Article FIFTEENTH.
>
> I disagree, because the complaint does not fairly allege facts supportive of the plaintiffs' abdication theory. Not even inferentially does it suggest the directors acted in bad faith or with intent to allow the shareholders to be harmed. For that reason and because the "director abdication" claim is equally consistent with director gross negligence as with conduct that was intentional or in bad faith, the plaintiffs have failed to establish that their timing claim is not precluded by Article FIFTEENTH of the certificate of incorporation.

Slip op. at 11-12 (emphasis added).

Here, as in Dataproducts, plaintiffs' "intentionally or recklessly" claims are likewise "equally consistent with gross negligence as with conduct that is intentional or in bad faith" and are likewise barred by a Section 102(b)(7) charter provision. Plaintiffs make no attempt in their answering brief to distinguish Dataproducts. (See PAB 33-35). Plaintiffs' allegations also are barred by the Section 102(b)(7) provision in the Caremark charter because the Third Amended Complaint offers no particularized allegations of fact to support plaintiffs' conclusions that the Director Defendants "intentionally or recklessly allowed the alleged wrongdoing to continue". See Weinberger v. UOP, Inc., Del. Ch., 409 A.2d 1262, 1264 (1979) (Rule 12(b)(6) motion "does not concede pleaded conclusions of law or fact where there are no allegations of specific facts which would support such conclusions"); Solomon v. Pathe Communications Corp., Del. Ch., C.A. No. 12563, slip op. at 11-12, 16, Allen, C. (Apr. 21, 1995) (in class and derivative litigation the "court cannot be satisfied with mere conclusions, as it might, for example, in an auto-accident case, because in this sort of litigation the risk of strike suits means that too much turns on the mere survival of the complaint"). Accordingly, plaintiffs' claims for money damages should be dismissed.

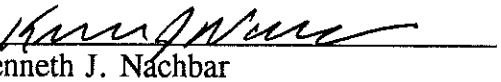
CONCLUSION

For all of the foregoing reasons, defendants respectfully request that the Court dismiss with prejudice the Third Amended Complaint pursuant to Chancery Court Rules 12(b)(6) and 23.1.

Kevin G. Abrams
Thomas A. Beck
Richard I. G. Jones, Jr.
Richards, Layton & Finger
One Rodney Square
P.O. Box 551
Wilmington, DE 19899
(302) 658-6541
Attorneys for Caremark International, Inc.

Of Counsel:

Howard M. Pearl
Timothy J. Rivelli
Julie A. Bauer
Winston & Strawn
35 West Wacker Drive
Chicago, IL 60601
(312) 558-5600



Kenneth J. Nachbar
Morris, Nichols, Arsht & Tunnell
1201 N. Market Street
P.O. Box 1347
Wilmington, DE 19899
(302) 658-9200
Attorneys for the Individual Defendants

Of Counsel:

William J. Linklater
Baker & McKenzie
One Prudential Plaza
130 East Randolph Drive
Chicago, IL 60601
(312) 861-8000

Date: May 26, 1995

EXHIBIT A

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark one)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 1994

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____.

Commission file number: 1-11328

CAREMARK INTERNATIONAL INC.
(Exact Name of Registrant as Specified in Its Charter)

Delaware	**36-3838069**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
2215 Sanders Road Northbrook, Illinois	**60062**
(Address of Principal Executive Offices)	**(Zip Code)**

(708) 559-4700
(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $1.00 par value	New York Stock Exchange
Series A Junior Participating Preferred Stock Purchase Rights (currently traded with Common Stock)	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Aggregate market value of voting stock held by non-affiliates of the registrant based on the closing price of the common stock on the New York Stock Exchange on January 31, 1995: $1,165,000,000.

At January 31, 1995, there were 71,704,455 shares of the registrant's common stock, $1.00 par value per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Annual Report to Stockholders for the year ended December 31, 1994 and Proxy Statement for use in connection with its Annual Meeting of Stockholders to be held on May 2, 1995 are incorporated by reference in Parts I, II, III and IV.

TABLE OF CONTENTS

PART I

ITEM 1. BUSINESS.

General

Caremark International Inc., a Delaware corporation ("Caremark"), was incorporated in August 1992 as a wholly-owned subsidiary of Baxter International Inc. ("Baxter"). On November 30, 1992, Baxter distributed (the "Distribution") to the holders of Baxter common stock all of the outstanding shares of common stock, $1.00 par value per share, of Caremark (the "Common Stock"), together with associated preferred stock purchase rights (the "Rights"; references herein to Common Stock shall be deemed to include a reference to the associated Rights).

Caremark provides a broad array of patient services through health care networks specializing in managed care, with operations in the United States and overseas. Caremark's Physician Practice Management segment provides management services to multi-specialty physician group practices. Caremark's Pharmaceutical Services segment provides pharmacy benefit management services through mail order and retail pharmacy service networks, formulary management, medical data management and outcomes research. Caremark's Disease State Management segment includes: hemophilia and immune deficiency services; distribution of human growth hormone; services to schizophrenic patients; nephrology services; orthopedic services; and oncology services. Caremark's International segment provides certain alternate site health care services in several European countries, Canada, Puerto Rico and Japan.

In January 1995, Caremark entered into a definitive agreement to sell its home infusion business to Coram Healthcare Corporation ("Coram"). Under the agreement, Caremark will receive $310 million in cash and securities, subject to certain adjustments, in exchange for the assets of its home infusion business, which includes home IV infusion therapy, women's health services and the Home Care Management System. The sale of the home infusion business is subject to government review under the Hart-Scott-Rodino Act and other conditions.

In February 1995, Caremark entered into a definitive agreement to sell its Clozaril® patient management system business to Health Management, Inc. ("HMI") for approximately $34 million in cash and notes. The sale of the Clozaril® patient management system business is subject to government approval under the Hart-Scott-Rodino Act and other conditions.

Management believes that Caremark is strategically well-positioned, as a result of its expanding managed care capabilities, to satisfy anticipated increased demand for lower cost, high quality health care services. In the Physician Practice Management segment, Caremark's growth strategy focuses on the provision of comprehensive management services to physician groups, primarily multi-specialty physician practices. In the Pharmaceutical Services segment, it focuses on the reduction of health care costs through the provision of efficient drug benefit programs. Caremark's strategy for growth within the Disease State Management and International segments focuses on new technologies, services and therapies in an effort to make patient services available for the treatment of various medical conditions, as well as on geographic expansion into selected markets that are not yet fully served.

Financial information concerning the net revenues, income before sundry and income taxes, identifiable assets, depreciation and amortization and capital expenditures of Caremark's operating segments is incorporated by reference to Management's Discussion and Analysis of Financial Condition and Results of Operation, "Industry Segments," appearing at pages 20 and 21 of Caremark's Annual Report to Stockholders for the year ended December 31, 1994.

To more closely parallel Caremark's business development strategy and internal operating structure, the company reorganized its businesses during 1994 into five industry segments: Physician Practice Management, Pharmaceutical Services, Disease State Management, International and Home Infusion. The company

previously utilized two reportable industry segments: Patient Care and Managed Care. Prior years' results have been restated to conform with the new segment reporting presentation.

Physician Practice Management

In 1992, Caremark initiated a physician practice management business that provides comprehensive management services to large multi-specialty medical group practices. Caremark is now one of the fastest growing companies in this field, having affiliated with Houston's Kelsey-Seybold Clinic, the Oklahoma City Clinic, Atlanta Medical Associates and North Suburban Clinic in the Chicago area. The company expects to complete its affiliation with Friendly Hills HealthCare Network in La Habra, California, in early 1995. Physician Practice Management segment revenues accounted for 7.9% of Caremark's total revenues in 1994.

Upon completion of the Friendly Hills affiliation, Caremark will serve some 600,000 patients, more than half of whom will be enrollees in prepaid managed health care plans. These practices cover five major metropolitan areas, include over 640 physicians and generate in excess of $425 million in annualized revenues.

Pharmaceutical Services

Caremark manages outpatient prescription drug benefit programs for corporations, insurance companies, unions, government employee groups and managed care organizations throughout the United States. Prescription drug benefit administration involves the design and administration of programs for reducing the costs and improving the safety, effectiveness and convenience of prescription drug benefits. Caremark's prescription drug benefit management business is the largest independent pharmacy benefit management ("PBM") network in the country. The company serves 29 million Americans through its PBM business, dispensing more than 40,000 prescriptions daily from four mail-order facilities. The company also manages patients' immediate prescription needs through a network of 52,000 retail pharmacies. Caremark, through its Continuum of Drug Cost Management™ program, offers a full range of drug cost and clinical management services, including mail service, a national retail pharmacy network with electronic claims processing and payment capabilities, prescription drug claims processing, drug utilization review, prescription drug data management and reporting and an aggressive cost and clinical management program. During the first six months of 1994, Caremark entered into multi-year agreements with four major pharmaceutical companies to provide access to comprehensive pharmaceutical data and to develop medical protocols through outcomes research. Pharmaceutical Services segment revenues accounted for 45.2% of Caremark's total revenues in 1994.

Disease State Management

Caremark is establishing disease state networks and programs aimed at treating high-cost, chronic diseases, such as hemophilia, kidney failure, HIV/AIDS, asthma and cancer. Caremark believes that these programs can eventually provide for all of a patient's health care needs and do so efficiently, using advanced protocols and eliminating unnecessary procedural steps. Disease State Management segment revenues accounted for 26.0% of Caremark's total revenues in 1994.

Hemophilia and Immune Deficiency Services

Through its therapeutic services division, Caremark provides therapies and services to individuals suffering from hemophilia, immune system deficiencies and other blood disorders characterized by protein deficiencies. Products provided in such therapies include, among others, coagulation factor for the treatment of hemophilia and immune globulin for the treatment of chronic immune system deficiencies. Many hemophilia patients were exposed to the HIV virus as a result of the plasma derivative therapy they received prior to the mid-1980's and are at risk of developing AIDS. Caremark provides recombinant factor therapies derived from non-plasma sources to mitigate exposure to the HIV virus.

As part of its HIV/AIDS disease state management program, Caremark operates a central data collection system to collect and analyze HIV/AIDS treatments and outcomes data. Caremark coordinates HIV/AIDS therapies that include: infusion therapies, aerosolized pentamidine, nutritional assessment, counseling, support services and educational programs.

Nephrology Services

In 1993, Caremark's nephrology services division was launched with the acquisition of the Regional Kidney Disease Program ("RKDP") in Minneapolis. This division provides a comprehensive range of nephrology support services, including dialysis and aspheresis services and supplies, transplant and vascular access support services, and laboratory services. In connection with the acquisition of RKDP, Caremark acquired 23 dialysis centers in Wisconsin, Minnesota and South Dakota. In May 1994, Caremark acquired an additional 5 dialysis facilities from Chabot Dialysis Clinic Inc., San Leandro Dialysis Clinic, Inc. and East Bay Peritoneal Dialysis Inc. The nephrology services division is also expanding its business to include the development and management of integrated delivery systems designed to provide the full continuum of care to patients with renal disease.

Growth Hormone Distribution

Caremark, pursuant to a distribution agreement with Genentech Inc., distributes recombinant growth hormone marketed under the trade name Protropin®. Orphan drug status for Protropin® human growth hormone and a therapeutic equivalent drug has expired. The approval by the Food and Drug Administration (the "FDA") of generic equivalents for these drugs could have an adverse impact on Caremark's sales of Protropin® human growth hormone.

Clozaril® Patient Management System

Pursuant to service and distribution agreements with Sandoz Pharmaceuticals Corporation ("Sandoz"), Caremark has provided various services to schizophrenia patients through a separate staff of phlebotomists, pharmacists, mental health nurses and case coordinators dedicated to this business. These services have included blood testing, analysis and monitoring to detect adverse reactions to the Clozaril® schizophrenia drug (clozapine) which Caremark distributes, as well as patient registration and case coordination. In addition, Caremark has maintained a nationwide database of clozapine users on behalf of Sandoz to monitor patients' responses to Clozaril®. The database agreement expired in September 1994. Clozaril® patient management system revenues were $84.0, $78.5 and $61.1 million in 1994, 1993 and 1992, respectively. Income before sundry and income taxes for this business was $42.3, $36.6 and $21.8 million in 1994, 1993 and 1992, respectively. The patent for clozapine expired in 1994. In 1991, Caremark restructured its distribution agreement with Sandoz resulting in reduced revenues and operating profit from patient services, offset by periodic payments from Sandoz to Caremark under the restructuring agreement. These payments have now been completed.

As noted above, Caremark agreed in February 1995 to sell its Clozaril® patient management system business to HMI.

Orthopedic Services

Caremark provides a broad range of outpatient physical therapy and rehabilitation services to patients suffering from accident, disability or disease related musculoskeletal impairments and patients requiring improved functional capabilities. Services include general physical therapy as well as a coordinated range of sports medicine and industrial programs targeted to meet the specific needs of athletes and workers. Caremark also provides ergonomics consulting and education programs to industrial customers to reduce injuries, cumulative trauma disorders and overall workers' compensation costs.

Oncology Services

Caremark provides management services to single specialty practices specializing in oncology and currently provides such services to 11 medical oncology practices located in eight states. Through 1994, Caremark operated free-standing ambulatory care centers for the outpatient treatment of specific long-term diseases, particularly cancer. The centers provided a range of other services, including monitoring and counseling. Therapies and products provided at the centers included chemotherapy, pain management therapy, antiemetics, antimicrobials, hydration, blood and blood products.

International

Caremark offers selected health care services outside hospitals in Canada, France, Germany, Japan, the Netherlands, the United Kingdom and Puerto Rico. For example, Caremark operates two HIV centers in Germany and is exploring additional center-based strategies in Europe. Caremark's Japanese subsidiary is providing enteral nutrition therapy and chemotherapy to patients in their homes. The specific therapies and services offered in each country are tailored to respond to the identified needs of the health care providers and patients in that country. Caremark believes increasing health care costs, an expanding population base over age 65, advances in medical technology and the ability to provide improved quality of life are conditions prevalent internationally that will foster growth of alternate site health care. Caremark is developing prescription benefit management programs in Europe with initial focus in the Netherlands. Caremark believes that these programs can provide cost effective alternatives to the current system of reimbursement for outpatient drug therapy. Medical Card System, Inc. ("MCS"), which was established in 1982 in Puerto Rico, has contracted for preferred rates among health care providers (hospitals, physicians, laboratories, dentists and pharmacies), on both a preferred and an exclusive basis, on behalf of large employer groups and insurers. MCS currently has contracts with every hospital and approximately 85% of the physicians in Puerto Rico. MCS is a full service third party administrator as well as a provider of utilization management services. International segment revenues accounted for 2.7% of Caremark's total revenues in 1994.

Home Infusion

As noted above, Caremark agreed in January 1995 to sell its home infusion business to Coram. Caremark's Home Infusion segment offers alternate site infusion therapies that include: total parenteral nutrition therapy ("TPN"-intravenous feeding for patients unable to ingest or absorb nutrients due to gastrointestinal illnesses or conditions); enteral nutrition therapy (nutritional therapy administered to patients who have at least partial digestive tract function); antibiotic, antiviral and antifungal therapies (therapies used to treat a variety of complex infections and diseases, including bone infections and infections related to HIV/AIDS); chemotherapy (the infusion of cancer-fighting drugs, blood product therapies and certain biotechnology drugs for cancer patients); and pain management therapy (the administration of pain-controlling drugs to terminally or chronically ill patients). Caremark's home infusion therapy business also includes women's health services and the Home Care Management System. Home Infusion segment revenues accounted for 18.2% of Caremark's total revenues in 1994.

Operations

Quality Assurance. Caremark maintains rigorous quality assurance policies and procedures. A focus on employee training and the development of comprehensive manuals for and monitoring of pharmacy and nursing operations help to maintain consistent and high quality care. Caremark's clinical quality assurance program provides for periodic reviews of Caremark's health care professionals to confirm that applicable licensure, certification and accreditation requirements are met and to maintain the consistency and effectiveness of clinical practices. Caremark's outcomes monitoring program involves the collection, investigation, evaluation and reporting of results of treatments for Caremark patients with the aim of maintaining and improving clinical procedures and services. All of Caremark's home infusion branches for which it has sought accreditation have been accredited by the Joint Commission on Accreditation of

Healthcare Organizations ("JCAHO"), a non-profit, private organization that has established written standards for health care organizations, including hospitals and alternate site health care providers.

Under Caremark's pharmaceutical services quality assurance program, a computerized order processing system reviews each prescription order for a variety of potential concerns, including reactions with other drugs known to be prescribed to that patient, reactions with a patient's known allergies, duplication of therapies, appropriateness of dosage and early refill requests that may indicate overutilization or fraud. Each prescription is verified by a licensed pharmacist before shipment. Caremark has retained the services of a national advisory panel of physician specialists that advises it on the clinical analysis of its intervention strategies and on cost-effective clinical procedures.

Sales and Marketing. Caremark employs over 175 full-time sales personnel, including specialized sales groups for marketing to employers, insurance companies and other payors and for marketing prescription services and therapy-specific products, such as hemophilia coagulation factor, intravenous immunoglobulin and physical therapy services. Caremark's Pharmaceutical Services segment markets its services to corporate financial officers and health benefits managers, health benefits consultants and national third party payors. Caremark's marketing strategy emphasizes complete and responsive service to clients and their employees and includes a strong focus on patient and provider education. An independent national advisory panel of practicing physicians and pharmacists assists Caremark in formulating and validating clinical strategies used in achieving a client organization's drug benefit objectives.

Reimbursement. Caremark derives most of its Pharmaceutical Services segment revenues, Disease State Management segment revenues, International segment revenues and Home Infusion segment revenues from third party payors, including private insurers and, to a lesser extent, Medicare and Medicaid and workers' compensation programs. Approximately 12% of Caremark's 1994 revenues were directly attributable to Medicare and Medicaid patients. Caremark accepts assignment of insurance benefits from patients and receives reimbursement directly from third party payors. Caremark also provides services as a subcontractor to hospitals or other alternate site providers, including joint ventures formed by Caremark with hospitals, nursing agencies and other health care providers, that receive the assignment of benefits or reimbursement from the patient and pay Caremark a negotiated fee. Caremark has contracted to provide physical therapy services to more than 175 health maintenance organizations and preferred provider organizations serving approximately 25 million people. Caremark's Disease State Management and International segments are subject to lengthy reimbursement periods as a result of third party payment practices which affect all health care providers. Caremark has consistently managed its accounts receivable to minimize the length of such periods and their effect on Caremark's cash flow.

Competition

Caremark's Physician Practice Management segment competes with several national physician practice managers as well as health maintenance organizations, other payors and hospitals. Competition is based on cost, service and financial stability.

Caremark's Pharmaceutical Services segment competes on the basis of cost, service and the flexibility and range of drug benefit plan design and management services offered. National prescription benefit drug competitors include Merck & Co., Inc.'s Medco Containment Services division, Eli Lilly and Company's PCS Health Systems and SmithKline Beecham P.L.C.'s Diversified Pharmaceutical Services. Caremark also competes with many local and regional pharmacies and with other prescription drug benefit programs. Caremark's claims administration services, management reporting services and plan management programs also compete with other prescription drug claims processors, regional claims processors, insurance companies and Blue Cross/Blue Shield plans.

In its Disease State Management, International and Home Infusion segments, Caremark competes with inpatient providers, including hospitals and nursing homes, and with other alternate site providers. Caremark

competes on the basis of quality, service, cost and reputation among physicians, hospitals, patients and third party payors.

Government Regulation

Significant aspects of Caremark's business are subject to state and federal statutes and regulations governing the operation of pharmacies, repackaging of drug products, dispensing of controlled substances, reimbursement under federal and state medical assistance programs, financial relationships between health care providers and potential referral sources, medical waste disposal and workplace health and safety. Caremark's businesses may also be affected by changes in ethical guidelines and operating standards of professional and trade associations and private accreditation commissions such as the American Medical Association and JCAHO.

Pharmacy Licensing and Operation

Caremark operates mail service pharmacies in Florida, Illinois, Texas and Virginia as well as pharmacies in states in which it provides infusion therapy, and consequently is subject to federal and state laws and regulations governing pharmacies. Federal controlled substance laws require Caremark to register its pharmacies with the United States Drug Enforcement Administration and comply with security, record-keeping, inventory control and labeling standards in order to dispense controlled substances. State controlled substance laws require registration and compliance with the licensing, registration or permit standards of the state pharmacy licensing authority. State pharmacy licensing, registration and permit laws impose standards on the qualifications of the applicant's personnel, the adequacy of its prescription fulfillment and inventory control practices and the adequacy of its facilities. In general, pharmacy licenses are renewed annually. Pharmacists employed by each branch must also satisfy state licensing requirements.

Several states have enacted legislation that requires mail service pharmacies located elsewhere to register with the state board of pharmacy prior to mailing drugs into the state and to meet certain operating and disclosure requirements. These statutes generally permit a mail service pharmacy to operate in accordance with the laws of the state in which it is located. In addition, various national and state pharmacy associations and some boards of pharmacy have promoted enactment of laws and regulations directed at restricting or prohibiting the services of mail service pharmacies by, among other things, requiring compliance with all laws of the states into which the mail service pharmacy dispenses medications whether or not those laws conflict with the laws of the state in which the pharmacy is located. To the extent that such laws or regulations are found to be applicable to Caremark's operations, Caremark would be required to comply with them. Some states have enacted laws and regulations which, if successfully enforced, would effectively limit some of the financial incentives available to plan sponsors that offer mail service prescription programs. With respect to self-insured plans, the United States Department of Labor has commented that such laws and regulations are pre-empted by the Employee Retirement Income Security Act of 1974. The Attorney General in one state has reached a similar conclusion and has raised additional constitutional issues. Finally, the Federal Trade Commission's Bureau of Competition has concluded that such laws and regulations may be anticompetitive and not in the best interests of consumers. To date, there have been no formal administrative or judicial efforts to enforce any of such laws against Caremark. To the extent that any of the foregoing laws or regulations prohibit or restrict the operation of mail service pharmacies and are found to be applicable to Caremark, they could have an adverse effect on Caremark's prescription mail service operations. Approximately 90% of prescriptions dispensed by Caremark are dispensed under self-insured plans. United States Postal Service regulations expressly permit the transmission of prescription drugs through the postal system. The United States Postal Service has authority to restrict such transmission.

Medicare Referral Laws

Caremark is subject to the laws and regulations that govern reimbursement under Medicare and Medicaid. Effective January 1, 1995, Federal law prohibits, with some exceptions, an entity from filing a claim for reimbursement under the Medicare or Medicaid programs for certain designated services if the entity has

one of any specified financial relationships with the referring physician. Caremark has taken the significant, voluntary step of not seeking reimbursement for such designated services even from payors other than Medicare or Medicaid programs if it has such a financial relationship with the referring physician. Federal law (the "Medicare Referral Payments Law") also prohibits the solicitation or receipt of remuneration in exchange for, or the offer or payment of remuneration to induce, the referral of Medicare or Medicaid beneficiaries. The Office of the Inspector General of the U.S. Department of Health and Human Services (the "OIG") has promulgated regulatory "safe harbors," subject to periodic change, under the Medicare Referral Payments Law that describe payment practices between health care providers and referral sources that will not be subject to criminal prosecution and that will not provide the basis for exclusion from the Medicare and Medicaid programs. Caremark retains hospitals and health care professionals to provide services and advice to Caremark in return for compensation pursuant to employment, consulting or service contracts. Caremark also enters into contracts with hospitals under which Caremark provides administrative services for a fee and enters into joint ventures with hospitals and other health care providers. Many of the parties with whom Caremark contracts are in a position to or do refer patients to Caremark. The breadth of the Medicare Referral Payments Law, the paucity of court decisions interpreting the Medicare Referral Payments Law, the absence of regulatory interpretations until the adoption of applicable safe harbor regulations and the absence of court decisions interpreting the safe harbor regulations have resulted in ambiguous and varying interpretations of the Medicare Referral Payments Law. No assurance can be given that the OIG or the United States Department of Justice will not seek a determination that Caremark's past or current policies and practices regarding contracts and relationships with health care providers violate the Medicare Referral Payments Law and no assurance can be given that Caremark's interpretation of these laws will prevail if challenged. A determination that contracts and relationships entered into by Caremark violate the Medicare Referral Payments Law could have a material adverse effect on the business of Caremark.

State Referral Payment Laws

Caremark is also subject to state statutes and regulations that prohibit payments for referral of patients, splitting of professional fees by physicians and referrals by physicians to health care providers with whom the physicians have a financial relationship. State statutes and regulations generally apply to services reimbursed by both governmental and private payors. Violations of these laws may result in prohibition of payment for services rendered, loss of pharmacy or health provider licenses as well as fines and criminal penalties. State statutes and regulations that may affect the referral of patients to health care providers range from statutes and regulations which are substantially the same as the Federal Medicare Referral Payments Law and the Federal safe harbor regulations to a simple requirement that physicians or other health care professionals disclose to patients any financial relationship the physicians or health care professionals have with a health care provider that is being recommended to the patients. These laws and regulations vary significantly from state to state, are often vague and in many cases have not been interpreted by courts or regulatory agencies. Caremark was not materially dependent upon revenues derived from any single state in 1994. However, adverse judicial or administrative interpretations of such laws in several states could, taken together, have a material adverse effect on the business of Caremark.

Future Legislation and Regulation

Legislative and regulatory initiatives relating to health care reimbursement, payment practices, physician-investor referrals and other health care cost containment issues are frequently introduced at both the state and federal level. Caremark is unable to predict whether or when legislation may be enacted or regulations may be adopted relating to Caremark's business or what the effect of such legislation or regulations may be.

Federal Trade Commission Investigation

In December 1994, Caremark was notified by the Federal Trade Commission (the "FTC") that it was conducting a civil investigation of the industry concerning whether acquisitions, alliances, agreements or

activities between pharmacy benefit managers and pharmaceutical manufacturers, including Caremark's alliance agreements with certain drug manufacturers, violate Sections 3 or 7 of the Clayton Act or Section 5 of the Federal Trade Commission Act. The specific nature, scope, timing and outcome of the investigation are not currently determinable. Under the statutes, if violations are found, the FTC could seek remedies in the form of injunctive relief to set aside or modify Caremark's alliance agreements and an order to cease and desist from certain marketing practices and from entering into or continuing with certain types of agreements.

Employees

As of December 31, 1994, Caremark had approximately 9,150 employees (over 2,100 of which are full-time home infusion employees). Management of Caremark considers its employee relations to be good.

ITEM 2. PROPERTIES.

Caremark operates a network of more than 260 facilities, approximately 80 of which are home infusion centers, providing services in 50 states, Puerto Rico and 6 countries internationally. Caremark hemophilia products are distributed through its licensed pharmacy in Redlands, California. Immune globulin products are distributed from both the Redlands facility and the Caremark branch network. Caremark currently operates and manages 92 outpatient physical therapy facilities in 12 states, including 3 work centers accredited for performing work hardening services by the Commission for Accreditation of Rehabilitation Facilities. Caremark's Physician Practice Management segment operates facilities of multi-specialty physician practices in Texas, Oklahoma, Illinois, and Georgia. Caremark's Pharmaceutical Services segment operates a central claims administration center, an FDA registered prescription drug repackaging facility and licensed mail service pharmacies located in Florida, Illinois, Texas and Virginia. Caremark's nephrology division of its Disease State Management segment operates dialysis facilities in Minnesota, Wisconsin, South Dakota and California.

Caremark leases the majority of its properties. Caremark believes that its properties are suitable for their respective uses and, in general, are adequate for Caremark's current needs. Caremark believes that existing leases will be renegotiated as they expire or that suitable alternative properties can be leased on acceptable terms.

ITEM 3. LEGAL PROCEEDINGS.

Caremark was notified in August 1991 that the OIG and the U.S. Department of Justice, with subsequent grand jury participation, were investigating Caremark. The nature, scope, timing and outcome of the investigation are not currently determinable. Caremark has provided and continues to provide information and documents in connection with the investigation.

Caremark is in discussions with the OIG and the U.S. Department of Justice to settle the investigation. Because certain state agencies are conducting related investigations of Caremark, representatives of various state health care programs are participating in these discussions. Caremark is seeking to settle not only the charges against Caremark in the indictment described below, but any and all other aspects of the investigation, including any potential claims by the federal government or any state agency, as applicable, under the federal laws prohibiting payment of remuneration to induce the referral of Medicare and Medicaid beneficiaries (the "Medicare Referral Payments Law"), the federal False Claims Act (the "False Claims Act"), or any other federal or state civil or criminal statute. No assurances can be given with regard to the outcome of these settlement discussions.

On August 4, 1994, a grand jury impaneled by the United States District Court for the District of Minnesota returned an indictment alleging that Caremark and employees of Caremark made payments and

provided other benefits to a physician in connection with the distribution of human growth hormone. The indictment charges Caremark with violations of the Medicare Referral Payments Law and the federal conspiracy statute. The indictment charges the employees with violations of the federal conspiracy, mail and wire fraud statutes. Criminal penalties under the Medicare Referral Payments Law could include fines of up to $25,000 per violation or up to five years imprisonment, or both. Criminal penalties under the federal conspiracy statute and the Medicare Referral Payments Law could be increased, under the alternative fines statute, to include fines of up to $500,000 per violation with respect to Caremark. Criminal penalties under the federal conspiracy, mail and wire fraud statutes could be increased, under the alternative fines statute, to include fines of up to $250,000 per violation with respect to the employees or up to five years imprisonment, or both. In each case, fines could be increased to a maximum of two times the amount of gross gain or loss in connection with the violation under the alternative fines statute, and could also be increased under the Federal Organizational Sentencing Guidelines. Civil penalties under the Medicare Referral Payments Law include exclusion from participation in the Medicare and Medicaid programs; civil penalties under the False Claims Act could include fines of up to $10,000 per claim and treble damages. If imposed, such penalties, although not estimable at this time, could have a material adverse effect on the company's business or on its income, cash flow or financial condition.

In August and September 1994, stockholders, each purporting to represent a class, filed complaints against Caremark and directors, officers and employees of Caremark in the United States District Court for the Northern District of Illinois, alleging violations of the Securities Act of 1933 and the Securities Exchange Act of 1934, and fraud and negligence in connection with public disclosures by Caremark regarding Caremark's business practices and the status of the investigation discussed above. The complaints seek unspecified damages, declaratory and equitable relief, attorney fees and expenses.

In August 1994, stockholders filed derivative actions on behalf of Caremark against directors, officers and employees of Caremark in the Court of Chancery of the State of Delaware and the United States District Court for the Northern District of Illinois alleging breaches of fiduciary duty and negligence in connection with Caremark's conduct of the business and the indictment discussed above and seeking unspecified damages, attorney fees and expenses.

In late August 1994, certain patients of the specific physician referred to above and the sponsor of the health insurance plan of one of those patients filed complaints against Caremark, employees of Caremark and others in the United States District Court for the District of Minnesota. Each complaint purported to be on behalf of a class and alleged violations of the federal mail and wire fraud statutes, the federal conspiracy statute and the state consumer fraud statute, as well as conspiracy to breach a fiduciary duty, negligence and fraud. Each complaint sought unspecified treble damages, attorney fees and expenses.

In September and October 1994, Caremark was named as a defendant in a series of new lawsuits added to a pending group of actions brought in 1993 under the antitrust laws by local and chain retail pharmacies against brand name pharmaceutical manufacturers, wholesalers and prescription benefit managers other than Caremark. The new lawsuits, filed in federal district courts in at least 13 states (including the United States District Court for the Northern District of Illinois), allege that at least 27 pharmaceutical manufacturers provided unlawful price and service discounts to certain favored buyers and conspired among themselves to deny similar discounts to the complaining retail pharmacies (approximately 1,300 in number). The complaints charge that certain defendant prescription benefit managers, including Caremark, were favored buyers who knowingly induced or received discriminatory prices from the manufacturers in violation of the Robinson-Patman Act. Each complaint sought unspecified treble damages, declaratory and equitable relief, attorney fees and expenses.

Caremark is party to various other claims and routine litigation arising in the ordinary course of business. Based on the advice of counsel, management does not believe that the result of such claims and litigation, individually or in the aggregate, will have a material effect on Caremark's business or its income, cash flows or financial condition.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS.

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

Incorporated herein by reference to Notes 11 and 17, "Common Stock" and "Quarterly Financial Results (unaudited)," respectively, of the Notes to Consolidated Financial Statements appearing at pages 38 and 45 of Caremark's Annual Report to Stockholders for the year ended December 31, 1994. The New York Stock Exchange is the only exchange on which any class of Caremark's common equity is traded.

ITEM 6. SELECTED FINANCIAL DATA.

Incorporated herein by reference to the "Seven-Year Summary of Selected Financial Data" appearing on the inside back cover of Caremark's Annual Report to Stockholders for the year ended December 31, 1994.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

Incorporated herein by reference to "Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing at pages 18 through 21, 23 through 25, 27 and 29 of Caremark's Annual Report to Stockholders for the year ended December 31, 1994.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

Incorporated herein by reference to the "Consolidated Statements of Income," "Consolidated Balance Sheets," "Consolidated Statements of Cash Flows," "Consolidated Statements of Stockholders' Equity," "Notes to Consolidated Financial Statements," and "Report of Independent Accountants" appearing at pages 22, 26, 28, 30 and 31 through 46 of Caremark's Annual Report to Stockholders for the year ended December 31, 1994.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

Not Applicable.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT.

Board of Directors

Incorporated herein by reference to "Election of Directors" and "Directors Whose Terms of Office Continue," appearing at pages 2 and 3 of Caremark's Proxy Statement for use in connection with Caremark's Annual Meeting of Stockholders to be held on May 2, 1995 (the "Proxy Statement").

Executive Officers

Information as of December 31, 1994 concerning the executive officers of Caremark follows. Biographical information related to Messrs. Piccolo, Connelly and Hodson is incorporated by reference above.

Kent J. De Lucenay, 46, is a vice president of Caremark, responsible for human resources, and from before 1990 to November 30, 1992, was a human resources vice president of a subsidiary of Baxter and a division of that subsidiary.

Kristen E. Gibney, 46, is a vice president of Caremark, responsible for the pharmaceutical services businesses. From before 1990 to October 1994, Ms. Gibney was president of the prescription services division.

Michele J. Hooper, 43, is a vice president of Caremark, responsible for the international business. From 1992 to June 1993, she was president of Caremark's international alternate site division. From before 1990 to 1991, she was president, Baxter Canada. Ms. Hooper serves as a director of Dayton Hudson Corporation.

Diane L. Munson, 44, is a vice president of Caremark, responsible for the physician services business. From August 1992 to June 1993, she was president of Caremark's health care services/east division. From before 1990 to 1992, she was president of Baxter's General Healthcare Division. Ms. Munson serves as a director of J.M. Huber Corporation.

Dennis R. Owczarski, 51, is the treasurer of Caremark and from before 1990 to November 30, 1992, was an assistant treasurer of a subsidiary of Baxter.

John M. Pellettiere, Jr., 44, is the vice president and controller of Caremark. From April 1992 to November 30, 1992, he was vice president, financial operations for Baxter's alternate site business group. From June 1991 to April 1992, Mr. Pellettiere was senior vice president of a subsidiary of Caremark. From before 1990 to 1991, he was vice president and controller for Baxter's alternate site business group.

Thomas R. Schuman, 53, is the vice president, secretary and general counsel of Caremark. From August 1992 to November 30, 1992, he was vice president, law for Baxter's alternate site business group. From before 1990 to August 1992, he held various positions at Baxter, including associate general counsel and vice president, law for Baxter's hospital business.

Donna C.E. Williamson, 42, is a senior vice president of Caremark, responsible for integrated services and managed care contracting. From before 1990 to November 30, 1992, she was a corporate vice president of Baxter and from November 1992 to June 1993, a vice president of Caremark. Ms. Williamson serves as a director of A.G. Edwards, Inc. and Haemonetics Corporation.

Additionally, on February 27, 1995, K. J. Michael McDonald, 54, became a vice president of Caremark, responsible for the therapeutic services and specialty pharmaceutical services businesses. He has served as president of the therapeutic services division since April 1992, having also assumed responsibility for the specialty pharmaceutical services businesses in 1994. From 1991 to 1992, Mr. McDonald was vice president and general manager of therapeutic services. From before 1990 to 1991, he held various positions at Baxter.

ITEM 11. EXECUTIVE COMPENSATION.

Summary of Compensation of Executive Officers

Incorporated herein by reference to "Compensation of Directors and Executive Officers," appearing at pages 7 through 10 of the Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT.

Incorporated herein by reference to "Ownership of the Capital Stock of the Company," appearing at page 6 of the Proxy Statement.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS.

Not applicable.

PART IV

ITEM 14. EXHIBITS, FINANCIAL STATEMENT SCHEDULES, AND REPORTS ON FORM 8-K.

The following documents are filed as part of this report:

(a) Financial Statements and Schedules

1. Financial Statements required by Item 8 of this Form (incorporated herein by reference to the "Consolidated Statements of Income," "Consolidated Balance Sheets," "Consolidated Statements of Cash Flows," "Consolidated Statements of Stockholders' Equity," "Notes to Consolidated Financial Statements," and "Report of Independent Accountants" appearing at pages 22, 26, 28, 30 and 31 through 46 of Caremark's Annual Report to Stockholders for the year ended December 31, 1994):

(i) Consolidated Statements of Income for the years ended December 31, 1994, 1993 and 1992;

(ii) Consolidated Balance Sheets as of December 31, 1994 and 1993;

(iii) Consolidated Statements of Cash Flows for the years ended December 31, 1994, 1993 and 1992;

(iv) Consolidated Statements of Stockholders' Equity for the years ended December 31, 1994, 1993 and 1992;

(v) Notes to Consolidated Financial Statements;

(vi) Report of Independent Accountants.

2. Schedule VIII, Valuation and Qualifying Accounts, required by Article 12 of Regulation S-X is incorporated by reference to Note 6, "Trade Receivables," of the Notes to Consolidated Financial Statements appearing at page 35 of Caremark's Annual Report to Stockholders for the year ended December 31, 1994. All other schedules have been omitted because they are not applicable or not required.

3. Management Contracts and Executive Compensation Plans and Arrangements required by Item 601 of Regulation S-K are listed as Exhibits 10.1 through 10.5 and Exhibits 10.11 and 10.12 in the Index to Exhibits, which is incorporated herein by reference.

(b) Reports on Form 8-K:

No Current Reports on Form 8-K were filed during the last fiscal quarter of 1994.

(c) Exhibits

Exhibits required by Item 601 of Regulation S-K are listed in the Index to Exhibits, which is incorporated herein by reference.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized on this 10th day of March, 1995.

CAREMARK INTERNATIONAL INC.

By: /s/ C.A. LANCE PICCOLO
C.A. Lance Piccolo
Chairman of the Board and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Name	Title
/s/ C.A. LANCE PICCOLO C.A. Lance Piccolo	Director, Chairman of the Board and Chief Executive Officer (Principal Executive Officer)
/s/ THOMAS W. HODSON Thomas W. Hodson	Director, Senior Vice President and Chief Financial Officer (Principal Financial Officer)
/s/ JOHN M. PELLETTIERE, JR. John M. Pellettiere, Jr.	Vice President and Controller (Principal Accounting Officer)
NANCY G. BRINKER* Nancy G. Brinker	Director
VINCENT A. CALARCO* Vincent A. Calarco	Director
JAMES G. CONNELLY III* James G. Connelly III	Director
J. IRA HARRIS* J. Ira Harris	Director
ROGER L. HEADRICK* Roger L. Headrick	Director
RALPH W. MULLER* Ralph W. Muller	Director
RAYMOND D. ODDI* Raymond D. Oddi	Director
PHILLIP B. ROONEY* Phillip B. Rooney	Director
PETER F. WHITINGTON, M.D.* Peter F. Whitington, M.D.	Director
BLAINE J. YARRINGTON* Blaine J. Yarrington	Director

*By: /s/ C.A. LANCE PICCOLO
C.A. Lance Piccolo
Attorney-in-fact

INDEX TO EXHIBITS

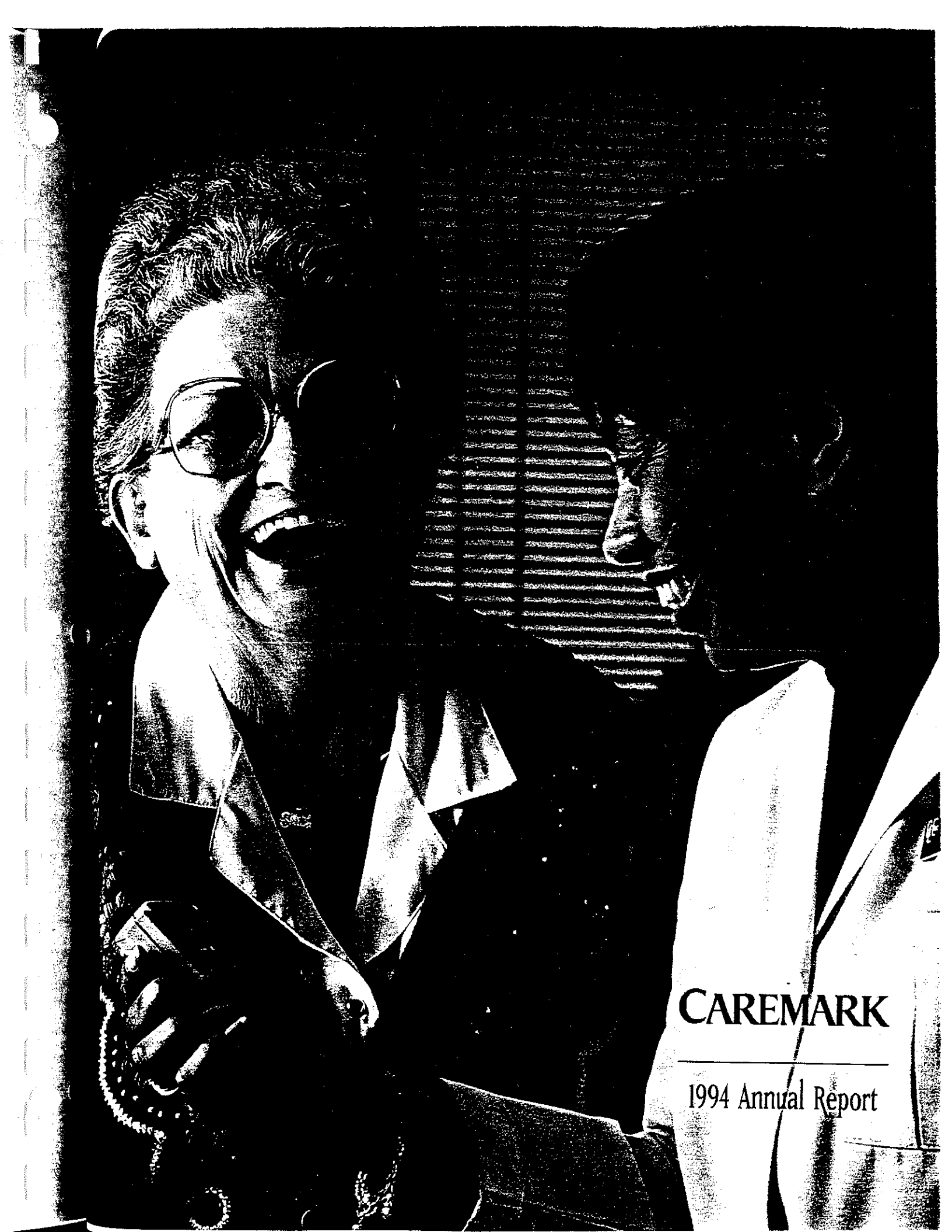
Exhibit No.	Document Description	Sequential Page No.
3.1	Caremark International Inc. Certificate of Incorporation, incorporated by reference to Exhibit 3.1 of the Registrant's Registration Statement on Form 10, File No. 1-11328 (the "Form 10").	
3.2	Caremark International Inc. Bylaws, incorporated by reference to Exhibit 3.1 of the Registrant's Current Report on Form 8-K dated December 14, 1993.	
4	Registrant hereby agrees to furnish to the Commission upon request, the instruments defining the rights of holders of each issue of long-term debt of the Registrant or any of its consolidated subsidiaries.	
*10.1	Caremark International Inc. Qualified Employee Stock Purchase Plan (amended and restated).	
10.2	Caremark International Inc. 1992 Incentive Compensation Program, incorporated by reference to Exhibit 4(c) of the Registrant's Registration Statement, File No. 33-55162, on Form S-8.	
10.3	Caremark International Inc. 1992 Stock Option Plan for Non-Employee Directors, incorporated by reference to Exhibit 4(c) of the Registrant's Registration Statement, File No. 33-55160, on Form S-8.	
10.4	Severance Compensation Agreement, dated December 4, 1992, between the Registrant and C.A. Lance Piccolo, incorporated by reference to Exhibit 10.4 of the Registrant's 1992 Form 10-K File No. 1-11328 (the "1992 Form 10-K").	
*10.5	List of employees party to Severance Compensation Agreements identical to agreement filed as Exhibit 10.4.	
10.6	Plan and Agreement of Reorganization and Distribution, dated November 30, 1992, between Baxter International Inc. and the Registrant, incorporated by reference to Exhibit 10.6 of the 1992 Form 10-K.	
10.7	Form of Indemnification Agreement between the Registrant and listed employees, incorporated by reference to Exhibit 10.7 of the Form 10.	
*10.8	List of employees party to Exhibit 10.7.	
*10.9	Long-Term Credit Agreement, dated as of October 3, 1994, among the Registrant, The First National Bank of Chicago, as agent, and the lenders listed therein.	
*10.10	Short-Term Credit Agreement, dated as of October 3, 1994, among the Registrant, The First National Bank of Chicago, as agent, and the lenders listed therein.	
10.11	1992 Caremark International Inc. Nonqualified Stock Options Terms and Conditions of December 8, 1992 Awards, incorporated by reference to Exhibit 10.11 of the 1992 Form 10-K.	
10.12	1992 Caremark International Inc. Restricted Performance Shares Terms and Conditions of December 8, 1992 Awards, incorporated by reference to Exhibit 10.12 of the 1992 Form 10-K.	
10.13	Rights Agreement, dated as of November 30, 1992, between the Registrant and First Chicago Trust Company of New York, incorporated by reference to Exhibit 10.13 of the 1992 Form 10-K.	

Exhibit No.	Document Description	Sequential Page No.
*10.14	Term Loan Agreement, dated as of January 17, 1995, among the Registrant, Credit Lyonnais Chicago Branch, as agent, and the lenders listed therein.	
*10.15	Master Note, dated as of April 12, 1994, executed by the Registrant in favor of Wachovia Bank of Georgia, N.A.	
*11.1	Computation of Primary Earnings per Common and Common Equivalent Share.	
*11.2	Computation of Fully Diluted Earnings per Common and Common Equivalent Share.	
*12.1	Computation of Ratio of Earnings to Fixed Charges.	
*13.1	Caremark International Inc. Annual Report to Stockholders for the year ended December 31, 1994 (such report, except to the extent incorporated herein by reference, is being furnished for the information of the Securities and Exchange Commission only and is not deemed to be filed as part of this annual report on Form 10-K).	
*21.1	List of Subsidiaries of the Registrant.	
*23.1	Consent of Price Waterhouse.	
*24.1	Powers of Attorney.	

Copies of the above exhibits are available at a charge of 35 cents per page upon written request to the Investor Relations Department, Caremark International Inc., 2215 Sanders Road, Suite 400, Northbrook, Illinois, 60062. Copies are also available at a charge of at least 25 cents per page from the Public Reference Section of the Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C., 20549.

*Copies attached.

Exhibit No. 13.1



CAREMARK

1994 Annual Report

Industry Segments

To more closely parallel Caremark's business development strategy and internal operating structure, the company reorganized its businesses during 1994 into five industry segments: Physician Practice Management, Pharmaceutical Services, Disease State Management, International and Home Infusion (subject to sale). Businesses comprising these segments are listed on page 48 of this Annual Report. The company previously utilized two reportable industry segments: Patient Care and Managed Care. Prior years' results have been restated to conform with the new segment reporting presentation.

Net Revenues

Year ended December 31 (in millions)	*1994*	*1993*	*1992*
Physician Practice Management	**$ 190.1**	$ 135.6	$ –
Pharmaceutical Services	**1,097.3**	631.2	522.1
Disease State Management[1]	**631.3**	548.5	448.2
International	**65.4**	47.4	33.8
Home Infusion	**441.9**	420.5	457.1
Totals	**$2,426.0**	$1,783.2	$1,461.2

Income before Sundry and Income Taxes

Year ended December 31 (dollars in millions)	*1994*	*1993*	*1992[2]*
Physician Practice Management	**$ 4.1**	$ (1.4)	$ (2.0)
% of revenues	2.2%	(1.0%)	–
Pharmaceutical Services	**$ 46.3**	$ 31.6	$ 11.5
% of revenues	4.2%	5.0%	2.2%
Disease State Management[1]	**$124.9**	$117.4	$ 78.3
% of revenues	19.8%	21.4%	17.5%
International	**$ (1.5)**	$ (2.4)	$ 1.4
% of revenues	(2.3%)	(5.1%)	4.1%
Home Infusion[3]	**$ (6.1)**	$ 10.6	$ (1.2)
% of revenues	(1.4%)	2.5%	(0.3%)
General Corporate	**$ (25.8)**	$(21.7)	$(40.7)
Totals	**$141.9**	$134.1	$ 47.3

(1) In February 1995, Caremark entered into a definitive agreement to sell its Clozaril® Patient Management System business (Note 16). Results for this business are included in the Disease State Management segment. Revenues of the Clozaril® business were $84.0, $78.5 and $61.1 million in 1994, 1993 and 1992, respectively. Income before sundry and income taxes for this business was $42.3, $36.6 and $21.8 million in 1994, 1993 and 1992, respectively.

(2) 1992 results include pre-tax distribution, restructuring and other charges of $67.6 million which were allocated as follows: Pharmaceutical Services ($8.6 million), Disease State Management ($4.5 million), Home Infusion ($26.7 million) and General Corporate ($27.8 million).

(3) 1994 results include a pre-tax charge of $25.0 million related to the integration of Critical Care America.

EXHIBIT B

Modern Healthcare

September 16, 1991

SECTION: THE WEEK IN HEALTHCARE; Legal; Pg. 12

LENGTH: 763 words

HEADLINE: Criminal investigation of Caremark shows feds won't ignore home-care industry

BYLINE: Mary Wagner with Sandy Lutz

BODY:

Attorneys and healthcare experts are saying a criminal investigation of Baxter Healthcare Corp.'s Caremark home-care affiliate for alleged Medicare kickbacks shows that the government is more than willing to prosecute the major players in the home-care industry.

The probe also is the first of its kind to come to light since the government issued "safe harbor" guidelines defining provider business arrangements that won't be vulnerable to prosecution under the Medicare fraud and abuse laws (MH, Aug. 5, p. 24).

"It's a tough time for home care. The government is not shying away from taking on the big guys," said Michael Peregrine, a healthcare attorney with the Chicago-based firm of Gardner, Carton & Douglas.

"It suggests that those organizations are best advised to take a look at themselves and their legal exposure," Mr. Peregrine said. "It's not a question of innocence or guilt; no one wants to get involved in (this kind of) litigation. It will cost a fortune."

The probe represents a second legal headache for Baxter, which is under criminal investigation in another case. A federal grand jury in Chicago is examining allegations that the supplier violated federal law by aiding the Arab boycott of Israel.

Meanwhile, Baxter and Caremark are denying any wrongdoing regarding payments Caremark made to physicians for case-management services. The HHS inspector general's office is conducting that inquiry. Lincolnshire, Ill.-based Caremark said it's cooperating with the investigation, which began on Aug. 9.

The inspector general's office originally summoned records of 800 contracts Caremark has with physicians for case-management services under its fee-for-service, or Quality Service Agreement, program; instead, it now will review a random sample of 130.

At issue is whether payments to physicians for case management of home-care patients constitute legitimate compensation for their time or are fees for referrals, which are prohibited under federal law.

As of Oct. 1, Caremark will discontinue paying case-management fees to physicians for Medicare and Medicaid home-care patients until the issue is resolved.

A company spokesman confirmed that reimbursement from Medicare and Medicaid constitutes about 20% of Caremark's estimated $ 650 million in annual revenues. Physicians receive $ 12 to $ 150 per week in case-management fees under the QSA program, he said.

The QSA contracts represent about 3,500 home-care patients, of which 600 patients receive Medicare or Medicaid reimbursement, Caremark said. But the federal government is a huge Caremark customer, paying the company an estimated $ 130 million per year for services to Medicare patients.

Most patients come to Caremark through pharmacists or nurses, without physician intervention, a company spokesman said.

Most experts said that some type of arrangement, such as fee-for-service payments or consulting fees, is common in home care, although it takes many forms. And most providers, including Caremark, said physicians deserve some compensation for time spent supervising home-care patients, particularly as such treatment grows more complex.

However, there's no clearly defined legal mechanism for payments to physicians supporting home-care treatment for Medicaid and Medicare patients. Caremark will "seek clear regulations" on the matter, said Charles Blanchard, chief executive officer.

Other groups already are seeking such regulation. Earlier this year, the National Assn. for Home Care, a Washington-based trade group, recommended that HCFA consider developing Medicare codes to categorize physician services to home-care patients by the intensity of care provided. The group also recommended that HCFA conduct a study on reimbursing physicians for home-care cases that require their intense involvement.

Meanwhile, the inspector general's decision to pursue the home-care industry's biggest player -- industry analysts estimate Caremark has 30% to 40% of the $ 2 billion home infusion therapy market -- sends an unpleasant message to all home-care providers, legal experts said.

But some analysts said the investigation could ultimately benefit the home-care industry.

"I don't think doctors are increasing referrals to home care because of any payments because the amount of money they receive is so small," said Randall Huyser, a healthcare analyst with the New York-based investment firm of Furman Selz. "Once the rules are defined, it may even stimulate growth in the home-care industry as people are more clear on what's legal and what's not."

EXHIBIT C

CAREMARK

Caremark Inc.
Affiliate Baxter Healthcare Corporation
455 Knightsbridge Parkway
Lincolnshire, Illinois 60069

FOR IMMEDIATE RELEASE

Contact: Les Jacobson
(708) 948-4555

CAREMARK RESTRICTS SOME MEDICARE AND MEDICAID SERVICES, COOPERATES WITH HEALTH AND HUMAN SERVICES REVIEW

LINCOLNSHIRE, Ill., September 6, 1991 -- Caremark Inc. announced today that effective October 1, 1991, it will no longer pay physicians for their assistance in caring for Medicare and Medicaid patients under the company's fee-for-service agreements with physicians.

The decision is a result of new "safe-harbor" guidelines under the Medicare fraud and abuse law that were issued in July to clarify permissible practices concerning Medicare and Medicaid patients.

Caremark is cooperating with the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS) in a review of Caremark's fee-for-service agreements with physicians and hospitals. The review was initiated on August 9, 1991, by the HHS Office of Inspector General.

Caremark is a leader in providing high-quality home and outpatient care. Caremark's fee-for-service program provides weekly fees to physicians for their role in monitoring patients in its home-care programs. Those fees typically range from $12 per patient for enteral therapy to $150 per patient for total parenteral nutrition (TPN) and antibiotic therapy.

Caremark has some 800 fee-for-service agreements with physicians and serves 3,500 patients nationwide through the fee-for-service program. Some 600 of those patients receive Medicare or Medicaid reimbursement. Caremark serves a total of 75,000 patients a year.

-more-

The new safe-harbor regulations fail to address agreements with physicians and hospitals such as those that have been made by Caremark and many other home-care providers. Various forms of fee-for-service or consulting arrangements are common in the home-infusion industry, and are seen as a way of involving physician expertise in the home care of patients.

"The safe-harbor regulations were created to determine what is beyond reproach regarding provider and physician practices with Medicare and Medicaid," said Charles H. Blanchard, president and chief executive officer of Caremark. "The regulations are drawn very narrowly, and do not address physician involvement in home care. As a result, Caremark is taking the conservative position of discontinuing this service to Medicare and Medicaid patients, effective October 1, until the issue is resolved.

"Caremark is working closely with HHS. Our actions have always been conducted in compliance with the law," Blanchard added. "We believe strongly that physicians should be involved in home health care. Unlike what happens in hospitals, no reimbursement is available through Medicare or Medicaid to physicians who support home-care patients. We will actively seek clear regulations that enable physicians to play an integral role in providing high-quality, cost-effective care to Medicare and Medicaid patients. In the meantime, we will continue to provide the highest possible level of care to all our patients."

Caremark is an affiliate of Baxter Healthcare Corporation of Deerfield, Illinois. Baxter is the leading international manufacturer and marketer of health-care products, systems and services.

# #

EXHIBIT D

Rank(R) R 1 OF 1
Database CHITRIB
Mode Page

.s. probes fees paid by Baxter unit
Chicago Tribune (CT) - MONDAY September 9, 1991
By: Mike Dorning
Edition: NORTH SPORTS FINAL Section: CHICAGOLAND Page: 2
Word Count: 447

TEXT:

The federal government is investigating a home health care subsidiary of Deerfield-based Baxter Healthcare Corp. to determine whether consulting agreements with doctors amount to illegal kickbacks for patient referrals, a spokesman for the company confirmed.

While denying any wrongdoing, Baxter's **Caremark** Inc. unit announced last week that it will discontinue such consulting arrangements for Medicaid and Medicare patients effective Oct. 1. The government investigation covers only those federally funded programs.

The contracts pay physicians weekly fees of between $12 and $150 to assist in evaluating home health care patients, Baxter indicated in a statement. The investigation centers on whether fees paid by **Caremark** , the largest home health care provider in the nation, are fair compensation for legitimate advisory services or kickbacks for steering chronically ill patients to the service.

Les Jacobson, spokesman for **Caremark** , said the advisory services include "going over charts, reviewing medications and issuing new orders, y much what (doctors) would do in a hospital at a nursing station."

"If you look at the amounts being paid to doctors, it cannot be construed as kickbacks," Jacobson said. "It's less by far than they would be receiving for the same services in the hospital."

Jacobson said **Caremark** contracts with referring physicians since they are most familiar with patients' medical histories.

Subpeonas for records involved in the consulting program, a common arrangement in the home health care industry, arrived at **Caremark** headquarters Aug. 9, less than two weeks after the U.S. Department of Health and Human Services issued long-awaited regulations clarifying a 1977 federal anti-kickback law in health care.

The regulations create a "safe harbor" of health care business arrangements that are presumed not to be kickbacks, but consulting contracts such as Baxter's are not on the list.

Because of the new regulations, **Caremark** decided to "be conservative" and discontinue the consulting program for Medicare and Medicaid patients, Jacobson said. It will halt the arrangements the same day the regulations go into effect.

Caremark will continue the arrangements for privately insured patients because "we want there to be doctor involvement at home," Jacobson d.

If **Caremark** is judged to be paying kickbacks, it could be barred from treating Medicare and Medicaid patients and forced to pay heavy fines under the anti-fraud and abuse law.

About a fifth of **Caremark** 's $650 million in annual revenues come from Medicare and Medicaid patients, Jacobson said. But he said the company only earns a 1 to 2 percent profit margin on the patients.

Caremark is currently using the consulting contracts in the care of 3,500 patients, 600 of whom are covered by Medicare or Medicaid, the company said in a statement. Some 800 doctors are receiving payments.

DESCRIPTORS: FEDERAL; PROBE; AGREEMENT; HEALTH; BUSINESS; MEDICINE; ISSUE; LAW

EXHIBIT E

Business Week

October 7, 1991

SECTION: THE CORPORATION; Number 3234; Pg. 110

LENGTH: 383 words

HEADLINE: JUST WHAT BAXTER DIDN'T NEED: A PAYOLA PROBE

BYLINE: Julia Flynn Siler in Chicago, with Susan B. Garland in Washington

BODY:

Lately, Baxter International Inc. can't dodge the bad news. On Sept. 6, the company revealed that **Caremark** Inc., its $ 800 million home health care unit, is being investigated for allegedly paying kickbacks to doctors. The Inspector General's Office of the U. S. Health & Human Services Dept. began its probe in August after complaints from **Caremark** rivals and physicians offended by the practice, government sources say.

The company has been paying physicians who refer privately insured patients since the early 1980s. It extended the payments to doctors who treat medicare patients about 18 months ago, say former executives, after losing market share to competitors such as Atlanta-based T2 Medical Inc.

Paying doctors for referrals is specifically prohibited by the 1977 Medicare-Medicaid Antikickback Statute. **Caremark** maintains that it paid doctors from $ 12 to $ 150 a week not for referrals but as fees for monitoring patients receiving treatment at home. The key issue is whether physicians actually did the paperwork and supervision the company claims they did.**Caremark** Chief Executive Charles H. **Blanchard** says the company knew that its payments fell into a gray area that it believes has not been addressed by HHS. But he adds that Caremark stands by its decision because the law remains so fuzzy. Even so, it will quit paying physicians and hospitals who refer medicare and medicaid patients to its facilities starting Oct. 1.

STANDARD PRACTICE. Observers say that offering financial incentives to doctors and hospitals is standard practice in the $ 2.5 billion home health care industry. But Parker H. Petit, chief financial officer for rival Home Nutrition Services, says the probe could spook doctors who've agreed to such deals: ''In the future, if doctors want to do transactions like this, they'll be very, very cautious.''

Even if **Caremark** is barred from participating in medicare, it won't feel much of a pinch. The company, with a 35% market share, was a top performer in the first half of 1991, when operating earnings rose more than 20%. Medicare patients contributed roughly 20% of revenues in 1990, but just 2% of profits. However, if the Inspector General refers the case to the Justice Dept. for further action, Baxter's image could need some nursing.

EXHIBIT F

WALL STREET JOURNAL
August 4, 1994

Caremark Probe Is Expected to Result In Indictments in Minnesota, Ohio Soon

By THOMAS M. BURTON
Staff Reporter of THE WALL STREET JOURNAL

A federal investigation of alleged kickbacks paid by home health-care concern **Caremark International** Inc. is moving toward culmination, with initial indictments in Minnesota and Ohio expected shortly.

The company, in response to an inquiry from this newspaper, said a federal prosecutor in Minneapolis told Caremark that she will ask a grand jury to indict the company and three midlevel employees "in connection with the company's business relationship with a Minneapolis physician." The move could come as early as today, according to people with knowledge of the inquiry.

Federal investigators also are scrutinizing doctors in Columbus, Ohio, and an indictment there could come within the next few weeks, according to these same people.

Caremark, based in Northbrook, Ill., and its activities in 12 U.S. cities have been under investigation by federal authorities since mid-1991. The inquiry is being conducted by the inspector general's office of the Department of Health and Human Services, the Federal Bureau of Investigation and various U.S. attorneys' offices around the country.

Federal agents are trying to ascertain whether doctors took money from Caremark to steer patients into sometimes expensive treatment by the company, which provides in-home infusions of liquid nutrition, antibiotics, chemotherapy agents and other medications. Caremark, which had total revenue from infusion and other medical services of $1.8 billion last year, is the nation's largest provider of in-home infusion treatment. It was a unit of **Baxter International** Inc., Deerfield, Ill., until Baxter spun it off in 1992.

The federal criminal inquiry, conducted in cooperation with various grand juries, is looking at possible kickbacks to doctors because such payments are generally illegal under federal Medicaid and Medicare insurance laws. **Caremark has long maintained that any payments it made to physicians were compensation for treatment or supervision of patients.** Some of the activities under investigation took place while Caremark was part of Baxter.

Thomas R. Schuman, Caremark's general counsel, said yesterday that the company denies any wrongdoing and "believes it will be vindicated when all the facts are evaluated in an unbiased forum." Mr. Schuman said the planned indictment is "unwarranted and inappropriate" and added, "We welcome the opportunity to present our side of the story in court."

The Minneapolis portion of the investigation, which appears to be the most advanced, involves at least one physician as well as former Caremark employees, according to the people familiar with the details. Federal investigators and U.S. prosecutors are focusing there on whether a research grant of about $100,000 may have constituted a payment to allegedly steer business to Caremark.

The Columbus case, which is expected to come to a conclusion in several days or weeks, involves one doctor who allegedly received payoffs on a regular basis from Caremark for home-infusion therapy.

In other parts of the country, according to people with knowledge of the inquiry, investigators plan shortly to interview between 100 and 120 doctors who received large payments from Caremark. Investigators seek to enlist them as cooperating witnesses or possibly may indict them, said people familiar with the case.

Moreover, federal authorities foresee pursuing possible civil restitution as well as criminal charges. The federal government, which administers Medicare and Medicaid insurance programs, has the ability to obtain recovery of three times what allegedly was improperly obtained from taxpayers.

In an earlier health-care fraud investigation, the civil restitution dwarfed the criminal penalties. In a June settlement with the U.S. and 28 states, National Medical Enterprises Inc. agreed to pay $380 million, $324.2 million of which was for civil restitution. National Medical, based in Santa Monica, Calif., runs acute-care and psychiatric hospitals, and is divesting itself of almost all of the latter as part of the settlement.

Caremark, which has said its so-called fee-for-service agreements with doctors were entirely proper, curtailed those payment agreements when it learned the federal government was examining the transactions. The payments in many instances involved several hundred dollars per patient per month. The medical treatment itself can cost up to $100,000 or more annually in cases in which patients receive nutrition through a tube.

In-home infusion treatments often are prescribed for cancer and AIDS patients, as well as for people who can't adequately use their gastrointestinal systems because of illness or recuperation from surgery.

The Minneapolis case also involves treatment by injection with the human-growth hormone Protropin, made by Genentech Inc. of South San Francisco, Calif. An employee of Genentech is also said to be under scrutiny by federal agents in connection with the Minneapolis events. Genentech said it was aware of the inquiry but declined to comment.

The Minneapolis matter is believed to be separate from a previously reported series of events, also under investigation by federal agents, involving a Caremark joint venture at the University of Minnesota Hospital.

EXHIBIT G

Citation | Rank(R) | Database | Mode
'2/95 WSJ (No Page) | R 1 OF 1 | WSJ | Page
3/2/95 Wall St. J. (Page Number Unavailable Online)
1995 WL-WSJ 2116016

The Wall Street Journal

Thursday, March 2, 1995

Health

School's Audit Finds **Caremark** Partnership Isn't Legally Protected

NORTHBROOK, Ill. -- A University of Minnesota audit found that a **Caremark** International Inc. partnership with university doctors isn't protected by the "safe harbor" rules of the federal antikickback law.

The "safe harbor" provisions under the law describe those types of financial relationships between doctors or hospitals and medical-care companies that are deemed legal. These, in turn, won't be prosecuted by federal prosecutors.

The partnership with **Caremark** at the University of Minnesota, originally described in The Wall Street Journal in October 1993, has provided home therapy to patients referred by University of Minnesota doctors.

Federal investigators have investigated the relationship as part of a broad national inquiry into whether **Caremark** may have violated the federal law that outlaws kickbacks to doctors for referring Medicare or Medicaid patients. Investigators have been looking into whether disbursements to the hospital from the **Caremark** partnership might have been a roundabout way of paying kickbacks to the hospital or doctors there.

Caremark already is under federal indictment in Minneapolis in an unrelated case alleging that the company paid kickbacks to another doctor.

The audit noted that "an activity which does not fit within the confines of a 'safe harbor' is not presumed to be unlawful." However, a person familiar with the federal inquiry noted that such a situation does at least elicit the interest of federal investigators.

Nancy Westcott, **Caremark's** vice president of investor relations and communications, said, "The audit described the amount of straightforward effort that went into the partnership. The university was well-informed about the establishment of the partnership. Auditors didn't come across any areas with which they were uncomfortable."

TICKER SYMBOL: CK

MARKET SECTOR: Consumer Non-Cyclical (NCY)

INDUSTRY: Health Care Providers (HEA)

NEWS SUBJECT: Colleges and Universities; High-Yield Issuers; Law & Legal Issues; World Equity Index (CLG HIY LAW WEI)

GOVERNMENT: Federal Government; Health and Human Services (FDL HHS)

REGION: Illinois; Minnesota; North America; United States; Central U.S. (IL MN NME US USC)

Word Count: 267
3/2/95 WSJ (No Page)
END OF DOCUMENT

EXHIBIT H

1ST STORY of Level 1 printed in FULL format.

Star Tribune

October 18, 1993, Metro Edition

SECTION: News; MONEY vs. MISSION at the University of Minnesota; Pg. 1A

LENGTH: 2813 words

HEADLINE: Kickback inquiries target home-care program at 'U'

BYLINE: Joe Rigert; Staff Writer

BODY:

For the 20-year-old father of two children, life had suddenly taken a tragic turn. A congenital blood-clotting disorder had required surgeons to remove most of his stomach. He survived the surgery, but will never again be able to eat or digest food.

A program of daily care known as home infusion saved his life. Through a pump and catheter, he can receive liquid nutrition at home. He is back with his family and has returned to work.

But his survival will be at great cost to the health care system - as much as $ 120,000 a year for the rest of his life.

The home-infusion industry, barely a decade old, now takes in $ 4 billion a year nationwide for treating patients like him.

In Minnesota, the Star Tribune has found, the industry has shared $ 3 million in profits from that business with a corporation of University of Minnesota doctors whose clearest contribution appears to be a steady flow of patient referrals.

The doctors have formed a largely secret joint venture with Caremark Inc. - the largest company in the industry - and provide about one-fifth of Caremark's home-infusion patients in Minnesota. The arrangement raises significant legal and ethical questions.

Both the FBI and the U.S. Inspector General for Health and Human Services have recently begun investigating the university-Caremark deal for possible violations of kickback laws, the newspaper has learned.

In fact, Caremark's national operations have been under investigation by the inspector general for two years, to see whether its payments to physicians and hospitals are simply kickbacks to get patient referrals.

The university denies any illegality in the 2 1/2 -year-old venture with remark, but acknowledges that the arrangement has been modified in an effort to assure compliance with federal law. Caremark declined to comment separately.

Question of kickbacks

Are the Caremark payments a kickback? Legal experts retained by the Star Tribune say the main question is whether the university doctors actually contributed something to Caremark that is worth the profits their corporation is receiving.

The doctors say the payments from Caremark are not for referring patients but for providing a unique technology of cost-conscious managed care that is not available anywhere else.

That program, they say, includes guidelines, medical overview and outcomes analysis to improve quality and control costs in the home treatments. And they claim that preliminary data indicate they are achieving those goals.

But the Star Tribune has learned that similar managed-care components are widely used in home-infusion programs and have been described in many published reports, making them available to anyone who wants to read them.

The university offered Caremark its program before it was developed and has yet to publish a word on it. One of the most important components, the "outcomes database," hadn't been started until after the joint venture was formed. Moreover, Caremark, of Northbrook, Ill., already had been working on such a program nationally for a year.

Compared with other technology transfers, the Caremark venture has involved a sizable sum of money. In the past 2 1/2 years, the doctors' corporation has received about $ 3 million from Caremark, most of which it turned over to the medical school.

In the past three years, the university has received a total of $ 2.5 million in royalties from 206 other deals with private companies paying to use its technology - including such inventions as an implantable drug-delivery system and a vaccine for Lyme disease.

Kickbacks are a violation of federal law. They can raise health-care costs if they lead to greater use of services. Joint ventures also can add to costs if they eliminate competition and result in higher charges.

Caremark's equipment billings for one of its main therapies - total parenteral nutrition - are significantly higher than the average for competing hospitals and companies, according to state Medicaid data obtained by the Star Tribune.

University officials said that none of the profits from the Caremark venture have been spent. They also said that guidelines are being prepared to ensure that the money will be used only for patient care, research and education - and not for the direct benefit of the doctors who refer patients to the joint venture.

The legal experts say that money need not go directly to doctors to constitute an illegal kickback. The test is whether the doctors derive a benefit - even indirectly, as when money applied to a particular program frees up

)ther funds for salary or research support.

Courts have ruled that the kickback law is violated if any part of payments .re for patient referrals rather than for the delivery of services.

On Friday, the university issued an 11-page response to Star Tribune questions about the enterprise. It said, "We have been advised that the formation and operation [of the joint venture] is in compliance with the .pplicable law."

Conflicts of interest

University regents have adopted policies over the years aimed at encouraging faculty relationships with industry, while limiting conflicts of interest that might interfere with their university duties.

And the year before the university-Caremark tie was arranged, a national medical society urged its members to avoid joint ventures in the home-infusion business because they pose an "inherent conflict of interest," might encourage overuse of medical services, and could otherwise affect decisions on patient care.

Dr. Frank Cerra, a key University of Minnesota doctor in the Caremark venture, is a member of the organization, known as the American Society for Parenteral and Enteral Nutrition.

Despite the society's warning, Cerra and two other doctors, Randall Moore and Sara Jane Schwarzenberg, acted as part-time medical directors for the university-Caremark venture in 1991. In return, the joint venture agreed to pay the university $ 183,340 for their work. The university said those payments were not continued the second year.

As program supervisor, Moore worked at least 10 hours a week for the university-Caremark operation, which agreed to reimburse his department $ 103,000 a year for his time.

Moore declined to be interviewed. In a written response Friday, he said the three doctors received their salaries from normal university accounts - not from the joint venture. But he did not say whether the outside money freed up other funds for salaries, thereby providing an indirect benefit for the doctors.

After having negotiated the agreement to set up the Caremark deal, Moore quit the university in late 1991 to become medical director at Caremark headquarters. But he continued for at least a year to spend a day a week at the university hospital, evaluating patients to determine if they should go to his company's program.

Dr. Frank Rhame, as head of the university AIDS clinic, referred patients to Moore for home infusion and said he found Moore's decisions medically sound. But he said disclosure of Moore's dual role "is not going to look too good."

Can patients choose?

In July 1992, the university signed an "interim agreement" stating that its octors "may choose to refer patients" to the Caremark venture, but didn't have o do so.

Patients also are shown a statement telling them of the Caremark elationship and giving them the freedom to choose other companies for the home herapy.

But Caremark has a special access to university patients that other local ıome-infusion companies do not. Although the university doctors say they don't :eep figures on total referrals, they think that almost half of the ıome-infusion patients have gone to Caremark. As of June, Caremark had served ;86 university patients in 2 1/2 years.

Caremark has such close ties to the university that company nurses are ;tationed in the hospital and help plan patient discharges to the program. The ıniversity declined to say whether other companies' representatives can see ›atients in the hospital; one company official said his nurses were turned away.

In one case, according to a source with direct knowledge of the incident, an ıIDS patient objected to being referred to Caremark because of the cost. Moore :old the patient he would no longer serve as his doctor if he chose another ɔmpany, the source said. The patient went to Caremark.

In his written response, Moore said the Caremark charges turned out to be . ver than those of another firm.

After they have been referred to the Caremark program, patients are given :he written statement advising them of the referral and of the ıniversity-Caremark financial arrangement. The statement also tells them that :he arrangement calls for university doctors to monitor their care 24 hours a lay and work to improve it.

Then the university statement advises patients that they are "free to :hoose" a different company. In 1992, however, 294 patients went to Caremark, ınd only 14 chose another company. Twenty-eight were required by their insurers :o go elsewhere.

Why do so many patients go to Caremark? "Because the communications pathways ıave already been established," Rhame said.

The university-Caremark venture was established without competitive bidding ɔn either the service or the supplies to support it. University officials say :hey have no information on whether they could reduce costs by running their own ɔrogram, as they did earlier, or turning to other companies.

Slow to publish

For eight years, since they started to develop the managed-care program, the ıniversity doctors have published no information on it. And since forming the venture with Caremark in 1991, they have shared the details only with the

ompany.

Today, Caremark holds a copyright on the managed-care program, with "all ights reserved."

University policy and tradition call for publicly sharing the fruits of cademic work. But the doctors say it has taken time to achieve a database that an be "statistically validated." Preliminary results of their studies, they ay, indicate that their program has reduced medical problems in the home herapy, and a report is being prepared for publication.

The university said Friday that the Caremark partnership will make it ossible to bring verified information to the medical profession and the public ore quickly than if the doctors had acted on their own.

Secret arrangements

University of Minnesota doctors have been able to keep secret many of the etails of their venture because they set it up through their private edical-practice system, outside normal university overview.

Abuse of that system in other departments of the medical school - especially n the use of funds - recently prompted regents to tighten controls and remove ome of the secrecy.

In this case, more is unknown than is known about the use of such funds and he operation of the doctors' corporation, and whether policies were followed. he university said the departments invested medical-practice money in the joint enture, but didn't say how much. It also said the corporation did not retain ny earnings, but it had given a different answer to that question earlier.

Cerra, president of the doctors' corporation, refused to be interviewed but greed to an exchange of questions and answers in writing, which took place over period of months. Although he and the university provided a considerable mount of information, they declined to give any details on the finances of the aremark venture, guidelines and protocols for the program or the transfer of he university technology. They said these were all proprietary matters.

In its final response Friday, the university said that the plans for the joint venture had been fully disclosed to appropriate university officials and approved by them, and that the funds had been properly handled.

Breakthrough? Buzzwords?

Caremark and the university describe their program as one of a kind. Critics all it a collection of buzzwords.

The university doctors say their program, which they call a technology, cludes guidelines and protocols on how to provide the treatments, "clinical athways" laying out details on what must be accomplished, and computerized data howing outcomes. They say it involves "total quality management," a process

assure effective patient care and find how to improve it.

But more than a dozen representatives of other home-infusion services, ncluding academic pioneers in the field, said the University of Minnesota rogram is far from unique. They describe similar programs in their own niversities, hospitals and companies: the guidelines and pathways, the outcomes ata and total quality management.

"All that is just standard buzzwords, and we're doing all that too; I don't ee any difference between what we are doing and what they are doing," said arol Schaffer, head of Cleveland Clinic Foundation Health Care Ventures, which uns a large home-infusion service.

The Oley Foundation in New York established a computerized database in 1985. t now has information from more than 200 programs on the results of treating 0,000 patients and has published its findings. In 1990 Caremark began setting p a national system to collect such data and now promotes it. Representatives f other company and hospital programs say they are doing the same.

At the request of the Star Tribune, home-infusion experts reviewed the niversity of Minnesota's four-page description of its program. The general eaction was summed up by Dr. Marvin Ament of the University of California at os Angeles, who set up one of the country's first home-infusion programs 20 ears ago.

"I don't know what they are talking about that is so special," he said. "We it, but we don't say it's a model."

In its response Friday, the university said that if the other programs have een successful, "that success has not been reflected in the academic medical/ cientific literature, nor have their techniques and protocols been made enerally available."

But the Star Tribune found more than 50 reports on home infusion in the edical journals. They included a 1986 cost study in Canada, a 1991 report on anaged care in New Mexico and extensive guidelines first published in 1987 and pdated since. None was from the University of Minnesota.

Peter Mitsch, treasurer for the corporation of doctors, said the physicians ave now completed a managed-care model for nutrition therapy that will be used irst in Minnesota, then nationally. What's different about it? "Heavier nvolvement of physicians," he said.

Dr. Lyn Howard, professor of medicine at the Albany Medical College in New ork and another pioneer in the field, sees promise in the university's effort o develop such a program, but added, "The rest of us are wondering, is that oing to happen?"

Star Tribune, October 18, 1993

Advances in medical care and technology now make it possible to inject nutrients and drugs into patients in their homes, rather than in the hospital. The most complicated procedure is known as total parenteral nutrition (TPN), is illustrated on the right. It calls for threading a catheter through the chest wall and into a large vein above the heart. A pump is then used to maintain a flow of liquid nourishment into the bloodstream. Another method, called total enteral nutrition, involves use of a tube to feed nutrients directly into the stomach. The purpose is to provide "food" for patients who cannot eat or digest food normally. Drugs also are injected into veins to treat cancer and kill pain, in cases in which taking drugs orally is not practical or effective. It's all known as home infusion - now a major industry.

How total parenteral nutrition works

1. A catheter is surgically inserted into the body through a 1/4-inch incision in chest tissue.

2. A thin guidewire is used to guide the catheter's tip into position just above the heart, in the vein that supplies the heart with blood from the rest of the body.

3. The position of the catheter is confirmed using X-ray or fluoroscopy.

4. Fluids, containing nutrients and/or medication, can be run through a mechanical pump, called an infusion pump. It provides a continuous or periodic flow of fluids to the blood.

A bag carrying a pump can be worn as a backpack or carried over the shoulder, giving a patient mobility.

Fluids can also be injected with a syringe inserted into the catheter by way of the injection cap.

Sources: Pharmacia Deltec, Inc., Minnesota Home Therapeutics Inc., 3M

Star Tribune, October 18, 1993

;RAPHIC: Illustration

.ANGUAGE: ENGLISH

.OAD-DATE-MDC: October 20, 1993

EXHIBIT I

THE WALL STREET JOURNAL
September 22, 1994

Doctor Charged With Kickbacks From Caremark

By THOMAS M. BURTON
Staff Reporter of THE WALL STREET JOURNAL

A federal grand jury in Columbus, Ohio, charged an osteopathic doctor in Columbus with receiving $134,600 in kickbacks from Caremark International Inc. for steering patients to the home-care company.

This is the second indictment arising from a three-year federal criminal inquiry into Caremark, the nation's leader in providing intravenous medicines and liquid nutrition in patients' homes. Caremark wasn't mentioned by name in the indictment, but federal investigators confirmed that the Northbrook, Ill., concern was at the center of the case against osteopath Elliot Neufeld, 42 years old.

The grand jury, working with the Federal Bureau of Investigation and the inspector general's office of the Department of Health and Human Services, charged Dr. Neufeld with soliciting and taking kickbacks to refer patients to Caremark. Kickbacks are illegal under the federal Medicare and Medicaid insurance programs.

People familiar with the inquiry said that the government continues to pursue multiple criminal cases involving Caremark and that investigators expect to seek other indictments. Caremark, which had $1.8 billion in 1993 revenue, was a unit of Baxter International Inc. at the time many of the alleged kickbacks were made. Baxter spun off Caremark in November 1992. Caremark closed at $22.25, down 37.5 cents, in composite trading on the New York Stock Exchange yesterday.

Caremark has long defended payments to doctors as compensation for monitoring patients receiving therapy at home, and not as kickbacks. The Columbus indictment alleges, however, that payments to Dr. Neufeld stretching from January 1991 until this year were in exchange for sending Medicare and Medicaid patients to Caremark. Caremark provides tube feedings and intravenous antibiotics, chemotherapy and pain medication to patients at home.

Dr. Neufeld didn't respond to requests for comment. A Caremark spokesman said, "Our relationships with physicians have always been designed to comply with the law and provide quality cost-effective care to patients."

Michael T. Dyer, Midwest regional inspector general for investigations with Health and Human Services, said kickbacks "greatly increase the cost of health care without providing any health-care service." Moreover, he contended, such financial relationships between doctors and home-care companies "also encourage unnecessary tests and procedures."

Edmund A. Sargus Jr., the U.S. attorney in Columbus, said the inquiry there is continuing. "Investigating health-care fraud is a top priority, and certainly something we plan to put a lot of our resources into," he said.

Dr. Neufeld was paid consulting fees and compensation under Caremark contracts known as "quality service agreements," according to the indictment, but the grand jury contends the payments were merely bribes. In addition, the indictment alleges, Caremark paid the salaries of Dr. Neufeld's nurses and supplied him with a computer and a facsimile machine.

Caremark was previously charged by a federal grand jury in Minneapolis with participating in a $1.1 million illegal-kickback scheme to induce a Minneapolis doctor to prescribe Protropin, a human-growth hormone that Caremark distributes. Caremark has said it "expects to be vindicated" once all legal proceedings conclude.

Doctor

CONTINUED FROM PAGE 1

month. He could receive a maximum of $60,000 a year, the indictment alleged.

The relationship between Neufeld and the company deprived the federal government and the State of Ohio of the right to "honest and faithful treatment decisions," the indictment charged, and exploited Neufeld's fiduciary duty to his patients, causing them monetary harm.

The home infusion company also provided Neufeld with a free fax machine, a computer and nurses to work in his office, according to the indictment.

The mail-fraud charges arise because Neufeld allegedly submitted claims for payment by Medicare and Medicaid through the mail and received the payments through the mail.

The indictment says the home infusion company provided patients with home infusion therapies, which include providing nutrition by tube or intravenously, chemotherapy, antibiotic therapy and pain management.

The infusion therapy business has grown rapidly in recent years into a $4 billion industry.

"The mere size of the industry creates opportunity for fraud and opportunity to conceal the fraud," said Michaael Dyer, regional inspector general for investigations at the U.S. Department of Health and Human Services.

Laws relating to payments to doctors in the home-care industry are in flux, said Marnie Frey, president of the Ohio Council for Home Care.

In many cases, federal regulations do not provide for payments to doctors to monitor the care of Medicare patients after they leave the hospital.

"Many times when you have IV therapy there is a reasonable amount of time spent in the monitoring process," she said. "The question for physicians i : b· 'How do I receive payr nt this activity that I perform.'

"The Health Care Finance ministration is in the pr ess re-evaluating that," she s: . " likely that there will b so regulation change that will p mit payment."

Wednesday's indictr w part of a series of pro / 1 Justice Department, th Depa ment of Health and Human Se ices and the FBI. An in iti tion of alleged kickbac a other improprieties result in $379 million civil settlement National Medical Enterpris Inc. this year.

Citation
22/94 WSJ B7
/22/94 Wall St. J. B7
994 WL-WSJ 2045681

Rank(R)
R 2 OF 9

Database
WSJ

Mode
Page

The Wall Street Journal

Thursday, September 22, 1994

Technology & Health

Doctor Is Charged With Kickbacks From **Caremark**

By Thomas M. Burton
Staff Reporter of The Wall Street Journal

A federal grand jury in Columbus, **Ohio,** charged an osteopathic doctor in Columbus with receiving $134,600 in kickbacks from **Caremark** International Inc. for steering patients to the home-care company.

This is the second indictment arising from a three-year federal criminal inquiry into **Caremark,** the nation's leader in providing intravenous medicines and liquid nutrition in patients' homes. **Caremark** wasn't mentioned by name in the indictment, but federal investigators confirmed that the Northbrook, Ill., concern was at the center of the case against osteopath Elliot Neufeld, 42 years old.

The grand jury, working with the Federal Bureau of Investigation and the inspector general's office of the Department of Health and Human Services, charged Dr. Neufeld with soliciting and taking kickbacks to refer patients to **Caremark.** Kickbacks are illegal under the federal Medicare and Medicaid insurance programs.

People familiar with the inquiry said that the government continues to pursue multiple criminal cases involving **Caremark** and that investigators expect to seek other indictments. **Caremark,** which had $1.8 billion in 1993 revenue, was a unit of Baxter International Inc. at the time many of the alleged kickbacks were made. Baxter spun off **Caremark** in November 1992. **Caremark** closed at $22.25, down 37.5 cents, in composite trading on the New York Stock Exchange yesterday.

Caremark has long defended payments to doctors as compensation for monitoring patients receiving therapy at home, and not as kickbacks. The Columbus indictment alleges, however, that payments to Dr. Neufeld stretching from January 1991 until this year were in exchange for sending Medicare and Medicaid patients to **Caremark. Caremark** provides tube feedings and intravenous antibiotics, chemotherapy and pain medication to patients at home.

Dr. Neufeld didn't respond to requests for comment. **A Caremark** spokesman said, "Our relationships with physicians have always been designed to comply with the law and provide quality cost-effective care

to patients."

Michael T. Dyer, Midwest regional inspector general for nvestigations with Health and Human Services, said kickbacks "greatly increase the cost of health care without providing any health-care service." Moreover, he contended, such financial relationships between doctors and home-care companies "also encourage unnecessary tests and procedures."

Edmund A. Sargus Jr., the U.S. attorney in Columbus, said the inquiry there is continuing. "Investigating health-care fraud is a top priority, and certainly something we plan to put a lot of our resources into," he said.

Dr. Neufeld was paid consulting fees and compensation under **Caremark** contracts known as "quality service agreements," according to the indictment, but the grand jury contends the payments were merely bribes. In addition, the indictment alleges, **Caremark** paid the salaries of Dr. Neufeld's nurses and supplied him with a computer and a facsimile machine.

Caremark was previously charged by a federal grand jury in Minneapolis with participating in a $1.1 million illegal-kickback scheme to induce a Minneapolis doctor to prescribe Protropin, a human-growth hormone that **Caremark** distributes. **Caremark** has said it "expects to be vindicated" once all legal proceedings conclude.

---- INDEX REFERENCES ----

.ICKER SYMBOL: CK

MARKET SECTOR: CONSUMER NON-CYCLICAL (NCY)

INDUSTRY: HEALTH CARE PROVIDERS (HEA)

NEWS SUBJECT: HIGH-YIELD ISSUERS; HEALTH; LAW & LEGAL ISSUES; LAWSUITS; WORLD EQUITY INDEX (HIY HLT LAW LWS WEI)

GOVERNMENT: FEDERAL BUREAU OF INVESTIGATION; HEALTH AND HUMAN SERVICES; JUSTICE DEPARTMENT (FBI HHS JUS)

REGION: ILLINOIS; NORTH AMERICA; **OHIO**; UNITED STATES (IL NME OH US)

Word Count: 484
9/22/94 WSJ B7
END OF DOCUMENT

EXHIBIT J

Rank(R) R 1 OF **2**
Database PTS-PROMT
Mode **Page**

Ohio doc with ties to **Caremark** faces kickback charges

Modern Healthcare September 26, 1994 p. 14
ISSN: 0160-7480

A Columbus, Ohio, physician with ties to **Caremark** International was indicted last week by a federal grand jury on charges of receiving $134,600 in illegal physician kickbacks.

Elliot Neufeld, 42, a Columbus osteopathic physician, was charged with conspiracy to solicit and accept Medicare and Medicaid kickbacks from an unnamed home infusion company, soliciting and accepting kickbacks, and mail fraud.

Dr. Neufeld declined to comment on the charges. His attorney, James Streicker of the Chicago-based law firm Cotsirilos, Stephenson, Tighe & Streicker, said his client will plead innocent.

Mr. Streicker also represents **Caremark** executive Judy Giel, who was indicted along with **Caremark** and four other individuals last month by a federal grand jury in Minneapolis, charged with paying a Minneapolis physician $1.1 million in illegal kickbacks (Aug. 8, p. 4).

Caremark wasn't specifically named in last week's indictment in Columbus. However, sources close to the events told MODERN HEALTHCARE that **Caremark** is the home infusion company referred to in the indictment and remains the focus of the federal investigation in Ohio.

The unnamed company was not charged in the indictment.

Meanwhile, **Caremark** denied any involvement in the case.

'We're not discussing details of the indictment,' **Caremark** spokesman Les Jacobson said. 'We were not involved. There is nothing to say.' When asked whether Dr. Neufeld was affiliated with **Caremark** , Mr. Jacobson declined comment.

Since August 1991, **Caremark** 's business arrangements with physicians have been the center of an ongoing federal investigation. At issue is whether the Northbrook, Ill.-based company violated federal laws by paying physicians illegal kickbacks in return for Medicare patients.

In 1993, approximately 14% of **Caremark** 's revenues, or about $250 million, came directly from Medicare and Medicaid patients.

- John Burns

WORD COUNT: 281

COMPANY:
*Caremark Intnl

PRODUCT: *Home Intravenous Therapy (8096140)
EVENT: *Justice & Safety (98)
COUNTRY: *Ohio (1639)

EXHIBIT K

Transcript

DATE February 22, 1995
TIME 10:00-11:00 PM (ET)
NETWORK ABC-TV
PROGRAM Prime Time Live

Sam Donaldson, host:

We've all heard the phrase, 'the doctor knows best.' Often, it's true. But tonight, we begin with a story of how some doctors made a lot of money by thinking what was best for them was not just for their patients. (sic) It's a story of doctors cashing in through secret deals with the country's biggest home health care company, Caremark. The patients they referred to Caremark got their care, alright, but at a cost that was sky-high, while the doctors who made the referrals were raking in a percentage off the top. Take a look at a story that gives new meaning to the phrase, 'the doctor knows best.'

This is the weekend home of Atlanta doctor Michael Rankin, located on four hundred thirty-seven acres near Lexington, Kentucky. (visual of home) He paid a million dollars cash for it. Doctor Richard Hudson moved from this modest house in Atlanta to this mansion in the city's luscious neighborhood. (visuals of homes) Purchase price- 1.9 million. According to sources, these and other Atlanta area doctors cashed in, thanks to secret deals with the largest home health care company in the nation, Caremark. Deals depended on patients like Alan Booth, who has AIDS.

Alan Booth (AIDS Patient): It was a money game; it was a way for them to make a lot of money.

Donaldson: Nearly three years ago, Booth became very ill. His doctor, Michael Rankin, arranged for him to receive all his intravenous drugs at home, through Caremark.

Did he recommend a number of companies and say, 'Now, look, you can go with this one or this one or this one?'

Booth: I was only offered one company. He brought a contract over to me and told me to read it, sign on the line, and that Caremark would take care of all billings.

Donaldson: For a long while, Booth never saw a bill. They went to his insurance company, Prudential, which paid them. Until a mistake, he started receiving copies. (sic) The totals shocked him. Caremark had billed his insurance

company almost fifty thousand dollars in one nine-week period alone. At that rate, Booth was afraid his one million dollars of lifetime coverage would soon run out.

Booth: I remember fear every week, wondering if I'm going to be told at my doctor's office that I'm cut off and I can't come back.

Donaldson: Booth began shopping around, and found he could get the same drugs and similar home care services elsewhere for much less. Like at Midtown Medicine. Caremark charged a hundred fifteen dollars for a dose of Encomycin (sp). Midtown charged only sixty-five. Caremark charged two hundred sixty-five dollars for a hundred AZT pills. Midtown charged a hundred forty-eight. Caremark charged over four thousand dollars for a one week supply of an intravenous nutritional supplement. Midtown's charge would have been just over fifteen hundred. (Graphics of information)

Alan Booth wondered why Dr. Rankin would refer him to a company with such high prices. He told us this woman, Ellen Sweet, who was Dr. Rankin's office manager, finally told him a secret. (Visual of Ellen Sweet) If Rankin referred a patient to Caremark, he would get twenty-five percent of all the money Caremark collected from the patient's insurance company.

Booth: At first I was upset and confused. That turned into anger and rage, and here I am, somebody very sick, and who do I talk to about this?

Donaldson: Did you go to Dr. Rankin and say, 'Is this true?'

Booth: I did. I confronted Dr. Rankin and I confronted Caremark, and both of them denied having any kind of business deals.

Donaldson: Booth filed a lawsuit, but shortly after speaking to us, he settled it. Caremark agreed to pay his attorney's fees and give him free home health care for life. In return, Booth signed a statement saying he'd received superior care and he had no personal knowledge of any kickbacks to doctors, a statement calling it all a misunderstanding.

But Prime Time's investigation has uncovered a lot of independent evidence pointing to the truth of what Alan Booth had told us. We tracked down five former Caremark employees, two of whom agreed to go on camera with identities concealed, who described for us an elaborate scheme involving doctors.

Employee #1 (Further Unidentified): I call it buying a doctor.

Donaldson: Here's the way they say it worked. A doctor referred a patient to Caremark for home health care. Caremark billed the insurance company, but in the name of a third company, set up by the doctor, who siphoned off a percentage of the insurance money, sometimes as much as thirty percent.
What did the doctors do for this?

Employee #2 (Further Unidentified): Refer the patient.

Donaldson: The doctor didn't perform any services for it?

Employee #2: In addition to the services that he would have performed on his patient normally?

Donaldson: Yeah.

Employee #2: No.

Donaldson: And of course, the doctor's financial interest was concealed. Take a look at one of Booth's bills. (visual of bill). Even though Caremark has provided all the goods and services, Booth's insurance company, Prudential, is being billed by a company called Family Medical Services at a Chicago post office box. Family Medical Services was nothing more than a front set up for the benefit of two doctors, one of whom was Michael Rankin, Booth's doctor. These arrangements were so irregular that some of Caremark's own staff thought it fishy, like this former employee.

Employee #3 (Further Unidentified): What my manager once told me when I questioned it was they have to pay the doctor something.

Donaldson: Or the doctor wouldn't refer patients to Caremark?

Employee #3: Or they would go somewhere else.

Donaldson: For the doctors, it was a gold mine.
How much money did this add up to?

Employee #2: Some doctors received as much as fifty thousand dollars a month.

Donaldson: A month?

Employee #2: Yes.

Donaldson: She says Dr. Rankin made the most of all.

Employee #2: There were two or three months in which he exceeded over a hundred thousand dollars.

Donaldson: Where was this kind of money coming from? We asked Don Creese, who owns Midtown Medicine, to go over some of the bills with us. Take the backpack that Booth and others use to carry around their intravenous drugs. How much do you charge a patient for the backpack?

Don Creese (Owner, Midtown Medicine): There is no charge for the backpack. But when I've got to buy a new backpack, if this one gets soiled, it costs me thirty dollars.

Donaldson: Caremark charged Booth three hundred twenty dollars. Caremark also billed for drug compounding, that is, mixing a drug with water, as Creese is doing here. A procedure which takes about a minute a dose. How much do you charge for it?

Creese: There is no charge for compounding.

Donaldson: What if you did a hundred of them?

Creese: There is still no charge for compounding.

Donaldson: Caremark charged Booth over a thousand dollars for compounding fourteen doses. That's a thousand dollars for about fourteen minutes' work. But there's more. Caremark not only charged exorbitant prices for its own services, it marked up the drug bills its patients incurred on their own, as Kevin Rausch belatedly discovered.

Kevin Rausch (Delivered Drugs for Patient): We all went through this horrible time together. He needed help.

Donaldson: Rausch is talking about Harry Grasmick, who died of AIDS two and a half years ago. When Grasmick got too weak to pick up drugs himself, his family hired Rausch to do it for him at Howell Mill pharmacy in Atlanta.

Rausch: We wanted him to live in dignity; we wanted him to die in dignity.

Donaldson: Who was Harry's doctor?

Rausch: Dr. Cole Woolford.

Donaldson: But when Rausch looked over the insurance bills and compared them to Howard Mills' stated prices, he was amazed. Howell Mills' charge for a hundred twenty Dilantin tablets was twenty-four dollars, eighty cents. But the bill to the insurance company was for forty-eighty. Howell Mills' charge for a hundred Biaxin pills was two hundred sixty dollars. But the insurance company was being billed for four hundred thirty-three dollars. (Graphics of information) According to sources, Dr. Woolford sent Grasmick to Howell Mill Pharmacy, which was submitting the bills to Caremark, which was jacking them up to the

insurance company, but not using its own name. No, the insurance company was being billed by something called Home Therapy Alternative, which, surprise, used a Chicago post office address.

We did some checking, however, and the federal tax i.d. number listed on Grasmick's bills referred us back to Georgia. We found the company registered with the secretary of state's office in Atlanta, and guess who turns out to be behind it?

Do you know who owns Home Therapy Alternative?

Rausch: No, I have no idea who owns Home Therapy Alternative.

Donaldson: We checked. The man who is the chief executive officer is Dr. Cole Woolford.

Rausch: Well, I... I'm amazed. I'm shocked. I don't know what to say. I didn't expect him to be involved in it, not like that.

Donaldson: What do you make of this, Mr. Rausch?

Rausch: It's blood money; it's pure blood money.

Dr. Lonnie Bristol (President-Elect, American Medical Association): Kickbacks are unethical, clearly.

Donaldson: We showed some of our tapes and materials to Dr. Lonnie Bristol, president-elect of the American Medical Association. He says doctors should only be paid for services rendered.

Bristol: Any time a physician receives a reward for simply sending a patient to an entity that's providing some sort of a service, that's a kickback arrangement. And if these statements are proven to be true, then that would be a kickback arrangement, and that's clearly unethical and would be deplored by the profession.

William Domby (National Association for Home Care): In my review of the Georgia law, this would not be illegal per Se. In a neighboring state like Florida, it would be.

Donaldson: William Domby heads the legal section of the National Association for Home Care. No matter what state law provides, he says his organization considers kickbacks unethical and that prices charged by some in the industry are outrageous.

Domby: We've supported legislation which would ban this kind of conduct.

Donaldson: Why do insurance companies pay these large bills?

Domby: I think one reason why is insurance companies really just looked at the charges as a charge compared to hospital care. If the charge for hospital care was greater than the charge for the home care services, they felt they were getting a good deal.

Donaldson: Certainly also a good deal for Caremark and the doctors. But it raises questions for the patients that go beyond money.

Booth: If you look at the cost of some of these drugs, five, six hundred dollars a bottle they charge, it makes me wonder how much of that was really necessary and how much of it was just a way for the doctor to get more kickback.

Donaldson: To get rich.

Booth: Exactly.

Donaldson: We wanted to get the doctors' side of all this. We caught up with Dr. Michael Rankin on his way to his Kentucky weekend home.

Doctor, is it ethical to get money from Caremark for patients that you have sent them? Can't you talk to me about it?

Dr. Michael Rankin (Accused of Accepting Kickbacks): I just wish you all a good day.

Donaldson: Dr. Rankin, we'd like to sit down with you and do a formal interview.

He declined, but his attorney sent us this letter, saying Dr. Rankin never did anything illegal, and never compromised the quality of care he delivered to his patients based on business as opposed to medical considerations. (Graphic of letter) Harry Grasmick's doctor, Cole Woolford, also declined to sit down with us. His only off the cuff comment was the same as Dr. Rankin's.

Is it ethical to do that, doctor?

Dr. Cole Woolford (Accused of Accepting Kickbacks): Have a nice day.

Donaldson: Dr. Richard Hudson, who lives in that Atlanta mansion, didn't return our phone call. For its part, Caremark, in a letter, acknowledged having percentage deals with some doctors, but said the arrangements complied with federal and state laws, and were structured to better serve the patients. The company writes, 'It was never Caremark's policy to pay physicians for referrals, and actually, it was the doctors who hired Caremark and paid it a percentage to provide home care and do the billing.' (Visual of letter)

According to Caremark, the doctors kept the rest to

handle things like home health coordination and home care planning assessment. As to the high prices, Caremark insists the prices charged were competitive with comparable services.

Prime Time has learned Caremark's deals with doctors extended well beyond Atlanta. Hundreds of doctors all around the country, including cancer specialists, internists and obstetricians made financial arrangements of various kinds with Caremark, deals that are now the subject of a widespread federal investigation. Caremark is already under indictment in Minnesota for allegedly paying 1.1 million dollars in kickbacks to a doctor for referring Medicaid patients to Caremark. The trial is scheduled to begin in July. Caremark says it expects to be vindicated.

# # #

EXHIBIT L

WALL STREET JOURNAL.

FRIDAY, NOVEMBER 11, 1994

'e for Service

Caremark Faces Heat For Paying Doctors Who Sent It Patients

Physician-Salesman Enlisted Fellow M.D.'s, Raising Fortunes All Around

Years of Treatment for Lyme

By THOMAS M. BURTON
Staff Reporter of THE WALL STREET JOURNAL

BLOOMFIELD HILLS, Mich. — When Bruce A. Margulis left the home-health-care business last year, the 39-year-old physician was a millionaire many times over. But not from practicing medicine.

The internist was a kind of super-salesman for Caremark International Inc., the U.S. leader in home intravenous therapy. When regular salespeople couldn't get into ...rs' offices, he often could, coaxing ...to direct patients into home care.

...is generated millions of dollars in revenue and won salespeople in Caremark's Detroit office vacations abroad. The suave and handsome Dr. Margulis made more than $2 million a year from a sales joint venture he established with Caremark. He built a stately home in this elite suburb and indulged his passion for luxury sports cars, finally selling his interest in the sales venture to Caremark for an estimated $23 million.

An Investigation

But now Dr. Margulis is a prime focus of a broad federal investigation into alleged kickbacks by Caremark and other health-care companies to doctors for patient referrals. One of his main sales methods, former colleagues say, was to offer doctors payments that sometimes reached $100,000 a year. Caremark says it paid doctors only as compensation for services such as monitoring patients' blood tests. But others, including some former Caremark employees, say many of the doctors did little or no work other than sending patients Caremark's way.

Caremark's "payments to doctors were a sales technique, and Caremark only paid if the doctor brought in the patient," says Richard P. Kusserow, former inspector ...l of the U.S. Department of Health ...man Services, which is conducting ...e inquiry along with the Federal Bureau of Investigation. "Patients think they're getting the best medical judgment available, but money has a corrupting influence on that medical decision. These payments can also lead to over-utilization and add to the cost of health care."

Payments for patient referral are illegal kickbacks when the patients are insured by Medicare and Medicaid, but the kickback law doesn't generally apply with patients who have private insurance. The FBI and HHS investigation has so far yielded indictments in Columbus, Ohio, and Minneapolis—the latter naming Caremark as a defendant — as well as a settlement in which T2 Medical Inc. (now part of Coram Healthcare Corp.) paid a $500,000 penalty without admitting wrongdoing.

Home Infusion

Dr. Margulis's attorney says his client believed the payments to doctors were legal, relying on counsel at Caremark and Baxter International Inc., which owned Caremark from 1987 through 1992. "He was doing his best to follow the rules as he understood them," says the lawyer, Martin I. Reisig.

Caremark denies any impropriety, saying that "compliance with the law has always been a high priority." It said three years ago that it would stop all payments related to Medicaid or Medicare patients, but by the accounts of several former company employees in Detroit, the arrangements persisted in Michigan. Caremark won't discuss arrangements with any individual doctors. The company has embarked on talks with federal prosecutors to resolve the matter.

Providing intravenous medicine and nutrition in the home—a practice known as home infusion — is supposed to be much cheaper than hospital care. Partly because of this promise, it has grown rapidly, into an industry with $4 billion a year in revenue. Yet "many times, home-infusion therapy has not been cheaper than hospitals, but higher," says Edward Acela, an investigator with Principal Mutual Life Insurance Co. in Des Moines, Iowa.

Lots of Lyme

Former employees from Caremark's Detroit office say the company charged some $250 per patient per day for a regimen of intravenous nutrients, although the ingredients cost it only about $6. Caremark terms the $6 figure "way low." It also points out that its bills include the cost of mixing nutrients and medicines and of home nursing visits. Home-infusion prices have declined about 5% in the past two years, after word of the federal inquiry emerged, partly because of pressure from managed-care groups.

Caremark's financial ties to doctors may have contributed to excessive medical care. One Michigan doctor generated Caremark sales of more than $2 million a year while placing hundreds of people on home antibiotic therapy for Lyme disease, law-enforcement officials say, although health authorities know of only a tiny handful of cases in the whole state.

Caremark had contracts with doctors spelling out what patient-monitoring services were expected and forswearing any effort to induce referral of patients. A Caremark attorney, Howard M. Pearl, says any doctors failing to perform patient

Fee for Service: How Caremark Physician-Salesman Enlisted Doctors to Send Patients the Firm's Way

Continued From First Page

mo.. ring "would have violated Caremark's clearly stated policies."

But many former Caremark employees dismiss the notion that most doctors were truly performing medical services once patients were home. Mark **Deponio**, former Caremark general manager in Grand Rapids, says he found the payments to doctors so ethically troublesome he quit his job after a few months in 1991.

"What came through at a sales meeting," he says, "was that the intent of these payments was to steer business. That shocked me. Some of Caremark's business practices cheapened the services Caremark offered." Barbara **Petroff**, a former Caremark pharmacist in Detroit who was in position to be aware of monitoring of patients, says, "Probably two-thirds of the payments were just paying off doctors." (Ms. Petroff says she left when her job was eliminated.)

Dr. Margulis was at the heart of efforts to line up doctors. A graduate of Bloomfield Hills' exclusive Cranbrook School and of the University of Michigan medical school, he was in his residency at the prestigious William Beaumont Hospital in Royal Oak, Mich., when he decided in the mid-1980s to enter the fledgling home-infusion business. He sealed a deal with Caremark that h direct Beaumont and other patients t ad split profits.

Patients ran the gamut. Some needed antibiotics, pain or cancer medicine given intravenously. Others needed very expensive (some $100,000 a year) IV feeding, known as total parenteral nutrition.

Dr. Margulis and Caremark set up a joint venture, Physician Health Resources, to do home infusion. Then a private company of Dr. Margulis's, Physician Care P.C., made the payments to the referring doctors, getting reimbursed by the joint venture, according to internal Caremark documents. The joint venture split its profits, which came to $4.7 million before taxes in 1989, between Caremark and the Margulis private company, internal Caremark correspondence shows.

The thriving Detroit office, which included the joint venture's results in its own, became a big reason for Caremark's rising sales and earnings. Last year Caremark, which is based in Northbrook, Ill., earned $77.7 million on $1.8 billion in revenue, of which $410 million came from home infusion. (Caremark also distributes human growth hormone, manages prescription benefits and offers other services.)

Dr. Margulis's deal with Caremark brought him earnings and distributions of million between 1988 and 1992, Care- documents show.

'Dollars for Docs'

Dr. Margulis enlisted doctors who were in position to forward lots of patients. Contracts called for doctors to document work they did for their payments. Former Caremark Detroit employees say that some physicians did so; but add that most didn't, and Caremark didn't insist. Some employees grew uneasy about the arrangements. What Caremark termed "fees for service" they joked about as "dollars for docs."

Darlene Weidner, a former Caremark secretary, says she "used to call them kickbacks in talking to Bruce [Margulis]. He would get upset. But basically, it was a joke that these were fees for service."

Adds Mr. **Deponio**, the former Grand Rapids manager: "The reality was there were no services, or limited services. The clear intent of the payments was to influence patient referrals."

Caremark top management evidently didn't share the employees' misgivings. "There was upper-management support for what Bruce was doing," says Pat Moorhatch, a former Caremark operations manager. "My impression was that Shelly approved of what Bruce was doing," she adds, referring to Sheldon D. Asher, then Caremark executive vice president.

Car Race

Mr. Asher, who declines to comment, stayed at the Margulis home on visits to Detroit and accompanied Dr. Margulis to Detroit Pistons basketball games. The two men maintained a friendly rivalry over exotic sports cars; when they heard about a new-model Porsche Carrera 4 coupe about to enter the market, the two raced to be first to acquire one.

Dr. Margulis won, say colleagues, one of whom adds that he crowed, "That [S.O.B.] Shelly is going to be so jealous." Former associates say Dr. Margulis was so devoted to his cars he would ask his maid to dust and scrub around the garage's baseboard. (His attorney says the family can't recall any such cleaning.)

Although Dr. Margulis wasn't technically a Caremark employee, people in the Detroit office were told to keep him happy. Another infusion company tried to lure him away in 1990, and he apparently was about to bolt; but Mr. Asher flew in with a sweetened deal that induced him to stay.

Dr. Margulis became president of the Detroit branch. At one point, revenue collection at the office slid, threatening his income. Law-enforcement officials have been told he grew angry over the sag, saying, "I have needs. I need to have $125,000 a month." The office began a cost-control program, going so far as to begin locking an office-supply cabinet.

Costly Feeding

The revenue slide turned out to be brief. A prime engine of growth was total parenteral nutrition, or TPN, in which patients with impaired digestive capacity take all nutrients intravenously. Former colleagues identify one physician who referred TPN patients to Caremark as Jay Collins, a surgeon in West Branch, Mich., who they say was enlisted by Dr. Margulis.

Eile n Dahn, discharge planner at the hospital where Dr. Collins practices, says the expensive feeding method wasn't always necessary; cheaper tube feedings or other liquid nutrition would have sufficed, she believes. "Our question is whether other methods would be just as effective," she says. There were times, she maintains, that his prescribing of TPN was "an off-the-wall idea."

The hospital is reviewing Dr. Collins's

treatment practices, according to a staff member there. And federal law-enforcement officials and Blue Cross Blue Shield of Michigan are probing his relationship with Caremark, according to people familiar with the inquiries. Dr. Collins didn't respond to requests for an interview.

Caremark paid Dr. Collins between $1,300 and $1,900 monthly in early 1992, records show. Kevin Roeder, former co-owner of a local Saginaw home-infusion company, says that when he and an associate tried to sign up Dr. Collins, the doctor asked, "What is the modus operandi, boys?" They told him they offered good patient service but didn't pay fees to referring doctors. "After he knew we weren't going to offer anything, he started to talk about sailing, and that was it," Mr. Roeder says.

"I believe these fees lead to overdiagnosis and over-utilization," Mr. Roeder adds. "Doctors are only human."

Dr. Margulis also helped a Caremark salesman sign up a Saginaw doctor named Joseph Natole Jr., former Caremark employees say. A 1992 Caremark document lists Dr. Natole as producing "good and growing volume" of some $866,000 a year. When that grew to over $2 million annually, it was yielding about $300,000 in profits each for Dr. Natole and for Caremark, Michigan authorities say.

Over five years, Dr. Natole diagnosed about 250 people as having Lyme disease. He placed patients on antibiotic therapy, some of it delivered at home by Caremark, that sometimes lasted for two years or more, according to transcripts of a hearing to revoke or suspend his medical license. (No decision has been reached on that.)

Michigan health authorities say it appears the vast majority of those patients didn't actually have Lyme disease, based on incidence of Lyme in the state and on populations of ticks that spread it. William Hall, chief of the state health department's disease-surveillance section, says that in the past two years there have been at most three confirmed cases of Lyme in the entire state. Other doctors, after reviewing patient records or examining patients, testified that Dr. Natole had wrongly diagnosed and overtreated patients.

At the hearing, Dr. Natole testified that "there is no way to currently culture the [Lyme] bacteria from blood" and said he put the patients on home antibiotic therapy partly for diagnostic purposes. But Susan Thompson, assistant professor of medicine at Michigan State University, testified that this "is not an accepted method of diagnosing Lyme disease."

And although Dr. Natole's lawyer, Scott L. Mandel, says there is "a healthy debate in the medical community about diagnosis and treatment of Lyme disease," this is denied by the doctor who first identified the disease in the U.S., Allen C. Steere of Tufts University, who adds that two or more years of antibiotic treatment are "absolutely" not necessary.

Phillip I. Frame, a state assistant attorney general, contends that "the overdiagnosis and the Caremark issue are intertwined. The more you overdiagnose, the more you make. Ninety-five percent of his cases are misdiagnosed."

Dr. Margulis also brought to Caremark doctors from as far away as Maine. But in 1991, a former Caremark finance manager says, Dr. Margulis sold his half of the outside-of-Detroit sales venture to Caremark for $6 million. Then, in December 1992, he negotiated a much larger severance package with Caremark, selling it his portion of the in-state sales venture.

Exultant, he called the former finance manager, Leigh A. Bonfils, to tell her about the terms. She declines to comment on all other matters but confirms this conversation. By her account, Dr. Margulis said Caremark would give him $10 million in immediate and deferred cash payments plus stock options potentially worth $7 million. And the company would keep him as a consultant.

Ms. Bonfils says he added one other thought: "He said he was going out on top."

EXHIBIT M

Citation
1/17/94 WSJ A3
11/17/94 Wall St. J. A3
1994 WL-WSJ 2053260

Rank(R)
R 2 OF 2

Database
WSJ

Mode
P LOCATE

The Wall Street Journal

Thursday, November 17, 1994

Caremark Probe Widens to Cover Billing Practices

Medicaid May Have Paid **False** and **Inflated** Bills For Home Health Care

By Thomas M. Burton
Staff Reporter of The Wall Street Journal

Federal investigators have expanded a criminal inquiry into Caremark International Inc. in Michigan, and now are focusing on whether the home-care company submitted **false** and **inflated** bills to insurers, including the Medicaid program.

The U.S. investigation in Michigan also centers on whether Caremark, Northbrook, Ill., presented similar false billings on antibiotics and liquid nutrition to Blue Cross Blue Shield of Michigan, people knowledgeable about the inquiry say.

Federal investigators, who in the last few days have delivered subpoenas to Caremark's Detroit-area office, are focusing on whether the allegedly false bills may constitute federal crimes by violating Medicaid and Blue Cross guidelines.

The Michigan inquiry is part of a three-year nationwide investigation into Caremark, the nation's leader in home-intravenous therapy. As in the rest of the country, the Michigan investigation largely centers on alleged kickbacks paid to doctors to refer patients to Caremark. The inquiry there also focuses on Bruce A. Margulis, a Detroit-area doctor who headed a sales joint venture with Caremark and became president of the Caremark office in metropolitan Detroit. Dr. Margulis has denied any impropriety, saying that he relied on advice from Caremark's lawyers.

Michigan's Medicaid program requires that health-care providers such as Caremark charge the program for their own cost of drugs, plus a handling fee. Law-enforcement officials say some other states have similar policies, suggesting that the Michigan issue could broaden into a national one as the inquiry proceeds.

Moreover, Blue Cross has a similar policy in Michigan, providing that it will pay only the "net acquisition cost," plus a handling fee. Blue Cross auditors have concluded that Caremark overbilled the insurer by substantially marking up charges for antibiotics and other medications, people familiar with the audit findings say. The people

say that auditors concluded that Caremark overcharged Michigan's Blue Cross by several million dollars over a number of years. Blue Cross declined to comment, citing the federal inquiry.

Caremark, which denies submitting false bills, has pointed out in the past that its charges include the cost of pharmacists mixing medications and of nurses who visit patients at home and instruct them in the administration of intravenous medications and liquid nutrition, known as home-infusion therapy.

In a written statement, Caremark said that "whenever there is a billing or payment question with any of our customers, we seek to resolve the matter as quickly as possible." The company added that audits are performed routinely, and that "payers would not be paying us over the years if they did not value our service." Caremark declined to elaborate.

Caremark's home-infusion business made up about $410 million of the company's $1.8 billion in 1993 revenue. More broadly, 1993 revenue for all of Caremark's home-care business care was about $918 million. Aside from home infusion, Caremark's home-care activities include services related to human growth hormone Protropin, the antihemophilia product Factor VIII and the schizophrenia drug Clozaril.

Federal law enforcement officials in Michigan also are scrutinizing whether Caremark also may have violated federal law by systematically failing to collect "co-payments" from Medicaid patients. These are percentages of medical fees that patients are supposed to pay.

Former Caremark employees in Michigan contend the co-payments regularly were not collected there. The company points out that its procedures manual spells out: "There will be no waivers of patient co-payments or deductibles."

In practice, health-care providers often find it difficult to collect these amounts from the lower-income families insured by Medicaid. However, the government is concerned about any systematic waiver of the payments, because they are intended, in part, to prevent overutilization of medical care.

---- INDEX REFERENCES ----

TICKER SYMBOL: CK X.BCB

MARKET SECTOR: Financial; Consumer Non-Cyclical (FIN NCY)

INDUSTRY: Health Care Providers; Life Insurance; Insurance (HEA INL INS)

NEWS SUBJECT: High-Yield Issuers; Health; Law & Legal Issues; World Equity Index (HIY HLT LAW WEI)

GOVERNMENT: Health and Human Services; Justice Department; State Government (HHS JUS STE)

REGION: Illinois; Michigan; North America; United States; Central U.S. (IL MI NME US USC)

Word Count: 590
11/17/94 WSJ A3
END OF DOCUMENT

EXHIBIT N

CAREMARK SEEKS TO CONTROL DAMAGE AFTER QUESTIONS RAISED ABOUT BILLING
Chicago Tribune (CT) - FRIDAY, November 18, 1994
By: Steven Morris, Tribune Staff Writer.
Edition: NORTH SPORTS FINAL Section: BUSINESS Page: 3
Word Count: 334

TEXT:

Caremark International Inc. defended its billing practices Thursday after its stock fell 6 percent following a report that its Detroit office has become a focus of a federal investigation.

At issue is whether **Caremark** overbilled insurers, including Medicaid and Blue Cross and Blue Shield of Michigan, according to an article in The Wall Street Journal.Investigators also reportedly want to know whether the Northbrook-based provider of home infusion therapy and other health-care services routinely violated federal law by failing to collect co-payments from Medicaid patients.

Dr. Bruce Margulis, a **Caremark** sales and marketing manager, is said to be a focus of the investigation. Margulis, a Detroit-area physician, headed a sales joint venture with **Caremark** before becoming an employee.

Caremark 's president, James Connelly, said the article is misleading.

It implied, he said, that **Caremark** was wrongly charging Blue Cross and Medicaid for services outside the "net acquisition cost." Overcharges totaled several million dollars over "a number of years," the article said.

"Net acquisition cost is just the cost (to **Caremark**) of the drug" used in home infusion therapy, Connelly said. But home infusion services "include far more than just drugs."

"Billing disputes such as those referred to in the Journal story are common in health care, and they are resolved through a routine of audit, discussion and/or negotiation," said Connelly. "The existence of a problem is by no means extraordinary, nor does it mean, as the Journal story implies, that there is a pattern of misconduct."

Connelly said **Caremark** 's policy is to "collect any co-payments and deductibles owed by patients, unless they financially are unable to pay, or if the cost of collection is greater than the amount due. In the case of Medicaid patients, an inability to pay is not unusual."

The Justice Department and the Department of Health and Human Services have been investigating possible illegal kickbacks for patient referrals and other practices in the home infusion industry for three years.

Caremark stock closed at $18.62, down $1.12.

;CRIPTORS: HEALTH; BUSINESS; FEDERAL; AGENCY; PROBE; FINANCE

EXHIBIT O

The New York Times

November 18, 1994, Friday, Late Edition - Final

SECTION: Section D; Page 5; Column 1; Financial Desk

LENGTH: 159 words

HEADLINE: COMPANY NEWS;
INVESTIGATION OF CAREMARK IS SAID TO GROW

BODY:

Expanding an investigation of kickbacks to doctors by home care companies, Federal officials have subpoenaed records from the Detroit area office of Caremark International, the nation's largest provider of intravenous drugs in patients' homes, people with knowledge of the case said yesterday. They said investigators were examining bills submitted to the Medicaid program and Blue Cross and Blue Shield in Michigan, looking for overcharges and payments to physicians to recruit patients. Kickbacks involving Medicaid and Medicare patients are illegal under Federal law. Steve Mazur, a Caremark spokesman, said the Northbrook, Ill., company had "fully cooperated" in the three-year Federal investigation. Caremark says its bills are legitimate.

In August, a Federal grand jury in Minneapolis indicted the company and a Caremark vice president, charging illegal kickbacks exceeding $1.1 million to David R. Brown, a Minneapolis pediatrician.

CERTIFICATE OF SERVICE

It is hereby certified that two copies of the foregoing Defendants' Reply Brief In Support Of Their Motion To Dismiss The Third Amended Complaint were served this 26th day of May, 1995, by hand delivery on local counsel as follows:

Joseph A. Rosenthal, Esq.
Rosenthal Monhait Gross & Goddess
First Federal Plaza
P.O. Box 1070
Wilmington, DE 19899

Kevin G. Abrams