PUBLIC

UNITED STATES OF AMERICA

BEFORE FEDERAL TRADE COMMISSION

In the Matter of

NORTH TEXAS SPECIALTY PHYSICIANS,

a corporation.

DOCKET NO. 9312

To: The Honorable D. Michael Chappell
Administrative Law Judge

POST - TRIAL COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT

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RECORD REFERENCES

References to the record are made using the following abbreviations and citation forms:

CX - complaint counsel exhibit

NTSP - NTSP exhibit

Complaint - Complaint of the Federal Trade Commission.

In camera content is indicated in bold text within brackets and marked *in camera*.

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Complaint Counsel respectfully submits its proposed findings of fact. In submitting these proposed findings, Complaint Counsel reserves the right to add additional proposed findings as necessary to respond to or rebut proposed findings tendered by NTSP.

I. Introduction

1. The Federal Trade Commission's complaint in this matter charges that North Texas Specialty Physicians ("NTSP"), an association of Fort Worth area physicians, has engaged in conduct that violates Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. *See* (Complaint of the Federal Trade Commission, "Complaint").

2. The Complaint alleges a horizontal agreement by and through NTSP to set the prices paid by health plans and other payors for the services of NTSP participating physicians. *See* (Complaint).

3. A preponderance of the evidence, the relevant standard here, establishes that NTSP has acted in and as an unreasonable restraint of trade as alleged in the Complaint.

4. NTSP restrains trade among its member physicians by acting as a coordinator/agent for physician price-fixing. In the first instance, its contractual relations with its physicians establish rights and forbearances that limit competition between the NTSP collective and member physicians. *See* findings 97-104. Second, NTSP and its member physicians establish consensus minimum prices for use in negotiating fee-for-service contracts with health plans. *See* findings 105-124. NTSP then explicitly uses these fixed minimum prices in its negotiations with health plans. *See* findings 125-128. And finally, NTSP adopts various anticompetitive practices to reduce the risk that health plans will be able practicably to contract around NTSP, thereby bolstering NTSP's collective bargaining power. *See* findings 129-142.

5. As economic theory would dictate, and as several health plan witnesses have attested, the effect of NTSP's actions for and with its physicians is to raise prices of fee-for-service medicine. This price-fixing conduct is not ancillary to any efficient integration among NTSP's fee-for-service physicians. *See* findings 258-292; 320-394; 226-257.

II. Jurisdiction and Related Matters

A. NTSP is Made Up of Member Physicians

6. NTSP was formed in 1995 and operated by physicians to facilitate the physicians' contracting with health plans and other payors for the provision of medical services for a fee. (CX0350 at 1 (NTSP was formed in an attempt to provide a "seat at the table of medical

business"); CX1196 (Van Wagner, 08.29.03 Dep. at 12) ("We obviously have an objective to affiliate and do contracts, do contracting with other area HMOs and PPOs."); CX1182 (Johnson, Dep. at 10-11); CX0311 at 5, 8-10, 14-15; CX0275 at 30-31).

7. NTSP is a corporation, and is controlled by and carries on business for the pecuniary benefit of its participating physicians, (CX0275 at 7 (each NTSP Board Member must at all times be a physician actively engaged in the practice of medicine); CX0275 at 30-31 (NTSP shall use best efforts to market itself and its Participating Physicians to payors and to solicit payor offers for the provision of Covered Services by Participating Physicians); CX0310 at 1 (stating that NTSP physician's ability to negotiate "substantially improved" by NTSP; noting NTSP's discussions with payors "should lead to contracts that are more favorable than we would be able to achieve individually or through other contracting entities"); CX0195 ("NTSP wishes to avoid having its members experience a Florida fee-for-service meltdown"); CX0159 (noting contractual issues addressed by NTSP include "maintaining minimum reimbursement standards for its member physicians").

8. NTSP's participating physicians are "members" of NTSP. (Van Wagner, Tr. 1492 (NTSP often refers to its physicians as members); *see e.g.* CX1178 (Hollander, Dep. at 21-24, 34) (NTSP physicians attend general *"membership"* meetings, pay dues and elect NTSP's Board); *see e.g.*, Vance, Tr. 592, 595-596, 615-616; Deas, Tr. 2527-2528; C0276; CX0319; CX0321; CX0945 (referring to NTSP physicians as members)).

B. NTSP is Engaged in, and its Acts and Practices Affect, Interstate Commerce

9. NTSP affects and does business in interstate commerce. (CX1187 (McCallum, Dep. at 162-168); CX1199 (Vance, Dep. at 297, 300-301) (NTSP members provide medical services to patients from outside the state of Texas, and purchase malpractice insurance from out-of-state carriers.); CX1195 (Van Wagner, 01.20.04 Dep. at 77); CX1187 (McCallum, Dep. at 162-166); CX1177 (Grant, Dep. at 115-116); CX1199 (Vance, Dep. at 299-301) (NTSP and its members make substantial purchases from vendors located outside the state of Texas.)). NTSP members also accept payments from the United States Government through the nationwide Medicare and Medicaid programs. (CX1177 (Grant, Dep. at 116-117); CX1178 (Hollander, Dep. at 163); CX1187 (McCallum, Dep. at 165-166); CX1199 (Vance, Dep. at 298) (NTSP member physicians recruit physicians from outside of Texas to join their own practices)).

10. NTSP's contracting practices have an effect on national and out-of-state costs of health care. (Roberts, Tr. 474; Quirk, Tr. 248; Grizzle, Tr. 667, 715) (NTSP has business relationships with Aetna, CIGNA and United, national health plans with out-of-state headquarters); (Roberts, Tr. 476; Quirk, Tr. 253-254; Grizzle, Tr. 681-682) (These health plans all provide health coverage to multi-state employers, including those with significant number of covered lives in the Fort Worth area.); *see e.g.*, CX1063 (listing United Healthcare's national customers); (Roberts, Tr. 476-477; Quirk, Tr. 253-254; Grizzle, Tr. 681-682) (The costs these health plans incur in the Fort Worth area affect their pricing of health coverage out-of-state nationally).

III. Background: Expert and Other Testimony on the Health Care Industry, NTSP, and Health Care in Fort Worth

A. Expert Testimony

11. Expert analysis and valuable insight into the health care industry and economics was provided by Dr. Lawrence Peter Casalino and Dr. H.E. Frech. (Frech, Tr. 1261-1453; Casalino, Tr. 2779-2950).

12. Dr. H. E. Frech is a professor of Economics at the University of California, Santa Barbara. He is also an adjunct professor at Sciences Politique De Paris, an adjunct scholar at the American Enterprise Institute, and an affiliate of the Law and Economics Consulting Group. (Frech, Tr. 1261-1262).

13. As a professor at University of California, Santa Barbara, Dr. Frech teaches and conducts research relating to the application of the principles of industrial organization to the health care industry. (Frech, Tr. 1263-1264) Dr. Frech has published numerous articles relating to the industrial organization of health care in peer-reviewed journals, and is the author of Competition and Monopoly in Health Care. (Frech, Tr. 1264-1275, Frech, Tr. 1276 (Dr. Frech has testified as an expert in previous health care antitrust cases, for both plaintiffs and defendants.)).

14. Dr. Frech's testimony has explained why economic principles predict that the practices of NTSP and its member physicians are likely to produce anticompetitive effects, including higher prices for medical care. (*See* findings 103, 104, 114, 116, 119, 122-124, 137, 140, 423, 477, 478).

15. In addition, Dr. Frech explained that their practices have, in fact, produced such effects. (*See* findings 103, 104, 114, 116, 121, 122, 140, 142).

16. In his analysis of NTSP, Dr. Frech has focused on the competitive implications of NTSP's contracting behavior. To formulate his analysis, Dr. Frech has reviewed substantially all transcripts, court filings, countless documents produced by NTSP and third parties, and interviewed several health plans and Fort Worth employers. (Frech, Tr. 1276-1278; 1395). Dr. Frech used his standard research methodologies in his analysis of NTSP, except to the extent that litigation gives greater documentary access than academic research. (Frech, Tr. 1278-1279).

17. Dr. Frech's experience, the considerable breadth of inquiry he undertook prior to formulating his opinion, the clarity of his analysis, and the consistency of his findings with the documentary record here, all indicate that Professor Frech's opinions in this matter are entitled to substantial weight.

18. Dr. Lawrence Peter Casalino is an assistant professor in the Department of Health Studies

at the University of Chicago Medical School. He has held this position since 2000. (CX1150 at 33; Casalino, Tr. 2779).

19. Dr. Casalino obtained a B.A. degree in Philosophy from Boston College in 1970; a M.D. degree from the University of California, San Francisco in 1979; a Masters degree in Public Health from the University of California, Berkeley in 1992; and a Ph.D. degree in Health Service Research from the University of California, Berkeley in 1997. His specialty area for his Ph.D. was organizational sociology and his dissertation researched how medical groups and IPAs affect the quality and cost of physician services. (CX1150 at 33; Casalino, Tr. 2779-2780).

20. Dr. Casalino practiced medicine privately for about 20 years as a family practice physician. During this time, Dr. Casalino had some responsibilities for managing his own medical group of five to nine physicians and served on the board of directors of one of the IPAs in which his medical group participated. (CX1150 at 42; Casalino, Tr. 2781-2785).

21. As a professor at the University of Chicago, Dr. Casalino teaches and conducts research relating to how the various forms of physician organizations affect the quality and cost of physician services. The research is national in scope and is published in peer-reviewed journals. (CX1150 at 34-37; Casalino, Tr. 2785-2789; 2941-2942).

22. In the course of his research, Dr. Casalino evaluates quantitative analyses of the cost and quality of physician services. Although he does not personally perform the technical statistical adjustments required to make comparisons of costs and quality between different patient populations, he is very familiar with the demographic parameters of these adjustments. (CX1150 at 34-37; Casalino, Tr. 2821-2825).

23. In his analysis of NTSP, Dr. Casalino has focused on NTSP's objectives of clinical integration, quality improvement, and cost control, as well as the necessity of NTSP negotiating collectively with health plans to achieve these objectives. To complete his analysis, Dr. Casalino has reviewed documents produced by NTSP and third parties; conducted electronic searches through these documents; and read deposition transcripts, expert reports, and trial transcripts. (Casalino, Tr. 2790-2791). Dr. Casalino used his standard research methodologies in his analysis of NTSP, except to the extent that litigation gives more documentary access than does academic research. (Casalino, Tr. 2791).

B. Organization of and Contracting By Physician Practices

24. Physicians often organize their practices into medical groups, which operate as single integrated entities having a single CEO, office manager and staff, and balance sheet. Physicians practicing through a medical group may be owners or employees of the group. (Casalino, Tr. 2795-96).

25. Physicians and medical groups often contract with health plans in order to increase the volume of patients available to them. (Frech, Tr. 1288-1289).

26. Competing physicians and medical groups sometimes enter into arrangements with one another to form independent practice associations, known as IPAs. IPAs are looser combinations of medical groups formed for the purpose of negotiating contracts with managed care health plans. (Casalino, Tr. 2796; Frech, Tr. 1292).

27. IPAs, including NTSP, lack direct authority to control the practices of their member physicians. (Casalino, Tr. 2799-2800).

28. Physicians and their contracting organizations, whether medical groups or IPAs, often reduce prices to health plans in return for the increased patient volume resulting from a health plan's steering of patients to physicians who participate in the health plan's network. (Frech, Tr. 1288-1289).

29. In general, this form of competition benefits consumers by, among other things, leading to lower prices. (Frech, Tr. 1289, 1291-1292).

30. Lower prices for physician services may enable employers to offer health care benefits or increased health care benefits to employees and may result in lower co-payments and deductibles for employees and other covered persons. (Frech, Tr. 1291-1292).

31. Health plans, thereby, can assist consumers in obtaining competitive pricing for physician services as well as in the search for and selection of physician providers. (Frech, Tr. 1281-1282).

C. Health Care Insurance and Managed Care

32. Historically, most health care insurance coverage was indemnity insurance. The prevalence of indemnity insurance skewed incentives in such a way that consumers often neither sought to reduce price by seeking lower-priced providers nor quantity by seeking to avoid over-utilization. (Frech, Tr. 1282-1283).

33. Managed care was introduced to address these deficiencies and control the cost of health care services through health plan contracting with physicians, control of utilization, and management of care. (Frech, Tr. 1282-1284, 1289).

34. One form of managed care is the Health Maintenance Organization ("HMO"). HMOs generally feature small provider panels, low co-payments for patients, broad administrative controls to limit utilization, with no coverage for patients who choose providers outside the network. (Frech, Tr. 1283-1284).

35. HMO contracts can involve a variety of physician compensation structures. In some

instances, participating physicians are paid a stated fee for each service rendered. This compensation structure is referred to as fee-for-service. (Mosley, Tr. 131-132).

36. Health plans that contract with physicians on a fee-for-service basis often do so based on a stated percentage of the "Medicare RBRVS" fee schedule, which provides reimbursement rates for a large number of specific procedures. (Frech, Tr. 1286; Mosley, Tr. 137; Grizzle, Tr. 692-693).

37. The Medicare RBRVS fee schedule refers to Medicare's Resource Based Relative Value System ("RBRVS"), a system developed by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for each service rendered to Medicare patients. (CX1204; *see* Complaint).

38. The RBRVS establishes weighted values for each medical procedure, such that the application of a percentage multiplier (such as 100% for Medicare itself), enables one to determine the fees for thousands of different services simultaneously. (CX1204; Frech, Tr. 1286).

39. Fee-for-service reimbursement arrangements do not provide a physician with any incentive to control the utilization of or enhance cooperation with other physicians with whom the physician competes. (Frech, Tr. 1345-1346).

40. In other instances, physicians participating in an HMO are paid (or share) a stated per patient, per month fee, irrespective of the quantity of services rendered. This is referred to as a capitation agreement. (Frech, Tr. 1293; Mosley, Tr. 131-132; Wilensky, Tr. 2177- 2178).

41. Capitation agreements shift the risk of overutilization of medical services to the capitated physician or physicians. Physicians respond to capitation and other incentive systems by modifying their utilization and other practice patterns as incented. (Frech, Tr. 1293-94; Casalino, Tr. 2811; Lovelady, Tr. 2637-38).

42. When capitation is made to a physician organization rather than to individual physicians, the arrangement gives the physicians in the organization the incentive to cooperate to control costs. (Frech, Tr. 1294; Lovelady, Tr. 2637-38).

43. Shifting financial risk to physicians also can be accomplished by paying a physician or physicians on a fee-for-service basis, but withholding part of the payment unless the contracting physicians meet or exceed certain utilization management goals. (Frech, Tr. 1294-1295; Mosley, Tr. 132-133).

44. To effectively encourage cooperation, collaboration, and interdependence among members of an IPA, the size of the withhold payable on the IPA's accomplishment of utilization management goals must be in the range of 25 to 30% of the total fee-for-service reimbursement

amount. (Frech, Tr. 1296-1297).

45. A less tightly controlled form of managed care is the Preferred Provider Organization ("PPO"). Relative to HMOs, PPOs generally involve fewer administrative controls and higher patient co-payments to limit utilization, but larger physician panels and greater access to out-of-network physicians, albeit at a reduced rate of reimbursement. (Frech, Tr. 1283-1284).

46. PPOs contract with physicians under fee-for-service reimbursement arrangements (Mosley, Tr. 137), which are by definition non-risk bearing. (CX1177 (Grant, Dep. at 78); CX1198 (Vance, Dep. at 36)).

47. When prices for HMOs and PPOs are roughly comparable, consumers prefer PPOs because they permit greater patient choice of physicians, through larger panels and the extension of benefits outside of the network. (Mosley, Tr. 133-134; Jagmin, Tr. 972).

48. When buying health coverage, employers look for networks that include all of the tertiary care hospitals in an area, most of the other hospitals within the area, and a broad selection of physicians in the locale, including a wide selection of specialists within each specialty. (Jagmin, Tr. 972, 1102-1103; Quirk, Tr. 270-272, 275-276).

49. Health plans respond by trying to assemble and market a panel of physicians that will satisfy employers' preferences for greater access to a wide array of conveniently located physicians, without compromising the overall cost of care. (Quirk, Tr. 270-272; Jagmin, Tr. 972); *see also* findings 154, 156, 296.

D. NTSP

50. NTSP is an IPA located in Fort Worth, Texas. It is organized as a non-profit corporation under the laws of the State of Texas. (Van Wagner Tr. 1297, 1489-1491; CX1196 (Van Wagner, 08.29.03 Dep. at 8)).

51. NTSP has approximately 600 participating physicians, of whom about 130 are primary care physicians (the remainder being specialists of various kinds). (CX1196 (Van Wagner, 08.29.03 Dep. at 12); CX1204).

52. Approximately 85-88% of NTSP's member physicians are located in Tarrant County, with the majority located in Fort Worth. (Van Wagner, Tr. 1471; CX1196 (Van Wagner, 08.29.03 Dep. at 15-16)).

53. NTSP's primary purpose and actions are the negotiation of contracts, including fee arrangements, with health plans for and on behalf of its 600 member physicians. (CX0350 (NTSP was started "to provide a seat at the table of medical business for the individual physicians in Fort Worth. . . . NTSP through PPO and risk contracts, has provided a consistent

premium fee-for-service reimbursement to the members when compared with any other contracting source."); CX1182 (Johnson, Dep. at 10-11); CX1196 (Van Wagner, 08.29.03 Dep. at 11, 12); CX0311 at 5, 8-10, 14-15).

54. NTSP originally focused on negotiating shared-risk contracting with health plans, but as the market moved away from risk-sharing arrangements NTSP increasingly sought to negotiate (and negotiated) fee-for-service contracts. (CX0195 (In "an environment where payors were moving to a fee-for-service approach," NTSP "wished to avoid its members experiencing a fee-for-service meltdown"). *See also* (CX0083 at 3 (NTSP Board acknowledges that "risk business is a small part of the business" and concludes that NTSP's "focus should center on how to benefit members on fee-for-service contracts as well.")).

55. In 2001, NTSP accepted risk on only approximately 32,000 lives. (CX0616 at 2 (NTSP takes professional risk on approximately 20,000 commercial and 12,000 Medicare lives); CX1197).

56. NTSP has only one risk-sharing contract– the one it shares with PacifiCare. (CX1177 (Grant, Dep. at 19)).

57. In contrast, NTSP has approximately 20 fee-for-service contracts, covering vastly more lives. (CX1196 (Van Wagner, 08.29.03 Dep. at 19); CX0265 (listing by health plan lives covered under NTSP's non-risk contracts)).

58. In total, NTSP-health plan contracts cover more than 660,000 lives. (CX0265 (listing by health plan lives covered under NTSP's non-risk contracts); CX1177 (Grant, Dep. at 113)).

E. NTSP Governance

59. All of NTSP's directors are, and under its organizational documents must be, physicians. (CX0275; Van Wagner, Tr. 1492). The Board of Directors ("Board") is elected from among NTSP's member physicians. (Van Wagner, Tr. 1493).

60. The Board manages the organization, determines NTSP's minimum contract prices, evaluates contract offers, and obtains contracts on behalf of its members. (CX0275 at 5; Van Wagner, Tr. 1642-43; Vance, Tr. 595; CX1177 (Grant, Dep. at 22-24); CX1174 (Deas, Dep. at 42).

61. NTSP participants are organized into specialty divisions, based on field of practice. (Van Wagner, Tr. 1510). NTSP's Medical Executive Committee includes the chairs of each of NTSP's specialty divisions, (Deas, Tr. 2559-2560), who are elected by the members within each specialty. (CX0275 at 5; CX1197 (Van Wagner, 08.30.03 Dep. at 203, 228)).

62. The Medical Executive Committee transmits information and feedback, including the

status of fee-for-service contract discussions, between NTSP's staff and Board and the membership. (CX1174 (Deas, Dep. at 6-7); Deas, Tr. 2560).

63. NTSP also communicates with its membership by sending faxes called "Fax Alerts" which keep its membership informed of the activities of NTSP including contractual issues. (CX1187 (Hollander, Dep. at 40; CX1198 (Vance, Dep. at 54)).

64. NTSP's executive director is Karen Van Wagner, PhD. Van Wagner joined NTSP in 1997, roughly a year after the organization was established. (Van Wagner, Tr. 1462).

65. Van Wagner was NTSP's principal fact witness. She is the person primarily responsible for conducting NTSP's anticompetitive activities. (*See findings* 50-53, 59-61, 64, 66, 68, 266, 324, 326, 333, 337, 339, 343, 358, 369, 374, 375, 393).

66. Van Wagner has a significant financial interest in the outcome of this proceeding. Van Wagner's current base salary as NTSP's Executive Director is approximately $270,000. (Van Wagner, Tr, 1813). In addition to her salary, Van Wagner regularly receives a bonus for her work with NTSP. In calendar year 2003, Van Wagner's total compensation as executive director of NTSP totaled over $300,000. (Van Wagner, Tr. 1813-1815 (indicating 2003 bonus paid of more than $40,000)). Van Wagner's husband is a partner in the law firm of Thompson & Knight, which does legal work for NTSP, and which was hired by NTSP to do this legal work only after Van Wagner became NTSP's Executive Director. (Van Wagner, Tr. 1815-1816). The continuation of these benefits may be substantially dependent on NTSP's continuation under its present "business model." Moreover, most of the conduct questioned in this proceeding was done, or at least supervised, by Van Wagner. (*See findings* 50-53, 59-61, 64, 66, 68, 266, 324, 326, 333, 337, 339, 343, 358, 369, 374, 375, 393).

67. Van Wagner's testimony in this proceeding at times conflicted with other NTSP testimony and with her prior testimony, was lacking in candor, and at times appeared dissembling. (*See* findings 68-72).

68. Van Wagner testified at trial that member physicians may negotiate fee-for-service arrangements with health plans at the same time that NTSP is considering a health plan offer; but in her investigational hearing of August 29, 2002, Van Wagner testified that a member physician may not act on an offer that he or she receives from a health plan if NTSP is engaged in negotiations with that health plan. (Van Wagner, Tr. 1855-1858).

69. Van Wagner testified that she did not have the authority to send out to members ("to messenger") Aetna's proposal in late 2001, (Van Wagner, Tr. 1713-1714), but Dr. Blue, an NTSP Board Member, testified in her deposition that there was nothing restricting the Board's authority to "messenger" contract offers that fell below NTSP's minimums, (CX1170 (Blue, Dep. at 10-11)), as did Dr. Grant, another NTSP Board member, (CX1177 (Grant, Dep. at 12)) *see also*, CX1194 (Van Wagner IH. at 29-30, 33, 60, 63) (Van Wagner, also testified repeatedly

that NTSP's Board lacked the authority to "messenger offers" below the minimums.)

70. Van Wagner testified on direct at length and without qualification that NTSP engaged in numerous utilization and quality initiatives; she indicated only under cross-examination that in fact those initiatives were not undertaken with respect to fee-for-service patients and physicians. (Van Wagner, Tr. 1834-1841;1853).

71. Van Wagner sought evasively to redefine terms to repudiate her own characterization of NTSP price offers, business documents as ongoing "negotiations" and "NTSP proposals," which clearly pertained to fee-for-service contracts. *See* (Van Wagner, Tr. 1924-1927, 1774-1777; CX0591).

72. Van Wagner testified at trial that NTSP did not propose to Blue Cross a fee-for-service arrangement with PPO prices at 145% of current Medicare. (Van Wagner, Tr. 1945-1947). She sought to characterize a document suggesting the contrary, CX0085, as a typographical error. Asked in impeachment if she was certain that the error was merely typographical and that she did not in fact discuss a 145% price with Blue Cross, she expressed her certainty that 145%, which was higher than NTSP's minimum price in effect at that time, had never been mentioned to Blue Cross. (Van Wagner, Tr. 1945-1947). She subsequently was impeached on this point, by the testimony of Blue Cross' Haddock, which was supported by a contemporaneous writing in which he recorded her seeking of the 145% price for fee-for-service PPO participation during a face-to-face meeting. (Haddock, Tr. 2742-2750).

73. Van Wagner's testimony is unreliable, and to the extent that it conflicts with the ordinary understanding of documentary evidence or the testimony of others it is entitled to little weight.

74. Dr. Thomas Deas is the current president and chairman of the Board of NTSP. In addition to heading the Medical Executive Committee, Dr. Deas is a medical director of NTSP. (Deas, Tr. 2524, 2556).

75. Dr. William Vance was one of the founding members of NTSP, serving as its president from 1996 until 2001. Dr. Vance was a member of the medical management committee from its inception through 2002. In addition, he was the chairman of NTSP's cardiology section. His role within NTSP ceased when his practice group, Consultants in Cardiology, withdrew from NTSP in April of 2002. (CX1198 (Vance, Dep. at 8, 48, 49)).

F. NTSP's Member Physicians

76. NTSP's member physicians have distinct economic interests, reflecting their separate clinical practices. (CX1182 (Johnson, Dep. at 21); *see,* CX0524 (Roster of NTSP members listing multiple physicians and/or physician groups practicing the same specialty in Fort Worth).

77. Many NTSP physicians and physician practices are in competition with one another,

except where they have restricted competition through NTSP. (CX1182 (Johnson, Dep. at 21) ("We compete for patients. We compete at the different hospitals at which we work."); Frech, Tr. 1280); CX0524 (Roster of NTSP members listing multiple physicians and/or physician groups practicing in the same specialty area in Fort Worth); (CX0550) (noting that NTSP's disagreements with payors were supported by its membership despite the fact that "short term advantage and perceived best interest are always controversial and potentially divisive, weakening the strength that our numbers provide.").

78. Substantially all of NTSP's physicians participate in fee-for-service contracts. However, only about half of those physicians–about 300– participate in any risk-sharing contract. Some of these physicians, participate in NTSP through a participation agreement under which they can gain access to NTSP's non-risk contracts, but are not eligible to participate in NTPS's risk contract. (CX0616 at 2-12; CX1196 (Van Wagner, 08.29.03 Dep. at 228); CX1197 (Van Wagner, 08.30.03 Dep. at 182, 228-29); Van Wagner, Tr. 1830; CX1194 (Van Wagner, 11.19.03 Dep. at 37-38).

79. Some of NTSP's non-risk sharing members have no desire to accept risk and consider it a great benefit to be able to profit from NTSP's higher rates without taking risk. (Van Wagner, Tr 1881-1884).

80. Many NTSP physicians join NTSP because the prices in NTSP health plan agreements were more favorable than the same doctors could obtain directly, and thus they "would do better financially." (CX1183 (Lonergan, Dep. at 23-25); Lonergan, Tr. 2731-2732; CX0550).

G. Health Care in Fort Worth

81. In contracting for health plan services, Fort Worth employers demand significant coverage by physicians who practice within the city limits of Fort Worth and who admit patients to Fort Worth hospitals. *See generally* (Grizzle, Tr. 688-689, 722; Frech, Tr. 1304-1305; Mosley, Tr. 141-142; Quirk, Tr. 276-277, 280; Jagmin, Tr. 1104-1107).

82. To be competitively marketable to Fort Worth area employers, health plans must include many physicians who practice in a variety of fields in the Fort Worth area. (Grizzle, Tr. 688-689, 720, 722; Jagmin, Tr. 1104-1107).

83. When an employer considers contracting with a particular health plan, the employer generally asks the plan to perform a "geographic access" study to determine whether the health plan network will satisfy the employer's and its employees' needs. The employer provides the health plan with a list of employees' residence zip codes; the health plan then assesses how many providers are available through the network within a certain distance of each of those zip codes. (Mosley, Tr. 141). Employers are also concerned about avoiding potential disruption of their provider network. (Mosley, Tr. 140-141; Jagmin, Tr. 1001-1002).

84. Fort Worth employers typically would consider adequate a network that had appropriate physicians within 10 miles of at least 85%, and preferably 90%, of its employees. (Mosley, Tr. 141-142).

85. Employers also are sensitive to the fact that employees usually schedule physician appointments during the work week and have to take time off their jobs to keep those appointments. (Mosley, Tr. 141-142).

86. As a result, employers generally prefer to have appropriate providers close to the work place, so that the employees' health care needs can be served with minimal workplace interruption. (Mosley, Tr. 141-142).

87. NTSP physicians agree that Fort Worth physicians are better able than physicians located elsewhere to address the needs of patients (and primary care physicians) located in Fort Worth. *See, e.g.,* (CX0583 at 1-2 (Dr. John W. Johnson, an NTSP member, writing: "Obviously a provider network whose business is based <u>entirely</u> here in Fort Worth is better positioned to address the needs of both patient and physicians.") (*emphasis in original*)). *See also* (CX1187 (McCallum, Dep. at 59) (NTSP Board Member testifying that Dallas physicians compete in a different market than NTSP physicians); CX1187 (McCallum, Dep. at 59 (NTSP Board Member testifying that a Dallas-based IPA is not a competitor of NTSP)).

88. NTSP has even identified separate service areas for specialty care within Fort Worth. *See, e.g.*, (CX1106 (Van Wagner noting that "what united needs to know is that they have eliminated several of the physicians who practice in southwest fort worth. . .i guess they do not recognize this as a separate service area which is wrong . . pcps in that quadrant and not using the downtown doctors as their preferred choice any more. . . .)).

89. A network of physicians located in Dallas or the Mid Cities that did not also have a large number of appropriate physicians located in Fort Worth would not achieve geographic access required by employers with large numbers of Fort Worth employees, and would not be acceptable to employers even if they were discounted by five percent relative to those areas. (Mosley, Tr. 142-143). Even a large network of physicians located in Dallas or in the Mid Cities, defined as the areas including Arlington, Hurst, Euless, Bedford, Coleyville, and Southlake. (CX1196 (Van Wagner, 08.29.03 Dep. at 16) would not be marketable to Fort Worth employers if the network did not also have a large number of appropriate physicians located in Fort Worth. (Mosley, Tr. 142-143; Jagmin, Tr. 1103-1104; Quirk, Tr. 280-282). A physician network requiring most patients to travel to Dallas or the Mid Cities to obtain medical care would not be marketable to Fort Worth employers even if discounted 10% relative to those areas. (Quirk, Tr. 279-280).

90. If all Fort Worth physicians increased prices by five percent, health plans serving Fort Worth employers would not be able to avoid the price increase by substituting away from Fort Worth. (Grizzle, Tr. 723; Quirk Tr. 280-282; Jagmin, Tr. 1103-1104).

IV. NTSP Physicians Are a Critical Part of a Fort Worth Network

91. Health plans must have NTSP physicians to serve Fort Worth clients. (Frech, Tr. 1299 (NTSP physicians make up a large percentage of Tarrant County practitioners in several medical specialties, 80 percent for pulmonary disease, 68.6 percent for urology, and 58.8 percent for cardiovascular disease.); (Grizzle, Tr. 719, 720, 921, *in camera* (*see Grizzle, Tr. 752-754*), 731, 757, 922, *in camera* (*see Grizzle, Tr. 752-754*) [redacted]; Jagmin, Tr. 1091 (A loss of NTSP's physicians from a health plan's network would have "a very deleterious affect" on the health plan's ability to market its product in Tarrant County.).

92. Harris Methodist Hospital is the "must have" hospital for a health plan to be marketable to Fort Worth employers. (Frech, Tr. 1303; Grizzle, Tr. 720-721).

93. In addition to the hospital itself, health plans also need to have the major admitters to Harris Methodist in their network in order to provide effective access to the hospital. (Frech, Tr. 1304, 1305; Grizzle, Tr. 720-721).

94. NTSP physicians represent the vast majority of admissions to Harris Methodist Hospital in many specialties. (Frech, Tr. 1303, 1305; Grizzle, Tr. 720-721).

95. Without adequate NTSP physicians in its panel, a health plan would have to seek to send patients to hospitals where the patients primary care physician is not available to participate in the patients' care. (CX0584 (letter from Dr. James F. Parker, President of Texas Health Care and a member of NTSP)).

96. NTSP's Board admitted that a health plan attempting to serve the employees of the City of Fort Worth "would not be able to satisfy employer/employee match or network access standards without NTSP Physicians Participating in the Network," and that, "NTSP is the <u>only</u> stable physician organization left in the Tarrant County market." (CX1042). *See also* (CX0576 at 3 (NTSP admitting that "without NTSP specialists in the Aetna network a severe network inadequacy problem will exist in Fort Worth")).

V. NTSP Restrains Trade Among its Member Physicians

NTSP restrains trade among its member physicians by acting as a coordinator/agent for physician price-fixing. In the first instance, its contractual relations with its physicians establish rules that limit competition between the NTSP collective and member physicians. *See* findings 97-104. Second, NTSP and its member physicians establish consensus minimum prices for use in negotiating fee-for-service contracts with health plans. *See* findings 105-124. NTSP then

explicitly uses these fixed minimum prices in its negotiations with health plans. *See* findings 125-128. And finally, NTSP adopts various anticompetitive practices designed to reduce the risk that health plans will be able to contract around NTSP, so as to bolster NTSP's price bargaining power. These restraints of trade are described in general in findings 129-142, below, and their operation demonstrated in the description of NTSP fee-for-service contract negotiations with three particular health plans, which follows at findings 157-257, 258-292, 297-394.

A. NTSP's Physician Participation Agreement Limits Competition Among Physicians and Supports NTSP's Exercise of Collective Price Bargaining Power

97. NTSP and its participating physicians enter into membership agreements establishing their relationship. (CX1204; CX0276 at 1).

98. The Physician Participation Agreement grants NTSP the right to receive all payor offers and imposes on the physicians a duty on members to promptly forward those offers to NTSP. (CX0276).

99. The Physician Participation Agreement also grants NTSP a right of first negotiation with payors, with the physicians agreeing that they will refrain from pursuing offers from a health plan until notified by NTSP notifies that it is permanently discontinuing negotiations with the health plan. (CX0276; CX0311 at 8; Deas, Tr. 2405-2406; CX1178 (Hollander, Dep. at 68) ("And there were various criteria like time limits that the participating physician generally agreed that they would just wait and after that time limit was expired, then they were free to negotiate on their own.")).

100. Pursuant to its Physician Participation Agreement, NTSP had a duty promptly upon receipt to deliver health plan price proposals (and other economic provisions of offers) for fee-for-service contracts to its physicians. (CX0275 at 9, 33).

101. NTSP did not do not this. Instead it rejected as inadequate, and did not pass on to its members, any health plan offer that fell below its minimum contract price. (CX1196 (Van Wagner, 08.29.03 Dep. at 68-69)).

102. In addition, the Physician Participation Agreement contains provisions whereby 50% of the membership must approve the reimbursement proposal of a health plan prior to an offer being "messengered" by NTSP to the physicians for actual opt-in/out of the proposed contracts; and providing for NTSP counter offers to health plan rate proposals based on direction of at least 50% of NTSP's physicians. (CX0276 at 1).

103. The Physician Participation Agreements hinder health plans in efforts to assemble a marketable Fort Worth area physician network without submitting to the collective bargaining of NTSP. (Frech, Tr. 1316; Deas, Tr. 2405-2406).

104. The Physician Participation Agreements thereby restrain competition and promote NTSP's ability to function as the coordinating agency of price collusion. (Frech, Tr. 1313).

B. NTSP and Its Participating Physicians Establish Consensus Prices for the Provision of Fee-for-Service Medical Care Including the Use of Polls

105. NTSP established "Board Minimum" prices for use in negotiating contracts with health plans at least as early as 1997. (CX1042; CX1194 (Van Wagner, 11.19.04 Dep. at 86-87); CX1195 (Van Wagner, 01.20.04 Dep. at 66-67)).

106. According to NTSP, in the year 2000, NTSP's member physicians "conveyed" to NTSP that a PPO offer of 140% of 2000 Medicare RBRVS met an acceptable minimum standard. However, the NTSP Board received and accepted this minimum standard from the membership without the benefit of poll results. (CX0565 at 1; CX0018 at 103 (NTSP Board minutes showing absence of PPO poll conducted prior to September 2001)).

107. The conveyance of this price information from the membership to NTSP later was communicated through NTSP's polling of its members with respect to specific health plan price offers; and the information obtained then was applied to subsequent health plan offers as well. (CX1195 (Van Wagner, 01.20.04 Dep. at 66-67)).

108. NTSP began to conduct "Annual Polls" to determine minimum reimbursement rates for use in negotiation of HMO and PPO product contracts with health plans on September 14, 2001. (CX1195 (Van Wagner at 66-67); CX0565).

109. NTSP's polling form explains to the participating physicians that annually "NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants." (CX0387 at 1; CX0633).

110. In addition, NTSP informs its physicians of the average poll results and NTSP's minimum contract prices based thereon will be relayed back to the physicians. (Van Wagner, Tr. 1320-21; CX1042; and CX1043).

111. On October 15, 2001, the NTSP Board received the first Annual Poll results. Based on the poll results, NTSP established minimum prices of 125% of 2001 Medicare for HMO products and 140% of 2001 Medicare for PPO products as minimally acceptable fee schedules for health plan contracts. (CX0103 at 6; CX0389).

112. These minimums were identical to those set by the Board as early as 1997, (CX1042), and were in excess of prevailing market rates reported to NTSP by its member physicians. *See* (CX0265 (rate comparison for seven health plans, prepared by NTSP in 2001)). *See also*

(CX1177 (Grant, Dep. at 113); CX0103 at 6; and CX0389).

113. On November 11, 2002, NTSP conducted its second Annual Poll to determine minimum reimbursement rates for use in negotiation of HMO and PPO product and anesthesia contracts with health plans. NTSP included the prior years' results, among other things, on the polling form. (CX0430).

114. NTSP uses its poll to establish consensus prices with and for its physicians, to be used as target prices in collective negotiation with health plans. (Frech, Tr. 1321).

115. NTSP's polling form asks each physician to disclose the minimum price that he or she would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. (CX0565; CX1194 (Van Wagner, 11.19.03 Dep. at 78-80); CX1196 (Van Wagner, 08.29.03 Dep. at 26-29, 43-44, 62)).

116. Physicians responding to the poll do not identify the actual minimum prices at which they are willing to contract; rather they identify the price that they believe should be the target price of the collective. (Frech, Tr. 1322).

117. The members indicate their price selection by placing a check mark next to one of several pre-printed Medicare RBRVS ranges. (CX1204; CX1196 (Van Wagner, 08.29.03 Dep. at 26-29, 43-44, 62); CX1194 (Van Wagner, 11.19.03 Dep. at 78-80); CX0274; CX0565; CX0633).

118. By quoting a particular percentage of RBRVS, one can establish the prices for thousands of different services simultaneously. Using the Medicare index and a percentage of Medicare as a conversion factor voluminous price information is reduced to a single dimension. (Frech, Tr. 1287).

119. By condensing complex pricing information, the Medicare index can serve to facilitate collusion, easing both the formation of pricing agreements and monitoring for deviations from agreed-upon prices. (Frech, Tr. 1287).

120. After receiving the poll responses, NTSP calculates the mean, median, and mode ("averages") of the minimum acceptable fees identified by its physicians, establishes its minimum contract prices, and then reports these measures back to its participating physicians. (CX0103; CX1196 (Van Wagner, 08.29.03 Dep. at 26-29, 43-44, 62); CX1194 (Van Wagner, 11.19.03 Dep. at 78-80); CX1204).

121. By providing this information to its member physicians, NTSP effectively informs the physicians as to the potential reward for deferring direct negotiations with health plans while seeking to negotiate collectively through NTSP. (Frech, Tr.1326).

122. Such price information sharing reduces each physician's uncertainty as to the conduct of

its competitors (in the aggregate); enhances solidarity among the membership; and increases the likelihood of collusion. (Frech, Tr. 1327). *See also* (Maness, Tr. 2254 (agreeing that reduction of uncertainty among competitors can facilitate collusion); CX1170 (Blue, Dep. at 33) poll results provide "a guideline where we saw the numbers, we would like to have these rates, if possible, and it kind of gave you an idea of where the market was. So if I got other communications independently and some I [*sic*] was paying 80 percent of Medicare, but it looked like a lot of plans were paying 110 percent, then 80 percent of Medicare sounded pretty low.")).

123. The setting of a collectively determined minimum price in and of itself is likely to raise prices. (Frech, Tr. 1322-1323).

124. Moreover, while NTSP represents a large number and significant portion of Tarrant County physicians in some specialties, within each specialty there are not a large number of independent sellers (solo practitioners or physician groups). Such a distribution is conducive to successful collusion. (Frech, Tr. 1299, 1302).

C. NTSP Collectively Negotiates Prices On Behalf of Its Members

125. NTSP regularly informs health plans that its physicians have established minimums fees for NTSP-payor agreements, identifies the fee minimums, and states that NTSP will not enter into or otherwise forward to its participating physicians any payor offer that does not satisfy those fee minimums. (CX1204; CX1196 (Van Wagner, 08.29.03 Dep. at 62-63, 153-154); CX1173 (Deas, Dep. at 26-29). *See also* (Van Wagner, Tr. 1822-1824 (stating that NTSP identified NTSP's minimum contract prices to payors on multiple occasions in 2000 and 2001)).

126. After NTSP rejected and refused to messenger health plan offers because the prices were below NTSP's minimum prices, health plans have submitted to NTSP new proposals with higher fees. At times NTSP has made counter-offers at prices above those earlier offered to it by the health plans. (CX0813 [redacted]; Roberts, Tr. 537-539; CX1098; CX1012; CX0627 at 1-2; CX0565 at 1; CX0580; CX0582; CX0585; CX0591 at 1; CX0104; CX0799, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*; CX0790 at 1, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*; CX0776).

127. NTSP collectively and aggressively negotiates prices for its member physicians. *See, e.g.*, (CX0256 (Referring to NTSP's successful negotiation tactic of terminating NTSP physicians from United's health plan: "This United negotiation is a template for other efforts that will need to occur in the near future and would best be coordinated by NTSP;" CX1042 (NTSP Board statement, in regard to United HealthCare negotiations, that the parties are "far apart in agreeing to a market reimbursement fee schedule" and that "NTSP is not asking for United to pay more than their competitors"); and CX0796 at 1; CX0795 at 2, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*; Grizzle, Tr. 740 (discussing NTSP e-mail to CIGNA stating that NTSP would not move forward with any proposal until the CIGNA PPO

price is brought up to current rates); *See also* (CX1177 (Grant, Dep. at 46); CX1182 (Johnson, Dep. at 10-11); CX0351; CX0295; Deas, Tr. 2538-2539, 2573; CX1061; CX0051 at 3; CX0704; CX0092; CX0526; Roberts, Tr. 537-539 (at NTSP Board meeting he attended, NTSP attempted to negotiate rates referencing powers of attorney)).

128. [redacted] (CX0710). *See also* (CX0813 (NTSP demanding higher prices than its minimums; CX1042).

D. NTSP Uses Various Anticompetitive Practices to Orchestrate and Execute Concerted Refusals to Deal in Order to Exercise its Collective Bargaining Power

129. NTSP told its physicians that, given "an environment where payors are moving to a fee-for-service approach," NTSP would act to help its members avoid a decrease in fee-for-service reimbursement, and indicated that it was addressing the maintenance of "minimal reimbursement standards." (CX0195; CX0195A; CX0159 at 2).

130. NTSP has explicitly recognized that a threat to NTSP's accomplishment of its aims was "the ability of payors to do end runs around the organization," (CX0159 at 2). For that reason, it has adopted various practices that strengthen unity in its price-fixing scheme and that reduce the ability of health plans to reach agreements with NTSP physicians through other means. *See* findings 97, 128, 131-146.

131. NTSP has cautioned its physicians to avoid undermining NTSP solidarity and its pricing consensus. *See, e.g.*, (CX0550 (Dr. Vance's "Open Letter to the Membership": "We must continue to move forward as a group or we will surely falter as individuals"); CX0380 at 2 (NTSP warning its physicians that physician fees will decline unless "NTSP or someone can provide a unifying voice for physicians"); CX0400 at 2 (NTSP warning its members that without their support "NTSP will not be around the next time Aetna, Cigna, or United come to town" with unsatisfactory rate proposals)). *See also* (CX0195A (responses to 2001 survey by NTSP of its Medical Executive Committee members: (1) "More take us or leave us in entirety contracting. United we stand, divided <u>we will fall</u>. - Kenneth A. Mair MD, Endocrinology;" (2) "[B]etter / more uniform response to contracts. Or it will be gone. - Donald A. Behr MD, Gen. Col-Rectal, Vasc. Surgery;" (3) "Cohesive negotiations for all members" - Mark B. Presley MD;" (4) "Need to remove the groups or individuals who weaken NTSP by continually signing contracts against the group as a whole's advice - Kenneth A. Mair MD, Endocrinology;" (5) "Find a way to keep division that have broken in the past (See Urology Cardiology), in line" - Donald A. Behr MD, Gen. Col-Rectal, Vasc. Surgery"; and "Educate all members of progress > cohesiveness" and (6) "Hold our own against MSM & other payors." - Mark B Presley MD); CX0904 ("THE NTSP BOARD STRONGLY URGES ITS MEMBERS TO AVOID SIGNING INDIVIDUAL CONTRACTS IN ANY SETTING WHICH WILL PLACE THEM AT ODDS WITH OTHER

MEMBERS OF THE ORGANIZATION.") (*emphasis in original*)).

132. A first step in maintaining solidarity is NTSP's trumpeting to its member physicians of the successes it already has enjoyed in obtaining higher fee-for-service prices on their behalf. *See, e.g.,* (CX0380 at 2 (NTSP informing its members that through "direct" negotiation or affiliation with other IPA's obtained for its members non-risk contracts at prices "5 to 15% over Tarrant County rates"); CX0550 ("An Open Letter to the Membership" stating that NTSP "has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source.")). And NTSP admitted that when an NTSP physician receives an offer for a contract that has also been sent to NTSP, the physician will sometimes just wait and see what happens through NTSP. (Deas, Tr. 2405-2406).

133. Then, through a variety of NTSP updates to member physicians, implicitly urges the physicians to delay or forgo direct contracting during NTSP's negotiations with health plans. *See, e.g.* (CX0310 (Dr. Deas' advising NTSP physicians that "discussions are ongoing with Aetna U.S. Healthcare, Cigna, and other major payors which should lead to contracts that are more favorable than we would be able to achieve individually or through other contracting entities"). During negotiations with specific payors NTSP has sent fax alerts to its members and held "General Membership Meetings" to continually provide contracting updates for specific payor negotiations and discuss and share NTSP's poll results with the membership. CX1178 at 21-23 (Hollander, Dep. at 21-23); CX0173 - CX0180, CX0182-CX0188 (minutes to general membership meetings, including references to updates to NTSP's negotiations with health plans); CX0615; CX0945; CX0903; CX0617; CX0103; CX0628; NTSP's members also provided NTSP with the price terms of direct offers from health plans. CX1177 (Grant, Dep. at 113).

134. NTSP is aware that it can at times increase its collective bargaining power by further encouraging physicians to avoid entering into direct contracts with health plans and by threatening or undertaking collective departicipation from health plan networks, and otherwise by coordinating physician contracting behavior. (CX0256; CX0400; CX0902; CX0259 at 1; CX0275 at 1-13; CX0195; CX0195A). *See also* (CX0159 at 2; CX1183 at (Longeran, Dep. at 23-25); Lonergan, Tr. 2731-2732).

135. Accordingly, NTSP has at various times solicited and obtained powers of attorney from its members, giving NTSP the unfettered right to negotiate non-risk contracts on behalf of those members. (CX1173 (Deas, Dep. at 56-57); CX1065; CX1061; CX1070; and Palmisano, Tr. 1250-1251). To incent other physicians to grant it power of attorney, NTSP includes in power of attorney solicitations information about the number of physicians who already have executed the powers of attorney. (CX1066; CX0548 at 1).

136. NTSP's agency agreements were meant to reduce or preclude health plans' ability to avoid NTSP and the consensus price by approaching member physicians directly. *See* (CX1178 at 30; CX1178 (Hollander, Dep. at 116)); and they have had that effect. For example, NTSP physicians have referred health plans that were attempting to contract directly with them back to

NTSP, at times noting that the deferral was based on agency or power of attorney held by NTSP; Beaty, Tr. 453-459; Grizzle, Tr. 696-698, 701, 724; CX0760 (verbal acts)).

137. Further, NTSP has advised health plans during rate negotiations for fee-for-service contracts and at other times that it represented NTSP member physicians, through powers of attorney, (Roberts, Tr. 540-541), or otherwise (CX0760 (verbal acts) (Letters from NTSP physicians to CIGNA citing NTSP as their contracting "agent"); Beaty, Tr. 453-459). NTSP's brandishing of agency rights and powers of attorney before health plans increases the likelihood that any such health plan will conclude that it has no practical alternative to dealing with NTSP as the collective bargaining agent of its member physicians. (Frech, Tr. 1328-1330).

138. In at least two instances, NTSP used its agency powers to terminate its members' participation in a health plan because NTSP determined that the price being paid by the health plan for fee-for-service medicine had become inadequate. (CX0546; CX0802; CX1054).

139. Using yet another scheme to enhance its collective price bargaining power, NTSP has orchestrated letter writing campaigns by its member physicians to employers and others seeking to undermine confidence in the adequacy of health plans physician networks. *See, e.g.*, (CX1036; CX1039; CX1046 at 1-2; CX1051; CX1053 (NTSP writing "on behalf of" 588 primary care physicians and specialists to United client, Texas Christian University (TCU), informing them that "due to United's positioning, Texas Christian may experience significant network disruption." NTSP also drafted a sample letter of similar effect for its members to send to TCU). *See* findings 185-186. *See also* (CX0583 at 1-2 (soliciting letters to Texas Department of Insurance threatening significant disruption of the Aetna network unless Aetna comes to price terms with NTSP). *See* finding 364.

140. Health plans have taken NTSP's threats seriously because they are credible and serious. As NTSP has itself said: "NTSP has become a 'gorilla network' with 124 PCP's . . . and 528 specialists." (CX0209 at 2; CX0310). NTSP and its physicians present themselves as a unified and strong force within Fort Worth, and the withholding by those physicians, or many of them, of services would severely damage the perceived adequacy of a health plan's physician network in Fort Worth and thereby injure the health plan in its ability to obtain or maintain business. (Grizzle, Tr. 730; Jagmin, Tr. 1091; Mosely, Tr. 140). Such threats raise the expected cost of seeking to contract around the NTSP collective, making health plans more willing to pay the NTSP-physicians consensus price. (Grizzle, Tr. 730, 746-747, 750-751; Frech, Tr.1325).

141. On at least three occasions, NTSP's coordinated actions and threats of departicipation have caused health plans to increase their offers or reimbursement. (CX0256 ("NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term the entire NTSP network last year"); CX0583 at 1; CX0786 at 1, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*; CX0583; Grizzle, Tr. 730, 738, 740-741).

142. NTSP's collective price-fixing and related acts and practices have effectively raised

prices and/or reduced output of physician services in the Fort Worth area of Tarrant County. (CX0310; CX0209; CX0351; Frech, Tr. 1280-1281, 1332-33; Roberts, Tr 472-473).

VI. NTSP Member Physicians Are not Mere Passive Beneficiaries of NTSP Price-Fixing

143. NTSP's member physicians are an active part of NTSP's price-fixing activities. Taken together, they are NTSP; but more pointedly, the member physicians enter into a relationship with NTSP founded on the Physician Participation Agreement, in which they grant NTSP a right of first negotiation with health plans, agreeing that they will refrain from pursuing offers from a health plan until notified by NTSP that it is permanently discontinuing collective negotiations with the health plan. (CX0276; CX0311 at 8; Deas, Tr. 2405-2406; CX1178 (Hollander, Dep. at 68)). In so doing, each physician necessarily understands that other member physicians are doing or have done likewise.

144. Further, NTSP member physicians actively participate in reaching the agreement on price. NTSP solicits each member's prospective minimum price by stating that it will use that information, together with price information provided by the other member physicians, to establish a minimum price that NTSP will use in negotiations with health plans for fee-for-service contracts. CX1195 (Van Wagner, Tr. at 66-67); CX0565; CX1194 (Van Wagner, 11.19.03 Dep. at 78); CX0103. Accordingly, each physician's participation in the polling is itself an agreement to establish and bargain for the NTSP consensus price.

145. In addition, NTSP physicians, sometimes in response to explicit urging by NTSP, refer health plan contracts to NTSP or refrain from direct contracting activity that could undermine NTSP's collective bargaining of fee-for-service contracts. CX1197 (Van Wagner, 08.30.03 Dep. at 198); CX0942; CX0811; CX0500; CX1008; CX1011: CX0392).

146. Going farther, some NTSP physicians have augmented NTSP's collective agency by executing powers of attorney authorizing NTSP to represent them without limitation in negotiations with health plans, including with respect to fee-for-service arrangements. *See* findings 214-225, 245, 286. These physicians necessarily understood that competing physicians were requested to and did provide NTSP with powers of attorney. (CX1066; CX0548). NTSP members also understood that NTSP would use those physicians' powers of attorney in collective bargaining of all of the terms of fee-for-service contracts. Insofar as some physicians then refrained from entering into direct negotiations with health plans citing those powers of attorney, *see, e.g.*, finding 340, those acts too were directly in support and furtherance of the NTSP-physicians price-fixing program. Similarly, insofar as some physicians authorized or acquiesced in NTSP's threats or actual withdrawals of their participation in a health plan's fee-for-service panel, *see, e.g.*, finding 134, 140-141, those acts as well were directly in support and furtherance of the collectively determined minimum price.

VII. NTSP's Price-Fixing and Related Acts are Demonstrated in its Dealings with Several Health Plans

A. United Fee-For-Service Negotiations With NTSP

In 1998 NTSP negotiated fee-for-service HMO and PPO contracts–including price terms–on behalf of its membership. To facilitate those negotiations, NTSP discouraged its member physicians from contracting individually with United and solicited powers of attorney from its members. Eventually, NTSP had proposed its members access to a United contract through another IPA with which it was affiliated at that time. The evidence further establishes that in 2001, NTSP rejected United's fee-for-service offer without presenting it to its member physicians; orchestrated and executed a concerted refusal to deal by terminating 108 physicians from United's network at a critical time for United; orchestrated its member physicians' opposition to the price terms of United's offer and a public relations campaign to give added effect to that concerted opposition; and solicited powers of attorney to be used with United for "all contracting activities." NTSP's negotiations tactics led to 10%-15% higher prices not only to the NTSP member physicians but to other physicians in the market.

1. General

147. United Healthcare Services, Inc. is a wholly owned subsidiary of United Healthcare through which United Healthcare offers its PPO and other non-HMO products in Texas. (Quirk, Tr. 234- 235, 239, 241, 247, 248).

148. United Healthcare of Texas is a wholly owned subsidiary of United Healthcare through which United Healthcare offers its HMO products in Texas. (Quirk, Tr. 235, 247, 248).

149. Since 1999, Thomas J. Quirk has been the CEO for the North Texas and Oklahoma Region of United Healthcare Services Inc. and the President, Chairman of the Board and the CEO of United Healthcare of Texas (United Services and United HMO collectively referred to as "United"). (Quirk, Tr. 234-235).

150. Quirk oversees all of United's operations for the North Texas and Oklahoma regions, which include sales for commercial employers, municipalities and school districts; account management for United's existing customers and network operations, which encompass contracting with physicians, hospitals and other provider networks, and maintenance of those relationships. United's customers have from two to five thousand covered lives. Quirk is also in charge of clinical operations, finance, quality and compliance. (Quirk, Tr. 235-236).

151. United believes that it is better suited to manage risk than doctors. Therefore, it has not offered any risk contracts to physicians since at least 1998. Currently, all of United's products are non-risk. (Quirk, Tr. 255-256).

152. United offers four different types of HMO products and approximately eight to ten non-HMO products. (Quirk, Tr. 242-243).

153. Employers may offer many of United's products on either a fully-insured or self-funded basis. (Quirk, Tr. 244-247).

154. The cost of health care, choice of physicians, and access to a wide array of physicians are all top priorities for United's prospective clients. (Quirk, Tr. 270-272).

155. Responding to its customers' wish for low health care costs, United dedicates vast resources to utilization management, quality control management and disease management. (Quirk, Tr. 257-273).

156. As part of its effort to offer its clients a wide network of physicians, United strives to market a large panel of physicians on terms that do not compromise the overall cost of care. (Quirk, Tr. 270-271).

2. NTSP Collectively Negotiated Reimbursement Rates with United in 1998

157. In June 14, 1998, NTSP discussed strategic initiatives it needed to take for the future, and stated that it would exhibit "[a]ggression toward any attempt to sub-contract NTSP" in non-risk contracts. (CX0011 at 8).

158. NTSP informed its members that United was attempting to standardize its physician agreements by, among other things, changing the fee schedule. (CX1005 (Fax Alert #79, dated July 14, 1998)).

159. In Fax Alert #79, NTSP sent its physicians an agency agreement for the purpose of obtaining consent to enter into negotiations on behalf of the membership. (CX1005). In Fax Alert #79, NTSP stated that "[b]ecause United Healthcare has the potential to be a major player in this market place, the NTSP Board wishes to contact them and negotiate on behalf of its membership." NTSP later explained that it was United's attempt to change fee schedules that prompted NTSP negotiations with United. (CX1014).

160. NTSP also encouraged its members to "refrain from responding to United Healthcare while NTSP's request for agency status was being tabulated." (CX1005).

161. NTSP's member physicians authorized NTSP to negotiate with United on their collective behalf. *(See, e.g.,* CX1006 (July 15, 1998 letter from Dr. Deas of Gastroenterology Associates of North Texas ("GANT") to Van Wagner allowing NTSP to serve as its agent in regard to future negotiations, including price terms, with United and instructing NTSP not to agree to any fee schedules lower than 135% of 1997 Medicare for United's HMO product and 147% for United's PPO product); Deas, Tr. 2573-2577)).

162. On August 19, 1998 NTSP requested and United granted an extension on the time line for the assignment of contracts. (CX1008).

163. NTSP informed its member physicians of the extension and instructed them that they did not need to sign or return any documents or contracts to United. (CX1008).

164. In September 1998 NTSP proposed to United that Dallas RBRVS be used in calculating the rates for its HMO and PPO products for NTSP physicians, and so informed its member physicians in Fax Alert #94 of September 8, 1998. (CX1010).

165. NTSP also informed its members in Fax Alert #94 that "[f]or many specialists, Dallas rates are approximately three to five percent higher than PPO rates applied to Tarrant County." (CX1010).

166. On October 27, 1998, NTSP in Fax Alert #101 informed its members that discussions with United had been productive, that the parties agreed to extend the deadline, and that members need not take any action in regard to standardizing their United contract until this extension expired. (CX1011).

167. United had offered NTSP a fee schedule for its HMO and PPO plans, and in December 2, 1998, in Fax Alert #112, NTSP informed its members that "we made a counter proposal which United will respond to in January." (CX1012).

168. On March 9, 1999, Fax Alert #12, NTSP recommended to its members that they transition their existing contracts into a standard United contract, and assured them that this would have no effect on the reimbursement rates they were receiving under their current contract and that "we [NTSP] continue our discussions with United Healthcare on proposed fee schedules for these products. . ." (CX1014).

169. Ultimately many NTSP physicians accessed United through the NTSP-HTPN arrangement. (CX1015).

3. NTSP Rejected United's Offer Without Conveying it to its Members

170. Beginning in March 2001, NTSP members contracted NTSP, asking that it seek and obtain a contract with United Healthcare. (CX1117 at 1).

171. On March 14, 2001, NTSP expressed to United its "desire for a group contract reflecting today's market." (CX1117 (letter from Palmisano); Quirk, Tr. 284-289).

172. NTSP's discussions with United involved only fee-for-service contracts. NTSP never indicated that it wanted to have a risk-sharing arrangement with United. (Quirk, Tr. 291, 293-294).

173. NTSP has never performed any utilization management, quality control management or disease management services for United's patients. (Van Wagner, Tr. 1830-1831, 1835, 1836-1837; Casalino, Tr. 2793-2794, 2809-2810, 2816-2817, 2858).

174. As of March 2001, United had contracts with approximately two-thirds of the NTSP physicians, either directly or through other organizations, such as Health Texas Provider Network ("HTPN"). (Quirk, Tr. 288-289). Therefore, United concluded that there was no need to enter into an agreement with NTSP because United had an adequate network in Fort Worth. (Quirk, Tr. 289-290).

175. HTPN, which is an affiliate IPA of Baylor Health Care System, is an organization of employed as well as independent contracted physicians in Dallas. NTSP and HTPN had an arrangement whereby NTSP members would be allowed to access HTPN's payor offers. A significant number of NTSP members accessed health plan contracts through HTPN. (Van Wagner, Tr. 1559; Quirk, Tr. 311-312).

176. On April 12, 2001, NTSP reported at its Primary Care Council Meeting that the reimbursement rates under the United-HTPN contract -- 130% of 1997 St. Anthony RBRVS (145% Radiology) for HMO, 145% of 1997 St. Anthony RBRVS for POS, and 145% of 1997 of St. Anthony RBRVS for PPO -- were below market. The majority of NTSP's members had accepted this contract in 1999. (CX1015). NTSP further reported that "an attempt is being made to raise those rates. Primary care physicians will be polled to determine an acceptable rate." (CX0209 at 3; CX1015).

177. In or about May 2001, notwithstanding its view that United already had a sufficient network in Fort Worth, United offered its then-standard rates in the Fort Worth area: 110% of 2001 Dallas RBRVS, which was the equivalent of 115% of 2001 Tarrant RBRVS to NTSP. (CX0087 at 11; Quirk, Tr. 290, 297-298; CX0089 at 3).

178. NTSP rejected this offer, and Van Wagner told the NTSP Board that "United was informed that this was not acceptable to NTSP and we will wait to hear back from them." (CX0087 at 11; Quirk, Tr. 295, 297).

179. NTSP continued to try to negotiate separate and different rates for United's HMO and PPO products, demanding higher rates for participation in United's PPO. *See* (CX1024; CX1023).

180. On June 19, 2001, Arrington wrote Carter, of NTSP, explaining that United's rates were identical for HMO and PPO reimbursement because from the physician's standpoint each United patient is administratively the same. (CX1027).

181. On June 25, 2001, the NTSP Board discussed United's rate offer and rejected it.

(CX0089 at 3; Quirk, Tr. 299).

4. In Negotiations NTSP Applied Collective Pressure to Obtain Higher Rates

182. Shortly after NTSP rejected the United offer, NTSP learned that United was negotiating with the City of Fort Worth to provide health coverage to city employees. (CX0089 at 3).

183. Having adequate network coverage, including physicians, was particularly important to the city of Fort Worth. In fact, United would not have been selected to serve as the City's claims administrator had it failed to have an adequate network. (Mosley, Tr. 141, 164, 167).

184. At that time NTSP member physicians provided health care to the majority of employees of the City of Fort Worth and their dependents through the City's relationship with PacifiCare. (CX1042).

185. Beginning in June 2001, NTSP implemented a strategy of encouraging its members to convince the City's decision makers that United's prices were not adequate. NTSP encouraged its members to contact "any city council members they know to let them know that United's panel is not adequate." (CX0089 at 3). NTSP also urged its Primary Care Council member physicians to contact the Mayor and City Council members to educate them about the situation with United and ask for help. (CX0211 at 3).

186. NTSP provided its members with model letters for the purpose of complaining to city officials. For example, attached to Fax Alert #44 was a sample letter to the Mayor of Fort Worth with the private fax number for the Mayor and the names, addresses, fax numbers, and e-mail addresses of the City Council. The sample letter included the following statements: 1) "Many of my patients are city employees or dependants and I/we have enjoyed caring for and managing their health for years;" 2) "I look forward for your assistance in communicating to United that they offer a reasonable solution to this situation so I/we can continue to see City Employees and their dependants without disruption;" 3) "In the best interest of my/our current City of Ft. Worth patients, I/we ask for your assistance in resolving this dispute before the City transitions to United Health Care." (CX1042 at 4). NTSP also attached talking points, titled "United Environmental Assessment," which included the following statements: "NTSP Board Minimums [125% for HMO and 140% for PPO] have remained constant for four years despite increases in other areas of health care costs"; "Major payors in market -Aetna, Pacificare, Cigna have all established payment schedules in this range:" "NTSP is the <u>only</u> stable physician organization left in the Tarrant County market:" "United Proposal of 110% of Dallas HMO/PPO is: Significantly <u>below</u> market, Will not be accepted, Is the only product paying the same for HMO/PPO:" "United cannot meet employer/employee match or network access standards without NTSP Physicians Participating in the Network;" "3000 Employees and dependents will lose all their physicians;" "11,000 will lose access to majority of their specialty physicians;" "NTSP is not asking for United to pay more than their competitors;" "NTSP is asking they match

market pricing to obtain a stable and high quality easily accessible network of physicians." (CX1042 at 3).

187. NTSP targeted United because NTSP believed that United's rates were below market rates. (*See* CX0211 at 3 (NTSP informing its Primary Care Physician Council that they had identified United as a re-negotiating target, noting that United was becoming a significant player in the Fort Worth market and that United's rates were well below market)).

188. NTSP's members agreed. On July 2, 2001, NTSP members Dr. Blue, Dr. Vance, Dr. Deas, and Dr. Grant signed a letter addressed to the Mayor of Fort Worth bearing NTSP's letterhead. The letter asserted that United's rates were "well below market benchmarks" and that "NTSP simply has not and will not accept United's request for our participation in their provider network for your employees." The letter also asserted that "the City may experience significant network disruption once United officially begins their duties (up to 588 doctors no longer available)." (CX1029; *see also* (CX1031 (July 9, 2001, letter from Dr. Vance to the Mayor of Fort Worth, stating that the City's recent switch to United placed the relationship between the city employees and their physicians "in serious jeopardy," that the United offer was "significantly below market," and stating that unless "this contractual issue is resolved" there was "likelihood that NTSP members will no longer be available to city employees.")). Other NTSP members also wrote letters to the Mayor of Fort Worth reflecting the points discussed by NTSP in Fax Alert #44. (CX1051; CX1036; CX1046 at 1-2; CX1039).

189. In addition to its letter-writing campaign, NTSP also met with public officials in an effort to exert pressure on United to raise its rates. (Mosley, Tr. 183, 186-187, 192) (At a meeting regarding United, NTSP representatives expressed their concerns about physicians' loss of income with the City Manager and Director of Human Resources of the City of Fort Worth, specifically stating that United's rates were unacceptable.). NTSP told the City it was going to reject the United offer, and warned the City that "that they may have a significantly different network on October 1" when the City would transition from PacifiCare to United. (CX1034; CX0211 at 3; CX1042).

190. On July 10, 2001, NTSP informed United that United's current offer of 110% for all products was below the Board Minimums that NTSP could accept. NTSP told United that the Board Minimums were 125% of Tarrant for HMO and 140% of Tarrant for PPO. (CX1034 at 1; Quirk, Tr. 299-301, 300).

191. On July 11, 2001, NTSP held a General Membership Meeting concerning United in which members received updates concerning the details of the proposed United contract. In the meeting "the importance of the physician providers' voice to the representative of the parties involved in the United negotiations was stressed." As indicated in a subsequent communication to the members, the target of the physicians providers' voice was United's clients. (CX0182; CX1042).

192. On July 13, 2001, in Fax Alert #44, the NTSP Board informed all NTSP member physicians that NTSP and United were in agreement as to basic fundamental language terms but "far apart in agreeing to a market reimbursement fee schedule." (CX1042).

193. The NTSP Board also noted in Fax Alert #44 that many NTSP physicians were contracted with United through HTPN. The rates under this contract were indexed to 114% of 2001 Tarrant County RBRVS for FFS HMOs and 127% for the PPOs and were reported to be below or little above Medicare for many NTSP specialties. (CX1042). The NTSP Board contrasted the NTSP minimums of 125% 2001 of Tarrant Medicare for HMO and 140% of Tarrant Medicare for PPO with United's direct offer to NTSP of 110% 2001 Dallas Medicare for all products. (CX1042).

194. The NTSP Board in Fax Alert #44 informed the member physicians that "the NTSP Board has authorized termination [of] the United Health Care contract. However, notice has not yet been sent to United as NTSP must attempt one last strategy." (CX1042).

195. The NTSP Board further informed its members in Fax Alert #44, that NTSP Board members met with the Mayor of Fort Worth regarding the "possible inadequacy of the United network" and shared with the Mayor "the most recent NTSP Network roster containing 600 physicians representing 24 different specialties who contract through NTSP." The NTSP Board stated that although they "got the attention of the Mayor, our work is not done" and recommended that its member physicians request that the Mayor and City Council members assist in the United negotiations. (CX1042).

196. The possibility that City employees might lose access to NTSP physicians was a matter of concern to the City, because most of NTSP's physicians participated in the United contract and a loss of those physicians would have caused network disruption. (Mosley, Tr. 173, 178-179).

197. In response to NTSP's efforts, at least as early as July 2001, City employees were expressing concern to City managers about the possibility of losing their NTSP physicians, which further troubled City decision-makers. They feared that the existing United network might not continue. (Mosley, Tr. 175, 178).

198. Jim C. Mosley contacted David Palmer of United and shared with him the City's concerns regarding the continuation, maintenance and preservation of the then existing United network. United was requested to maintain the network without compromising costs. (Mosley, Tr. 179-180, 182; Quirk, Tr. 309).

199. In addition to its efforts to disrupt United's contracts with the City of Fort Worth, NTSP also attempted to disrupt United's contracts with other Fort Worth employers. Around the same time United's offer to NTSP was rejected, physicians within NTSP, encouraged by NTSP's Board and staff, began contacting United's customers and questioning the rates at which United reimbursed physicians. (Quirk, Tr. 304).

200. For example, Michael Parks, a Fort Worth insurance broker, contacted Arrington on behalf of a joint client. The joint client had expressed concerns over United's network in Fort Worth. Parks pointed out that there was a possibility that United's network would be compromised. (Quirk, Tr. 303-304).

201. In response to the customer's concerns expressed by Parks, Arrington assured Parks that United had contracts with 400 of NTSP's physicians. Arrington further explained that 113 NTSP physicians are contracted with United through ASIA (another IPA), 108 through HTPN (another IPA), 55 through MCNT as well as smaller numbers through other organizations or direct contracts with United. (CX1055, Quirk, Tr. 302-304). Relying on the fact that United had solid relationships with those 400 NTSP physicians, United concluded it had a stable and adequate network and that "[n]one of these contracts are in risk of termination." (CX1055; Quirk, Tr. 306-307).

202. Less than a week later, NTSP moved to terminate United's contracts with its members. (CX0188).

203. United's concerns intensified as it started to receive a tremendous number of inquiries from brokers and customers, particularly the City of Fort Worth and its consultant, Mosley, regarding the stability of its network. The complaints expressed by NTSP member physicians, encouraged by its Board and staff, focused on United's rates and the manner in which it paid claims. (Quirk, Tr. 308-310, 331-333).

204. NTSP also directed its disruptive efforts toward Texas Christian University, another United customer. On July 23, 2001 NTSP wrote to William Koehler, Provost and Chief Academic Officer of Texas Christian University, stating that significant network disruption may occur because of United's low reimbursement rates to NTSP physicians. (CX1053).

5. NTSP Orchestrated and Executed a Concerted Refusal to Deal, Terminating its Members' Participation in the United Contract

205. Contemporaneous with its efforts directed at United's clients and Fort Worth brokers to undermine the perception of adequacy of United's network, on July 23, 2001, the NTSP Board approved the termination of all NTSP members' participation in United network through HTPN. The NTSP Board also approved the sending of agency letters to its member physicians. (CX0091).

206. On July 23, 2001, NTSP orchestrated a concerted refusal to deal and terminated the contracts of all 108 of its members who were participating with United through Managed Care & Network Development of HTPN. The termination was applicable even to physicians who were compensated above NTSP's Board Minimums, such as "Surgery Thoracic" physicians who were being reimbursed at 149.6% of 2001 Tarrant RBRVS for HMO and 166.9% of 2001 Tarrant RBRVS for PPO; and "Surgery Neurological" physicians who were being reimbursed at 142%

for HMO and 158.3% for PPO. (CX1118, CX1201 (Youngblood, Dep. at 122-25, 127 and 129); CX1042 at 2).

207. The effective date of termination was October 20, 2001, less than three weeks after the City of Fort Worth had planned to transition its employee health plans from PacifiCare to United. (CX1051B; CX1042 at 1).

208. NTSP sent a copy of the termination letter to United and to the Mayor of the City of Fort Worth. (CX1118; Quirk, Tr. 312-313).

209. The unexpected termination of a large number of physicians caused United a great deal of concern. (Quirk, Tr. 312-315, 331-333).

210. Prior to receiving the termination letter, United had not received any notable number of terminations from physicians who were contracted with it through HTPN, nor did HTPN itself indicate that physicians were likely to terminate their United contracts because of price or any other reason. In fact, United was not aware, or informed, of any reason, other than the fact that it was engaged in direct bargaining with NTSP, that could have caused this sudden termination. (Quirk, Tr. 315).

211. On the evening of July 23, 2001, NTSP held a General Membership Meeting where the "environmental" assessment of United contract and the United termination letter was discussed. NTSP continued encouraging its members to complain about contract terms. *See* (CX0184 ("[t]he importance of the physician providers' voice to the representatives of the parties involved in the contract negotiations was once again stressed.")).

212. On July 26, 2001, David C. Beaty, United's Senior Network Account Manager, recorded in an internal United e-mail his lack of understanding as to how a "messenger model" IPA can terminate a contract on behalf of its physicians, noting a prior reference to an agency clause in the agreement between NTSP and its physicians. This same lack of understanding was shared by Quirk and was another source of concern to United. (CX1056; Quirk, Tr. 314-315).

213. NTSP and its members understood that the United contract was terminated because United offered rates below NTSP's minimum price. *See* (CX1062 Fax Alert #52, dated August 9, 2001, informing member physicians of NTSP's termination of United through HTPN and explaining that the termination was a result of United's proposed PPO/HMO rates falling below Board approved Minimums and United's use of a single fee schedule for both HMO and PPO)).

6. NTSP Sought Powers of Attorney to Negotiate Exclusively with United

214. On August 9, 2001, in Fax Alert #52, NTSP solicited powers of attorney from NTSP member physicians because "[a]s with previous contracts, several members have requested that

NTSP act on their behalf in regards to all contracting activity between themselves and United Health Care." (CX1062).

215. Fax Alert #52 explained to the physicians that "[t]his power of attorney grants the authority to the agent to act on the undersigned's behalf regarding the foregoing described agreements in all respects, including the authority to negotiate the terms of, enter into, execute, amend, modify, extend or terminate any such agreements." The power of attorney attached to the Fax Alert was not limited in any way to non-economic terms. (CX1062).

216. On August 13, 2001, the NTSP Board reviewed Fax Alert #52, to which the power of attorney was attached, and decided to keep pressuring the City and Texas Christian University with regard to their choosing United as their health plan. (CX0096).

217. A copy of Fax Alert #52 was obtained by United. Quirk made a handwritten notation on this copy indicating United's view that it needed to redevelop a network strategy for Tarrant County. Quirk made this notation because of NTSP's termination of 108 physicians and NTSP's coordinated "public relations campaign" against United which caused United's customers to question its ability to deliver a quality network in the Fort Worth area. (CX1051; Quirk, Tr. 320-321).

218. After carefully examining the power of attorney and the text of Fax Alert #52, Quirk and United's counsel concluded that the power of attorney gave NTSP the right to negotiate all contractual terms, including financial terms. Based on that conclusion, United believed that NTSP would negotiate collectively on behalf of its member physicians for price and non-price terms. (Quirk, Tr. 322-326 (the testimony related to United's antitrust counsel concerns - Tr. 324-326 - not for truth but for state of mind); CX1051; Quirk, Tr. 326).

219. United decided to try to recruit the terminated NTSP physicians directly. (CX1056; CX1057 at 1). In August of 2001, shortly after NTSP's termination letter, United made the decision that Beaty would contact all of the affected HTPN/NTSP physicians who were terminated by NTSP, in an effort to restore the relations with the terminated physicians via direct contract. (Quirk, Tr. 334; Beaty, Tr. 452, 454).

220. Beaty wrote to these physicians inviting them to continue participation in United's network under a direct contract with United, and offered them the same reimbursement rates as they had received under the HTPN-United agreement prior to the termination. Only a few physicians accepted this offer. (Quirk, Tr. 334; Beaty, Tr. 452; CX1068).

221. On August 24, 2001, Fax Alert #56, NTSP informed its member physicians that it was receiving calls from some member physicians regarding direct offers they had received from United. NTSP repeated its unfavorable assessment of the United offer, reported that the rates paid to the NTSP physicians through the United-HTPN arrangement were below the NTSP acceptable Minimums, and noted that this had been NTSP's reason for terminating the HTSP

arrangement. NTSP also informed it member physicians that it "would continue to pursue a direct contract with United Healthcare [*sic*] that meets or exceeds the fee schedule minimums set by the NTSP membership." (CX1066).

222. Also, through Fax Alert #56, NTSP informed its members that it had already received 107 executed powers of attorney from member physicians that assigned NTSP "to act on their behalf in regard to all contracting activity between themselves and United Healthcare," and sought the submission of executed powers by additional members. (CX1066).

223. NTSP advised those member physicians who signed the powers of attorney that they "should inform all United representatives who contact you that NTSP is your contracting agent for United Healthcare and instruct them to contact NTSP directly." (CX1066; CX0499; CX1002 at 1-12 (spreadsheet listing names of 107 physicians)).

224. United obtained a copy of Fax Alert #56 and learned that NTSP had gathered 107 powers of attorney from physicians and continued to solicit additional powers of attorney to be used in collective bargaining with United. (Quirk, Tr. 326; 330-331; CX1051A).

225. NTSP in a September 13, 2001 letter to Garry Jackson, City Manager of Fort Worth, stated that "several offices have contacted NTSP to state they do not wish to contract with United unless a group contract through NTSP is negotiated on their behalf." (CX1075 at 2).

7. United Capitulated to NTSP's Demand to Increase its Rates

226. In the summer of 2001, in an attempt to restore customer confidence in the stability and adequacy of United's network in Fort Worth that was compromised by NTSP's activities, United increased its offer to ASIA, another Fort Worth IPA through which had contracts with 113 NTSP physicians. (CX1055). United's offer was 125% of 2001 Tarrant RBRVS for HMO and 130% of Tarrant RBRVS for PPO. (Quirk, Tr. 336-337, 345, 347). The increased offer was also made to MCNT. (CX1119 at 1).

227. NTSP understood that the increased offer to ASIA was a direct result of NTSP's activities (CX0256; CX1199 (Vance, Dep. at 310-311)).

228. The same increased offer of 125% of 2001 Tarrant RBRVS for HMO and 130% of 2001 Tarrant RBRVS for PPO was extended to the NTSP physicians whose contracts had been terminated. (CX0658; CX1119 at 1). More than 10 physicians' groups failed to respond to United's offer at this rate, notwithstanding the fact that it was higher than rates they had prior to their termination by NTSP. (Beaty, Tr. 454-455 (as instructed by NTSP in Fax Alert #52); CX1062).

229. Beaty visited the physician groups that rejected the new United offer. (Beaty, Tr. 454-455; CX0658; CX1119). Some of those groups responded that they rejected United's offer for a

direct contract because NTSP was negotiating on their behalf. (Beaty, Tr. 459-460).

230. On August 28, 2001, Quirk, wrote to NTSP's Board of Directors expressing United's view that "there may be serious antitrust issues raised by the manner in which [NTSP] is representing its physicians membership in their contractual arrangements with United Healthcare." (CX1067). Specifically, United was concerned with the use of powers of attorney to allow NTSP to negotiate "all contract activity" with United and with NTSP's withdrawal of member physicians from participating in the HTPN-United contract. Quirk also cautioned NTSP that United might alert state and federal agencies if United's antitrust concerns were not resolved. (CX1067; Quirk, Tr. 334-336).

231. In an August 30, 2001 Board of Directors meeting, NTSP's Board decided to invite Quirk to discuss United's antitrust concerns as previously expressed in his August 28 letter. (CX0097).

232. On September 5, 2001, NTSP held a General Membership Meeting, at which Van Wagner updated NTSP's member physicians on recent progress in contract negotiations with United. (CX1076; CX0158).

233. On September 7, 2001, United declined NTSP's offer to attend a Board meeting because NTSP had not yet submitted an adequate written response to United's August 28 letter. (CX1121; Quirk, Tr. 338-339).

234. On September 13, 2001, in Fax Alert #60, NTSP reported to its member physicians that United had increased reimbursement levels "via a contract with ASIA, as well as individual direct offers to several NTSP physicians." (CX1076).

235. As a result of the increased offers, NTSP deferred activation of the powers of attorney for two weeks subject NTSP's reconsideration. (CX1076).

236. On September 13, 2001, NTSP again invited United to meet with the Board in order to address United's concerns regarding NTSP's conduct, as stated in United's August 28 letter. (CX1072).

237. On September 13, 2001, NTSP met again with representatives of the City of Fort Worth. NTSP represented that even United's new, increased PPO reimbursement offer to NTSP physicians still was unacceptable. NTSP further expressed concerns about United's practice of "bundling" claims, pursuant to which physicians who provided multiple services on a single occasion were reimbursed at a single, bundled rate (lower than the rate at which each service would be compensated if billed separately). NTSP expressed its view that United's bundling practice under-compensated physicians. (Mosley, Tr. 185-189, 190-193; CX1075).

238. At the same meeting, NTSP's Dr. Deas made the suggestion that physicians might have to resort to "billing games" to offset losses caused by United's bundling logic. (Mosley, Tr. 189-

190).

239. On September 13, 2001, NTSP again contacted the City of Fort Worth to complain about United's rates and inform them that some NTSP members would only contract with United through NTSP. *See* (CX1075 (Letter from Dr. Deas to Gary Jackson, City Manager for the City of Fort Worth, noting that despite some "positive movement" United's overall rates "may still prove inadequate" and this "may affect the overall size of United's physician network." Dr. Deas also reported that several offices refused to contract with United unless a group contract through NTSP was negotiated on their behalf and noted that NTSP's termination notice to HTPN would take effect October 21, 2001. Notification letters to patients could be sent as soon as October 1, 2001, the same day as the City was supposed to transition to United)). Copies of this letter were sent to NTSP member physicians. (CX1075).

240. On September 19, 2001, NTSP informed its membership that in order to allow them to consider the increased United offer available through ASIA or directly, NTSP would defer any further action until September 27, 2001. NTSP would then contact each member who previously gave a power of attorney to determine if those members desired additional action by NTSP on their behalf. Members who considered individual contracts with United were invited to review the proposed negotiated group contract. (CX1079 (Fax Alert #67)).

241. In a September 20, 2001 letter, United accepted NTSP's invitation to meet with the Board but reminded NTSP that United still wanted a substantive response in writing to the antitrust concerns raised in United's August 28 letter. (CX1080; Quirk, Tr. 344-345).

242. On September 21, 2001, Van Wagner updated NTSP's Medical Excutive Committee on contract negotiations with United. (CX0198). Several additional updates to the membership were provided between September 21, 2001 and September 25, 2001. (CX0171 at 1-5).

243. NTSP and its members also made an effort to convince the State of Texas that United's rates were too low. In meetings with Texas Governor Rick Perry, NTSP sought support in raising prices and "shared the magnitude of the problem of lower reimbursement rates to physicians." Physicians were encouraged to write to the Governor in that regard. (CX0198; CX0100).

244. On September 24, Quirk and Robert Jacqmin of United met with NTSP's Board. NTSP stated that it opposed United's offer of one rate for all products. United's representatives were told that PPO rates should be higher than HMO rates. (Quirk, Tr. 340-341, 344).

245. At this meeting, after United already had threatened to reveal NTSP's anticompetitve conduct to federal and state agencies, NTSP for the first time asserted that its members' powers of attorney were used only for negotiation of non-price contractual terms, not rates. (Quirk, Tr. 341-342). In light of the plain language of NTSP's communications with its members concerning the powers of attorney, Quirk continued to believe that the powers of attorney were

being sought for "all contracting activity" and were not limited to non-financial terms. (Quirk, Tr. 341-342).

246. Also for the first time, the NTSP Board told United that NTSP's contractual arrangement with HTPN enabled it to terminate the arrangement on behalf of its physicians for United's products. (CX1081).

247. NTSP's Board Minutes of September 24, 2001 reported that Dr. Deas met with Texas Commissioner of Insurance, Jose Montemayor to discuss predatory pricing by health plans. The Commissioner stated that he would send letters to CEOs of major plans cautioning them against predatory pricing activities. Dr. Deas also discussed the impact of HMO and PPO contracting revisions on Tarrant County physicians with the Commissioner. (CX0100).

248. In a September 24, 2001 letter, Dr. Deas invited United to reopen negotiations. (CX1084).

249. On September 24, 2001, NTSP provided its member physicians with a summary of terms to be included in any direct contract with United. The summary included price related terms such as: (1) United's reimbursement methodologies should not translate in less then what Medicare would have paid (Point 10); and (2) a fee change from 80% of usual and customary to 100% usual and customary (Point 23). (CX1064).

250. Because NTSP's actions turned United's Fort Worth network "upside down," United on or about October 10, 2001 sent NTSP a new, enhanced offer. (CX1088; CX1096). United offered NTSP an increased rate of 125% of 2001 of Tarrant RBRVS for HMO and 130% of Tarrant RBRVS for PPO, in order to put an end to the contractual battles that NTSP imposed on United and its customers. (Quirk, Tr. 347-349).

251. Nevertheless, NTSP still was unsatisfied with these price terms, particularly for the PPO plan. (CX1088).

252. On October 29, 2001, in Fax Alert #83, NTSP communicated to its members the results of NTSP's annual reimbursement poll of NTSP members' acceptable rates on both HMO and PPO levels. (CX0393).

253. On October 29, 2001, NTSP held a General Membership Meeting in which the offer from United was detailed along with the latest poll results which reflected a higher minimum for PPO than United's fee proposal. The PPO rate was listed as an "open issue." (CX0186 at 1).

254. Eventually, NTSP and United signed a contract at 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO, effective November 1, 2001. (CX1095 at 9). The new contract represented an increase of 10% from the initial HMO offer and 15% from the initial PPO offer. (*Cf.* CX0087 at 11; Quirk, Tr. 290, 297-298; CX0089 at 3).

255. On November 1, 2001, in Fax Alert #84, NTSP sent the contract to its member physicians to opt in/out indicating it was a result of "negotiations," and that the 125% of the 2001 Tarrant County RBRVS for the HMO was "at the average level of acceptable reimbursement." Yet again, NTSP noted to its members that the PPO rate of 130% was below the acceptable reimbursement levels set by the NTSP Board. (CX1097).

256. Because the rates were less than the collectively set minimums, the level of acceptance by NTSP members was very low. (CX1100). Fax Alert #95, dated November 19, 2001, indicated that 258 NTSP members responded; 24% accepted the HMO contract while 76% rejected it, and 23% accepted the PPO contract while 77% rejected it. (CX1001 at 2).

257. Dr. Vance, a former NTSP President who at the time was a member of the NTSP Board of Directors, summarized NTSP's success in these United negotiations to his medical group, in an effort to convince the group to continue their membership with NTSP: "United Health Care came to town six months ago and offered a straight, 110% of Medicare contract. . . . Through the efforts of NTSP lobbying the City [of Fort Worth] and terming a group contract with Health Texas, United blinked. United was so eager to dilute our effectiveness that they refused to negotiate with NTSP but offered an improved contract thru ASIA. The fees in the Asia [*sic*] contract are very close to the numbers that NTSP presented as market rates for FW [Fort Worth] and were rejected out of hand by United officials. United has now returned to the table with NTSP at the direct request of the commissioner of the Dept of Insurance. This United negotiation is a template for other efforts that will need to occur in the near future and would best be coordinated by NTSP." (CX0256; CX1199 (Vance, Dep. at 310-311)).

B. NTSP Collectively Raised Physician Reimbursement Rates for CIGNA Health Plans

The evidence shows that NTSP collectively negotiated fee-for-service contracts with CIGNA and secured higher rates by repeatedly threatening to terminate its physicians from CIGNA's network. CIGNA was introduced to NTSP in 1997, after purchasing another health plan. NTSP's physicians who were directly contracted with this health plan refused to assign their contracts to CIGNA, and insisted that CIGNA negotiate its contracts with its bargaining agent, NTSP. In its 1999 HMO negotiations with NTSP, CIGNA met NTSP's rate demand and agreed to pay at the Board minimum rate. In 2000 and 2001 NTSP negotiated aggressively to add its cardiologists and primary care physicians into the CIGNA-NTSP contract, and specifically to allow those physicians higher reimbursement rates than CIGNA was already paying to them. Eventually CIGNA did not allow those physicians into its network after NTSP's repeated threats to terminate its contract with CIGNA. CIGNA agreed to these cost increases despite the fact that CIGNA would receive no commensurate benefits. Although it first rejected this demand, CIGNA eventfully accepted the rate increase. The negotiations were conducted after CIGNA determined that the impact of a potential termination of all NTSP's physicians

would leave it without a marketable network in Fort Worth. NTSP's coordinated efforts increased the level of NTSP's physician reimbursement above market levels.

258. In late 1997, CIGNA purchased Healthsource, a company which offered both HMO and PPO products covering approximately 1 million lives nationally. (Grizzle, Tr. 695).

259. The acquisition improved CIGNA's physician network in the Fort Worth area and CIGNA requested that the physicians in Healthsource's network assign their contracts to CIGNA. (Grizzle, Tr. 696-697; CX0760 (verbal acts)).

260. CIGNA sent assignment letters to Fort Worth physicians to attempt to contract independently with physicians. (Grizzle Tr. 696-697).

261. NTSP learned of the letters and orchestrated and effectuated a concerted refusal of its member physicians to assign their Health Source contracts to CIGNA in order to negotiate as a collective on behalf of the membership (Van Wagner, Tr. 1752; CX0332). NTSP provided and sent to its members a sample letter refusing the contract assignment and directing CIGNA to negotiate with NTSP as their agent, as well as an agency agreement that authorized NTSP to negotiate on the behalf of consenting members. (In the same communication, NTSP informed its members that termination of the members' Health Source provider agreements would risk "depleting [CIGNA's] Health Source provider network.") ("The NTSP Board has determined that this is a contracting situation in which NTSP can be helpful in serving as the agent for its members. Attached you will find an agency form regarding the Healthsource/CIGNA provider agreements. If 50% or more of NTSP members concur that agency is appropriate, NTSP will contact CIGNA and Healthsource directly in regards to this matter. IN THE INTERIM, NTSP ADVISES ITS MEMBERS NOT TO CONSENT TO THE ASSIGNMENT OF YOUR HEALTHSOURCE PROVIDER AGREEMENTS TO CIGNA. YOUR REFUSAL TO CONSENT TO THIS ASSIGNMENT SHOULD BE SENT TO CIGNA FOR YOUR POSSIBLE USE. FINALLY PLEASE RETURN THE AGENCY REPRESENTATION FORM AT YOUR EARLIEST CONVENIENCE.") *(emphasis in original)*.

262. In response to the assignment letters, CIGNA received 40 letters all virtually identical to the sample letter provided by NTSP, representing more than 50 NTSP member physicians, in which NTSP physicians refused to assign to CIGNA the Healthsource agreement, and directed CIGNA to negotiate with NTSP on their behalf. (CX0760 (verbal acts); Grizzle, Tr. 696-698, 709, 724).

263. Upon receiving these refusal letters, CIGNA concluded that the doctors would not directly contract with CIGNA and that CIGNA would need to deal with NTSP. (Grizzle, Tr. 697, 709-710, 747).

264. As a result, CIGNA contacted NTSP and negotiated with NTSP for the participation of NTSP's specialist member physicians in CIGNA's HMO product at significantly higher fee-for-

service prices than market level consistent with NTSP price demands. (Grizzle, Tr. 710-714 (stating that the contents of price discussions included CIGNA's typical offer in the market and what rates NTSP would accept, adding that NTSP "ultimately" accepted 125% 1998 RBRVS); CX0764 at 1, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*).

265. PPO coverage for NTSP specialists was later added in an amendment to the NTSP/CIGNA contract at a reimbursement rate of 135% of Dallas County 1998 RBRVS. (CX0769; Grizzle, Tr. 714).

266. A year later NTSP renegotiated with CIGNA its specialist physician reimbursement rates for both CIGNA's HMO and PPO products at significantly higher prices than CIGNA paid other Fort Worth physicians for the same services. The resulting rates were consistent with NTSP's price demands. (Grizzle, Tr. 711-714 (stating that CIGNA unsuccessfully tried to negotiate lower rates with Karen Van Wagner and David Palmisano of NTSP, arriving at rates consistent with NTSP's demands.); Grizzle, Tr. 719; CX0764, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04);* CX0769). This agreement was effectuated in a second amendment which increased the fee-for-service HMO rate to current year RBRVS and provided that the rates would be adjusted annually to maintain rates 125% of then current RBRVS. (CX0771 at 1, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*; Grizzle, Tr. 741 (CIGNA estimates that adjustments to current year RBRVS increase its costs). (These new rates were 15 to 20 percent higher than "CIGNA's other reimbursement rates in the Ft. Worth area." (Grizzle Tr. 715-716; Grizzle Tr. 723-724).

267. CIGNA agreed to meet NTSP's price demands because CIGNA could not compete in Fort Worth without NTSP's member physicians in its network. (Grizzle, Tr. 719 (noting that the core group of NTSP, the specialists in Fort Worth, were "critical" and referencing a CIGNA analysis which showed that NTSP specialists "covered key facilities, good reputation, often requested by employers; therefore, it was important for us to have that to compete against our primary competition."); Grizzle, Tr. 720 (Question: "Could you have put together an adequate network of physicians without NTSP's doctors?" Answer: "Not and sell in Ft. Worth").

268. (CX0771 at 2, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*; CX0769 at 1, CX0770; Grizzle, Tr. 713 (agreement did not include cardiology, urology, oncology, podiatry and gastroenterology); 718 (primary care physicians were not part the agreement, "We were contracting for the specialty coverage, and that was NTSP's core business.")

269. Though NTSP's cardiologists were "carved out" of the agreement, NTSP attempted to secure their inclusion. (Grizzle, Tr. 725; CX0776). CIGNA responded by offering NTSP's cardiologists an opportunity to contract with the entity CIGNA had contracted with for

cardiology services, American Physician Network ("APN"). Accordingly, APN submitted a fee-for-service offer to NTSP's cardiologists. (Grizzle, Tr. 726-727; Van Wagner, Tr. 1768.)

270. NTSP rejected APN's offer and sent a letter to APN, stating that the offer "was shared with affected members of NTSP's Cardiology Division and NTSP's board. At this point, we must decline your proposal as it does not meet our minimum reimbursement levels." (CX0349; CX0777A; Grizzle, Tr. 726-727).

271. NTSP then threatened CIGNA with the termination of NTSP's contract with CIGNA in order to secure the inclusion of the NTSP cardiologists. (CX0776; Grizzle, Tr. 730; CX0777 (NTSP letter to CIGNA stating that NTSP's Cardiology Division and Board found CIGNA's proposal to be "woefully inadequate." The letter also states that "obviously Cigna's failure to resolve this issue may affect current NTSP participation and future dialogue with Cigna regarding a PSN type risk.")).

272. CIGNA took the threat seriously and performed an analysis of the impact of the potential loss of NTSP's physicians from its network. CIGNA determined that NTSP's termination would leave it with gaps in specialty coverage [redacted] (Grizzle Tr. 730-731 (stating that CIGNA took the threat seriously because NTSP presents "a fairly unified force, well-represented and looked like a strong entity and working in Fort Worth"); CX0779, *in camera* (charting impact of NTSP termination by specialty)).

273. NTSP then linked the on-going issue of the inclusion of NTSP's cardiologists to the inclusion of NTSP's primary care practitioners under the contract. (Grizzle, Tr. 732; **{CX0786, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*** [redacted] **(CX0786, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*).}**

274. In negotiating for the inclusion of its primary care physicians, NTSP also solicited "assistance" from Texas Health Resources ("THR"). (Van Wagner, Tr. 1474-1475). THR is a large hospital system that includes Harris Methodist Fort Worth. In a letter to THR, NTSP writes: "Given that the CIGNA HMO is offered by THR to many of its employees, we would ask your support in allowing NTSP's contracted PCPs to participate through NTSP's contract with CIGNA. Participation through NTSP's contract would be economically advantageous to many existing PCPs and would provide a single point of entry for every 100 PCPs and 300 specialists. Specifically, we have requested that Yerxa contact THR's CIGNA representative to make him aware of this contracting situation and urge his support for the inclusion of NTSP's PCPs in the NTSP/CIGNA contracts. By not offering Tarrant County PCPs a market rate, CIGNA puts its ability to provide quality primary health care services to your employees at risk." (CX0709 at 2).

275. CIGNA had already contracted with a sufficient number of primary care physicians at significantly lower rates than those under the NTSP specialist agreement. Allowing NTSP's primary care physicians to opt-in to the NTSP/CIGNA specialist contract would increase CIGNA's costs with *no additional benefit* to CIGNA. (Grizzle, Tr. 733-734; Grizzle, Tr. 718-719).

276. In order to maintain the relationship with NTSP and despite increasing its costs, CIGNA offered NTSP's primary care physicians a tiered reimbursement fee schedule in which the primary care physicians would initially receive NTSP's specialist rates and return over time back to a "market level." (Grizzle Tr. 734-739).

277. NTSP rejected CIGNA's offer on behalf of its primary care physicians. (CX0791 ("NTSP's Board absolutely cannot and will not negotiate or offer an agreement in which our PCP partners are paid less than our specialists ...The 125% of the then current Dallas (not Tarrant County) RBRVS must stand as per our current agreement.")).

278. [redacted] **(CX0795 at 2, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*** [redacted] **CX0795 at 2, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04).}*** NTSP demanded that CIGNA bring the PPO rates to current year RBRVS. (Grizzle, Tr. 740).

279. On June 7, 2001, NTSP e-mailed CIGNA seeking a new fee arrangement: "Currently, NTSP is receiving approximately the same reimbursement from CIGNA for the HMO and PPO fee schedules which NTSP has communicated to CIGNA that this [*sic*] is unacceptable." NTSP sought to change this fee schedule reimbursement "to reflect 135% of Current (2001) Dallas County RBRVS." In addition, NTSP again demanded that CIGNA include NTSP primary care physicians into the NTSP/CIGNA agreement on the PPO product. The e-mail acknowledged that CIGNA requested that NTSP communicate to its Board that it would not unconditionally agree to the inclusion of NTSP's primary care physicians. NTSP's response was that "the Board will be discussing this outcome and will be poised to act accordingly." (CX0800 at 1).

280. By return e-mail that same day CIGNA agreed to reimburse NTSP specialists at 135% of Dallas 2001 RBRVS for the PPO product, which CIGNA projected would increase the cost of specialty services. However, CIGNA reiterated its resistance to NTSP's demands to include NTSP's primary care physicians at NTSP's specialist rates. (CX0800 at 2; Grizzle, Tr. 740-741).

281. In response, NTSP orchestrated and executed a concerted refusal to deal, terminating the NTSP/CIGNA PPO contract for the stated purpose of securing the inclusion of NTSP's primary care physicians. (CX0802).

282. (Grizzle, Tr. 749-751; Van Wagner, Tr. 1771; CX0810).

283. At trial, Van Wagner offered her own definition of the contractual term "specialist," as it appears in the CIGNA contract, to justify NTSP's attempts to pressure CIGNA to include primary care physicians in the contract. (Van Wagner, Tr. 1762-1763). Van Wagner testified that the term "specialist," **(CX0771, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*)]}**, references a defined term in NTSP's Participation Agreement and Bylaws. (Van Wagner Tr. 1762-1763). Not only does NTSP's Participation Agreement fail to contain a defined term for "specialist;" but NTSP's bylaws actually contain separate definitions for "Medical Specialty Physicians" and "Primary Care Physician or PCP." (CX0311; CX0275 at 5 ("The term Primary Care Physician" or "PCP" shall mean those Participating Physicians who provide primary care medical services.")).

284. **(CX0814, *in camera (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*** **(Grizzle, Tr. 877-879, *in camera (See Grizzle, Tr. 752-754)*.}**

285. **(Grizzle, Tr. 881-882, *in camera (See Grizzle, Tr. 752-754)*).}**

286. NTSP's coordination of a collective refusal to deal with CIGNA effectuated through its collection of agency agreements from its member physicians and threats of and actual mass departicipation thwarted CIGNA's attempts and ability to contract at market rates. (Grizzle Tr. 716; 719; 723-724; 738; 746-747 (NTSP as a "unified force"); Grizzle, Tr. 749; Grizzle, Tr. 750-751).

287.

(Grizzle, Tr. 880, *in camera (See Grizzle, Tr. 752-754)*, 896, *in camera (See Grizzle, Tr. 752-754)*).

288. **Grizzle, Tr. 903, *in camera (See Grizzle, Tr. 752-754)*, 914-915, *in camera (See Grizzle, Tr. 752-754)*).** (Grizzle, Tr. 756-757 (NTSP's cost to CIGNA is higher than average)).

289. **(Grizzle, Tr. 755, 879-880, *in camera (See Grizzle, Tr. 752-754)*).}**

290. The third amendment also provided CIGNA's only HMO flat file date data to NTSP. CIGNA has not seen any analysis that NTSP has done with this data and is not aware of any analysis. CIGNA has not provided PPO flat file data to NTSP. (Grizzle, Tr. 755-756).

291. During the last annual contract period with CIGNA, NTSP did not meet its cost performance target in its HMO contract with CIGNA. (Van Wagner, Tr. 1868).

292. CIGNA has never paid anything to NTSP for meeting CIGNA's quality service incentives in the NTSP CIGNA contract. (Van Wagner, Tr. 1868).

C. Aetna's Fee-for-Service Negotiations with NTSP

The evidence of NTSP's dealing with Aetna indicates that NTSP collectively negotiated price with Aetna, which led to higher prices. In late 2000 NTSP and Aetna negotiated a fee-for-service agreement. Aetna initially offered its standard rate in the marketplace – some 125% for PPO, 111% for HMO and $40 for anesthesia. NTSP countered with 140% for PPO, 125% for HMO and $45 for anesthesia. After negotiating the prices, Aetna agreed to raise its PPO offer to the 140% demanded by NTSP and offered a higher HMO reimbursement rate of 116%. This was unacceptable to NTSP. Further negotiations ensued and NTSP applied additional pressure by collecting powers of attorney from its physicians, terminating NTSP's physicians from Aetna's network, and imposing pressure on Aetna through employers, brokers and the Texas Department of Insurance. Eventually Aetna capitulated and signed a contract that mirrored NTSP's counter offer of 140% for PPO, 125% for HMO and $45 for anesthesia. In 2001, realizing that it was paying NTSP higher rates than any other IPA, Aetna tried to reduce the rates to reflect market conditions. During the negotiations, NTSP claimed that its efficiencies justified higher rates. After throughly analyzing the data, Aetna concluded there was no empirical justification to support the higher rates and terminated its NTSP contract.

1. General Aetna Background

293. Aetna currently has around 13 million covered lives in its different health plans, around 650,000 of them in North Texas, and around 40,000 - 50,000 HMO and 100,000 PPO members in Fort Worth. (Jagmin, Tr. 981; Roberts, Tr. 476).

294. Aetna's network has about 7,200 physicians in the Dallas-Fort Worth Metroplex. (Jagmin, Tr. 1121).

295. Dr. Jagmin is currently the medical director for medical policy (Jagmin, Tr. 969). Although Dr. Jagmin works for Aetna's national operation, based out of Blue Bell, Pennsylvania (Jagmin, Tr. 974), he consults and advises for the north Texas area. (Jagmin, Tr. 972, 974).

296. During the relevant time about 55% of Aetna's business, both HMO and PPO, was large national accounts that had multi-state business. When those customers were asked what they were looking for in health care coverage, they responded that they would like broad networks and access to most of the hospitals and the majority of the physicians in a given area. (Jagmin, Tr. 972, 1102-1103).

2. NTSP Physicians Initially Provided Physician Services Pursuant to MSM's Agreements With Aetna

297. Prior to NTSP's direct involvement with Aetna, many of NTSP's members were contracted with Medical Select Management (referred to herein as "MSM" or "Select") to provide physician services pursuant to MSM's agreements with Aetna. (Jagmin, Tr. 982).[1]

298. The contract between MSM and Aetna which served about 115,000 patients, was primarily a "global risk deal" under which MSM was capitated to cover physicians services. (Jagmin, Tr. 997; 984-985).

3. Initial Contract Negotiations Between Aetna and NTSP

299. In late 1999 NTSP initiated a meeting with Aetna and proposed a direct contracting relationship between Aetna and NTSP. (Jagmin, Tr. 981-982). This meeting did not develop into broader negotiations. (Jagmin, Tr. 988-989).

300. Around April 2000, NTSP again initiated negotiations with Aetna to discuss a direct contract between NTSP and its member physicians and Aetna. (Jagmin, Tr. 989-990).

301. When Aetna and NTSP first met, NTSP alleged that it was efficient in managing hospital

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[1]MSM was a Texas corporation that recruited and contracted with Tarrant County physicians and physician associations to provide a network of physician services for health plans. In 1999 MSM was contracted with 2,000-2,500 physicians. (Deas, Tr. 2608-2609).

care, but the information it provided as proof of its efficiency lacked supporting data. In fact, the information provided by NTSP was based on another health plan. Aetna was not given information that would enable it to examine the data in the context of its own needs; it was impossible to compare the other health plan's population to Aetna's population, to determine whether the other population's health care risks were higher or lower, or to make a comparison between product designs. (Jagmin, Tr. 1095-1096).[2]

302. In early June 2000, NTSP met with Aetna to discuss future business and contract arrangements. (CX0177). NTSP told Aetna that its member-physicians would pull out of the MSM contract with Aetna. (Jagmin, Tr. 995-996).

303. Aetna then discussed internally the possible contracting scenarios with NTSP, concluding that the most favorable scenario was keeping NTSP's physicians within Aetna's current contract through MSM rather than signing a separate contract with NTSP. This conclusion was based in part on the knowledge that a separate contract would duplicate administrative costs, among other unfavorable effects. (CX0525).

304. The internal Aetna discussion considered a scenario in which Aetna would lose most of NTSP's member physicians. This turn of events was envisioned as a realistic possibility if NTSP's member physicians were to pull out of MSM, Aetna were to fall short of reaching an agreement with NTSP, and only a few of NTSP's member physicians were to contract with Aetna directly. Aetna's conclusion was that this scenario would create undesirable holes in particular specialities and perhaps service areas. Under the same scenario Aetna was also "very concerned" with the fact that many of its members, especially "given their national client base," would complain that his/her doctor was no longer in the network. Aetna had concerns that this scenario would risk both utilization and quality. (CX0525; Jagmin, Tr. 1000-1002).

305. In these internal Aetna discussions NTSP was perceived as representing the "majority of the preferred SPECs [specialists] in Ft. Worth," and specialist-dominated. (CX0525).

306. Aetna wanted NTSP to take obstetrics and gynecology (OB-GYN) risk, but NTSP replied that it did not have OB-GYNs within its network and did not want to assume the risk. (Jagmin, Tr. 1115).

307. Aetna's position was that in order to have effective clinical integration it was important to include primary care physicians of all sorts, obstetrics and gynecologists (OB-GYNs), and pediatricians in the global capitated entity, because a lot of care is generated in those areas,

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[2]When Aetna performs an analysis designated to look at relative efficiency it controls for 67 variables, such as: age, sex, past medical history, plan design, type of product, geography, presence of chronic diseases, presence or absence of certain medication usage in relation to those diseases, member's medical history, previous events, allergies, race, type of speciality care, and more. (Jagmin, Tr. 1096, 1101).

particularly in normal child birth and pediatrics. Without those types of physicians in the network, care can become fragmented, members get caught in the middle, and the exchange of information regarding the patient is harmed. Also, without those types of physicians, the capitated entity tries to avoid the additional cost associated with referring the patient to outside specialists, even if this treatment is the most appropriate. (Jagmin, Tr. 1112-1114).

308. Roughly 30% of hospital days are consumed by OB-GYNs issues, and the large cost associated with that requires coordination between primary care physicians, specialists and OB-GYNs. Customers are interested in "one-stop shopping," where all care will be delivered by one entity. (Jagmin, Tr. 1114-1115).

309. Therefore, the lack of OB-GYNs in the NTSP risk contract was another reason for Aetna to view the deal with NTSP as less attractive. (Jagmin, Tr. 1115-1116).

310. According to the minutes of an August 2, 2000 general membership, NTSP members were informed that negotiations were ongoing with Aetna, and that each member "will be asked to reconfirm their agency agreement with NTSP in relation to Aetna agreement." (CX0178).

311. In a Fax Alert dated August 7, 2000, Van Wagner informed NTSP member physicians that "NTSP has started negotiations with Aetna in regards to a risk and non-risk contract. As of this date, a term sheet has been received and is being reviewed. It is the goal of both parties to implement a new contract effective January 1, 2001. Given the stages of our negotiation, NTSP will know in approximately thirty days whether or not a direct contract with Aetna will be in the best interest of its members." NTSP asked its members to allow NTSP to continue discussions with Aetna for the next thirty days with the goal of identifying any "deal buster points." (CX0942).

312. NTSP's August 7, 2000 Board Minutes stated that, "[a]s a result of conversations with Aetna on Friday, both parties have agreed to a thirty-day time frame for negotiations. After Board discussion, two major points to be emphasized were reserve requirement and the need for a fee schedule comparable to MSM." (CX0061 at 5).

313. At the October 2, 2000, general membership meeting, NTSP reported that "A motion was made, seconded and amended for NTSP to accept responsibility for Aetna negotiations when power of attorney assignments are received from at least 66% of the NTSP physician providers. . . ." (CX0179).

314. Aetna preferred to sign a global capitation risk deal similar to the contract it had with MSM, over a fee-for-service deal, since, among other reasons, the MSM global capitation deal was performing the most favorably in Tarrant county and better than a number of fee-for-service deals that Aetna had in Tarrant county. (Jagmin, Tr. 994-995; CX0525).

315. Aetna decided to offer NTSP the same terms it had with MSM because: (1) Aetna knew

that NTSP was familiar with the terms of the MSM-Aetna contract, and therefore could not offer a lower risk contract; and (2) Aetna thought that offering a better deal to NTSP would risk its relationship with MSM and thus the coverage of about 115,000 patients under that contract. (Jagmin, Tr. 996-997).

316. Aetna and NTSP were interested in reaching an agreement by October 2000, in order to best accommodate Aetna's need to put its network together before the end of the calendar year and the "open enrollment season," when its patient-members re-enroll and typical changes in membership occur. (Jagmin, Tr. 990-991).

317. From Aetna's experience, network stability was very important to its customers – both employers and employees. (Jagmin, Tr. 1001-1002).

318. An October 5, 2000 Fax Alert reported of the October 2, 2000 general membership meeting: "A motion was made and passed that 66% of all affected NTSP physicians should agree to NTSP's role as agent or attorney in fact regarding this matter. Attached to this fax is a copy of Power of Attorney for each member's consideration. If you wish NTSP to represent you as your attorney in fact regarding your contracts with Aetna US HealthCare please sign below and fax return to the NTSP offices. . . ." The Attached Power of Attorney appointed NTSP to act as the signatory attorney in fact with respect to "all contracts and agreement (including without limitation all prospective contracts or agreements)" with Aetna, MSM and other entities. (CX0347 at 1-3).

319. In October 2000 the risk negotiations between NTSP and Aetna reached a dead end. (Jagmin, Tr. 1006-1007; CX0540 at 4). (Jagmin, Tr. 1008). (Jagmin, Tr. 1009; CX0540 at 4).

4. In Late 2000, NTSP Began Focusing on a Non-Risk Contract in its Negotiations With Aetna, and Continued to Negotiate Price

320. In late 2000, NTSP began negotiating a non-risk contract with Aetna. (Jagmin, Tr. 1004-1005). (Jagmin, Tr. 1030; CX0717 at 4). (CX0544 at 3).

321. In these negotiations, NTSP sought to negotiate rates for anaesthesiologists. Aetna's initial offer of $40 per unit for anesthesia was countered by NTSP proposed rates of $46-$48. (Jagmin, Tr. 1034-1035, 1045; CX0544 at 3).

322. Dr. Jagmin rejected NTSP's offer in an October 20, 2000 letter, and stated that NTSP's counter offer for anesthesia was too high. (CX0540 at 4; Jagmin, Tr. 1017).

323. Aetna and NTSP had a series of back and forth negotiations on rates for primary care physicians. (Jagmin, Tr. 1010-1016; CX0540 at 4).

324. Van Wagner asked "if there was any possibility of increasing those rates," by writing to

Dr. Jagmin: "we are having pcp meeting in the next couple of weeks... your cap proposal is probably going .. to come in too low for most to consider . . . even with the ffs add ons [*sic*].. however, we continue to get significant interest in the ffs option. . . before we close the cap option off completely is there any movement that you have on these figures. . ." (CX0558 at 2 [*capitalization, spacing, and incorrect ellipses are as in original*]; Jagmin, Tr. 1053-1054).

325. Aetna's offer to NTSP at that time aggregated to about 123% to125% RBRVS for PPO and about 111%/112% RBRVS for HMO. (Jagmin, Tr. 1022-1024).

326. NTSP did not present Aetna's rate offer to its member physicians because it fell below the Board's minimums. (Van Wagner, Tr. 1927-1928).

327. Dr. Jagmin met with NTSP's Board, had conversations with Board members and with Van Wagner and Palmisano, in which both physicians and staff conveyed to him their wish to get an HMO reimbursement rate of 125% of RBRVS. (Jagmin, Tr. 1021-1022).

328. NTSP countered Aetna's rate offer with 140% of current RBRVS for the PPO. (Jagmin, Tr. 1023, 1033-1034).

329. NTSP continued to demand 140% for PPO in an October 24, 2000 e-mail to Dr. Jagmin: "[P]lease confirm that your group ppo rate of 140% of current medicare is available to ntsp physicians if the ipa agreement is to cover both products. . . ." (CX0543 at 3-4; Jagmin 1040-1041).

330. Also, NTSP offered "an across the Board uniform rate," instead of the different rates to each speciality that Aetna initially had offered. Thus NTSP wrote to Dr. Jagmin on October 24, 2000, "we are running divisional analysis on the ffs data you sent via email today and will share that with our divisions this week...the fee schedule contains considerable variations...we would propose as an alternative an across the Board uniform rate as a more desirable approach that could also be budget neutral....3....am assuming that the fee schedule you sent would apply to all specialties including pcps...if that is not correct please advise....." (CX0543 at 3-4).

331. Aetna was concerned that NTSP's "across the Board" approach, which dictated one rate to all specialties, would impose overpayment to some NTSP specialties, while other NTSP physicians would choose not to participate in this contract on the basis of underpayment, and Aetna would have to contract with these physicians individually at the appropriate higher rate. (Jagmin, Tr. 1031-1032).

332. Despite Aetna's concerns regarding an "across the Board" rate, during the negotiation process Aetna decided to increase its HMO offer and abandoned its "reasonable equitable fee schedule" methodology, to across the Board 116% RBRVS of current year, to "salvage the deal." (Jagmin, Tr. 1076-1077).

333. On November 1, 2000, Van Wagner e-mailed to Dr. Jagmin: ". . . .chris. thanks...on the ppo anesthesia rates...what is your assessment of market for their services...also did we get a confirm on the rates for other physicians to be the 140 of current medicare as based as some factor increase on the hmo fee schedule...kvw. " (CX0544 at 2).

334. Aetna at this time was concerned about losing physicians because it was late in the enrollment period. (Jagmin, Tr. 1060-1061 (referring to NTSP, "we were – had to face the possibility of either capitulating on rate terms or seeing a relatively public group of physicians, large group of physicians walk out our network at a very inappropriate time of the year"); 1067-1068,1041). Aetna's concerns grew when Dr. Jagmin talked to physician groups to contract with them directly and they referred him back to NTSP as their bargaining agent. This reinforced Aetna's belief that it could not contract around NTSP. (Jagmin, Tr. 1042-1044 (verbal acts)).

335. Therefore, Aetna decided to accept NTSP's counter offer of 140% of current RBRVS for PPO, thinking it would allow it to "at least hold the line on [its] HMO based business." (Jagmin, Tr. 1041-1042).

336. Thus, on November 2, 2000, Aetna accepted NTSP's counter proposal of 140% for PPO, while holding to Aetna's position regarding the anesthesia rates. (CX0544 at 2-3 (Dr. Jagmin letter to Van Wagner: "Upon further consideration, I am willing to offer 140% for non-hmo based products, predicated on REF [Aetna's standard 'reasonable and equitable' fee schedule] for [FFS] HMO-based products. I must hold firm on the anesthesia rates.")).

337. At Van Wagner's request, Dr. Jagmin reiterated Aetna's offer for Anesthesia: "$40/unit." (CX0544 at 2; Jagmin, Tr. 1045).

338. As NTSP and Aetna continued to discuss the contract and the rates associated with it, powers of attorney were obtained by NTSP. (Jagmin, Tr. 1029).

339. Van Wagner sent Aetna a roster of physicians who had signed powers of attorney "delegating NTSP as the organization that would conduct negotiations for them." (Jagmin, Tr. 1029; CX0534).

340. Dr. Jagmin asked both physicians and NTSP staff about the powers of attorney and was told that the powers of attorney also assigned to NTSP *direct* contracting efforts between Aetna and physicians. (Jagmin, Tr. 1029).

341. On November 10, 2000, Van Wagner informed Dr. Jagmin that NTSP had sent approximately 180 powers of attorney from NTSP member physicians to MSM, stating that: "have a few more are wandering in and some of our members wish to send their own correspondence directly which is of course their option... given that the power of attorney covers any direct contracting with Aetna as well. I will also send you a packet." (CX0558 at 2).

342. This e-mail, a copy of the blank power of attorney that was sent to Aetna, and discussion between NTSP and Aetna conveyed that the powers of attorney "covered any sort of contracting relationship" and any contract term, including price terms, between NTSP member physicians and Aetna. (Jagmin, Tr. 1058-1059).

343. Van Wagner informed Dr. Jagmin that with these powers of attorney, NTSP would be representing any member physicians if Aetna would not contract with the IPA. (Jagmin, Tr. 1051).

344. Consequently, Aetna believed that "we were now losing our last option with the physicians, which was to contract directly with them because we read this very clearly that whether we did an IPA deal or not, NTSP was going to represent each one of those individual physicians or physician group in a contract negotiation. And to us, that was very concerning because we felt this was even more pressure to do a – an IPA deal and to agree to contract rate terms that we felt were above market." (Jagmin, Tr. 1058, 1060).

345. Although Dr. Jagmin expressed concern that the powers of attorney covered price terms, neither Van Wagner nor anyone associated with NTSP disabused him of that view. (Jagmin, Tr. 1059-1060).

346. In the November 10, 2000 e-mail, Van Wagner informed Dr. Jagmin that she thought that Aetna's PPO fee schedule of 140% of current medicare would be "well received when we messenger it out by all except anesthesia...as you know their contracting minimums on PPO rates were not met." Dr. Jagmin understood that most member physicians would accept the 140% rate for PPO but that no anesthesiologist would sign up under the contract. (CX0558 at 2; Jagmin, Tr. 1052).

347. In addition to negotiating actively on behalf of competing physicians, NTSP also contacted health plan brokers and customers in order to pressure Aetna to raise rates. For example, at the instigation of NTSP, Blake Woodward, a broker, sent the following message to the brokerage community in late 2000: "Subject: URGENT ALERT: AETNA LOSES ITS BEST TARRANT COUNTY SPECIALISTS! Dear Colleagues: I have just received notice that North Texas Specialty Physicians, which includes 230 of the top specialists in Tarrant County, has just dropped off the Aetna network.. . . It is my understanding that NTSP has been negotiating with Aetna for some time to get their own contract independent of Aetna's contract with the powerful Medical Pathways IPO (also called Medical Select and formerly Harris Select). If this is true, it is bad news for Aetna, because these are the docs that handle most of the adult specialty care in Tarrant County. I suggest that everyone contact your Aetna rep and find out what the facts are and put the heat on Aetna to resolve this situation." (CX0560 at 2). *See also* (CX0559 at 1).

348. Aetna was extremely concerned. *See* (Jagmin, Tr. 1089 (It was troubling "[T]o have the people that sell our business believe that a group of physicians was leaving suddenly and to find out such event not from us.").

349. Aetna contacted Woodward, and based on Woodward's statement that he had received the information from an NTSP Board member, Aetna immediately started calling brokers and employers in order to tell them that the negotiations with NTSP "appeared not to be going well and while we continued to negotiate in good faith, it may not work out." (Jagmin, Tr. 1089-1091. (Woodward's statement not for truth.))

350. Aetna also reconsidered its rate offer to NTSP because it was obvious that the information alluding to the departure of NTSP physicians from Aetna's network would have "a very deleterious effect" on Aetna's "ability to sell business in Tarrant County." (Jagmin, Tr. 1091).

351. On November 20, 2000, NTSP sent Aetna an e-mail: "North Texas Specialty Physicians' (NTSP) 260 doctors have treated Aetna patients for over ten years....We are pleased that Aetna has contacted us in an effort to work out the details for a direct contracting relationship....If a direct contracting relationship between NTSP and Aetna is accomplished, all of Aetna's PPO lives will be served directly by NTSP physicians. In addition, approximately 15,000 of the 100,000 Aetna HMO covered lives will have direct access to NTSP doctors. The remaining approximately 85,000 Aetna HMO covered citizens are contracted through Medical Select Management's Aetna contract. As of today, NTSP has notified Medical Select Management that under current contractual conditions, NTSP physicians can no longer participate." (CX0559).

5. NTSP Continued to Negotiate Non-risk Fee-for-Service HMO Rates

352. On November 21, NTSP wrote to Aetna: "Attached you will find a Summary Term Sheet for NTSP/Aetna group contract. The purpose of this term sheet is to identify important variables that have either been agreed upon or are still in the discussion phase. . . . I would like to share this with our General Membership tonight as a status report." (CX0561; Jagmin, Tr. 1072).

353. Attached to the NTSP letter was a term sheet in the form of a table representing "the state of the negotiations between NTSP and Aetna." The table compared the parties' HMO offer and counter-offer at that time: NTSP's position of "Across the Board 125% of current Medicare" versus Aetna's position: "Across the Board 116% of current Medicare." The term sheet was also a manifestation of Aetna's earlier capitulation to NTSP's PPO demand of 140% and the parties' inability to reach an understanding on the anesthesia rates. (CX0561; Jagmin, Tr. 1071-1072).

354. At this point in the negotiations, NTSP and Aetna mainly disagreed over the HMO rate and bundling logic issues that affected the pricing of the product. (Jagmin, Tr. 1073-1075).

355. On November 17, 2000, NTSP updated its Division Chiefs on the Aetna negotiations and fee schedule and received feedback. (CX0193).

356. NTSP also discussed its negotiations with Aetna at a general membership meeting on November 21: "Aetna's response and the NTSP public position was discussed as she [Van Wagner] prepared the group for what is expected to occur next." (CX0180).

6. As Part of the Joint Negotiations, NTSP Re-Polled its Members to Establish Minimum Compensation Rates

357. On November 29, 2001, NTSP sent Fax Alert #81 to its members stating that Aetna's offer was 116% of RBRVS for the FFS HMO, and further stated: "In keeping with the minimum compensation standards as conveyed from the membership earlier this year, the PPO offer... approximates an acceptable minimum standard. The minimum standard previously shared by the membership on an HMO product is 125%... or approximately 9% less than Aetna's present offer. Anesthesia rates for both the HMO and PPO are priced at $40 per unit... .Because this is a fee-for-service offering falling below the minimum as previously shared via the messenger model to NTSP Board, we are re-polling the membership on the acceptability of the present Aetna offering. Please check in the space below what your minimum acceptable range of compensation for the Aetna HMO product is." (CX0565 at 1).

358. The polling ballot listed ranges of rates for selection by NTSP's members. NTSP put down Aetna's offer amount (116 percent) as the lowest minimum acceptable compensation that its physicians could choose. (CX0565 at 2; Van Wagner, Tr. 1929-1930).

359. As reported at NTSP's December 4th Board meeting, sixty-one responses had been received with the majority choosing the 121%-130% range. At the meeting it was also noted that the termination of the contract with Aetna through MSM would be carried through in 13 days. (CX0074 at 4).

360. On December 8, NTSP conveyed the poll results to Aetna: "the numbers on the messenger model return for the hmo product are as follows...mean: 124.89% of current medicare; mode 127.38% of current medicare; median 123.70% of current medicare." NTSP wrote to Aetna that those numbers were essentially a repetition of the NTSP counter-offer of 125%. (CX0571).

361. Aetna then convened an internal meeting and concluded that increasing its offer by 9% to match NTSP's counter offer-meant losing money on NTSP HMO services. (Jagmin, Tr. 1080).

362. On December 11, NTSP sent Fax Alert #84 to its members, containing the following statements: "The membership's message that a 125% of current Medicare HMO fee schedule is required has been transmitted to Aetna and a response on this final contractual item is expected within the next 24 to 36 hours... .**NTSP Continues To Act As Your Agent Both With Aetna Direct And With MSM. At This Point, No Further Action Is Required On Your Part...** Please refer all contacts and materials received from either Aetna or MSM to NTSP directly." (*emphasis in original*) (CX0500; CX0573).

7. Under Pressure Orchestrated by NTSP, Aetna Capitulated "After NTSP Threatened to Term the Entire NTSP Network." (CX0256)

363. NTSP continued to lobby third parties to pressure Aetna to reevaluate its position. On December 12, 2000, David Palmisano wrote to NTSP's primary care physicians asking them,"[a]s part of our Aetna negotiation," to send faxes to Texas Insurance Department Commissioner Jose Montemayor, and to raise concerns regarding "NTSP no longer participating with the Aetna HMO," because "without NTSP specialists in the Aetna network a severe network inadequacy problem will exist in Fort Worth." Palmisano included a sheet of bullet point statements to be included in the faxes, including the following statements regarding NTSP's departicipation from Aetna's HMO product:

- "approximately **240 NTSP specialties** representing **21 different specialties** will no longer be participating providers for the Aetna HMO."
- Primary Care Physicians contracted directly through Aetna US Healthcare or Medical Select **<u>will not have the ability to make necessary Referrals</u>** to these physicians and existing patients who are currently receiving care from these physicians will be re-directed and disrupted."
- "Aetna and Medical Select will have **<u>an inadequate network</u>** to provide **medically necessary service to approximately 100,000 Aetna HMO covered lives in Fort Worth**."
- "Many patients have chosen the Aetna HMO through recent open enrollment and these specialists were represented to be part of the network." *(emphasis in original)* (CX0576).

364. As a result of NTSP's directive, its member physicians did send letters to Commissioner Montemayor. For example, one NTSP member wrote the following to the Commissioner: "I also belong to a local physician IPA known as North Texas Specialty Physicians (NTSP) whose organization is wholly based here in Fort Worth. This network is composed of physicians representing all specialties throughout Fort Worth. NTSP is currently seeking a direct contract with Aetna at the <u>current</u> rate Aetna is paying for these services. Obviously a provider network whose business is based <u>entirely</u> here in Fort Worth is better positioned to address the needs of both patient and physicians. Many of us at NTSP will terminate our existing contracts with Aetna administered through MSM effective December 17. Such wholesale termination will result in significant physician provider panel deficiencies within our geographic area and disrupt physician patient relationships that have been mutually satisfying for years. Please assist me in continuing to provide care to my Aetna patients by contacting Aetna to review the status of current negotiations. . . ." (*emphasis in original*) (CX0583 at 1-2).

365. Another NTSP member, James F. Parker, M.D., who was the President of Texas Health Care wrote to the Commissioner: "[I]n portions of our community, not having NTSP specialists will require patients to have to go to hospitals where the PCP is not available to participate in the patients' care." The letter stated that NTSP specialists "represent the 'cream of the crop' for

specialty care for patients in our community." (CX0584).

366. In December 2000 the Texas Department of Insurance called Aetna's Regional Manager to express concern that the loss of NTSP would cause adequacy problems in Aetna's network. (Jagmin, Tr. 1091-1092).

367. In response to NTSP's physician letters, the Texas Department of Insurance also sent Aetna a letter calling into question the adequacy of its network. (CX0586).

368. As a result of the Texas Department of Insurance's expressions of concern, Aetna had internal discussions regarding "the rates that we [Aetna] were willing to ultimately accede to." (Jagmin, Tr. 1093-1094; Jagmin, Tr. 1070-1071).

369. NTSP wrote to Aetna on December 12 to inform it that Van Wagner had "polled the Board informally today" and that the NTSP Board "would urge aetna [*sic*] to reconsider their position on not accepting the members [*sic*] poll results on compensation for the hmo direct contract." (CX0578).

370. On December 13, after being instructed by his general manager and regional manager to reject the HMO terms and to attempt to finalize a PPO only contract, Dr. Jagmin replied to NTSP, agreeing to proceed with the PPO contract and stating that "the physician expectations for the HMO contracts are not acceptable to Aetna and are rejected." (CX0580 at 1). *See also*, (CX0582 at 1); Jagmin, Tr. 1082-1083).

371. On December 15, NTSP received Aetna's final proposed IPA agreement which repeated Aetna's position: "Per your discussion with Chris Jagmin, MD, non HMO based products to be paid at 140% of then current RBRVS per the Fort Worth, TX geographic locality. Anything with no established rate is paid at Company's then current Reasonable Equitable Fee Schedule (REF). Anesthesia services at $40 per unit." (CX0660).

372. Aetna consumers were not satisfied with Aetna having only a PPO contract while losing NTSP as its HMO providers, and expressed their concerns to Aetna. (Jagmin, Tr. 1082).

373. The conflict between NTSP and Aetna received significant publicity in the marketplace. (Jagmin, Tr. 1081-1092, 1005-1006). Aetna received "calls from large employers in Tarrant County such as the Arlington independent school district," expressing their concern about the loss of NTSP's physicians from Aetna's network.. (Jagmin, Tr. 1094) (*not admitted for truth*). Pressure from employers and brokers during open season ultimately caused Aetna to capitulate to NTSP rate terms. (Jagmin, Tr. 1083).

374. On December 18, 2000, Van Wagner reported to the NTSP Board that the PPO arrangement had been completed. Van Wagner referred the Board to a letter from Commissioner Montemayor concerning complaints that the Texas Department of Insurance had recently

received from physicians. Van Wagner further "reported that NTSP will continue to **negotiate** with Celina Burns [General Manager] of Aetna on an HMO contract. There was a lengthy discussion on an acceptable fee schedule. The membership's response when polled was 125%. The Board instructed NTSP to present 125% on a direct contract." (*emphasis in original*) (CX0076 at 2-3).

375. Later that day Van Wagner wrote to Aetna's Burns: "[A]s followup [*sic*] to our conversation this afternoon, ntsp"s (sic) proposal is as follows 1. PPO...at 140% of current medicare; anesthesia at $45.00; fee schedules adjusted every April of the new year; hcpcs at 100 percent of medicare; non-medicare codes at 100% of aetna ref for ppo...status: completed; awaiting signature copy to be delivered to ntsp offices today 2. Direct HMO... 125% of current medicare; anesthesia at $43.00; fee schedules adjusted every April [*sic*] of the new year; hcpcs at 100 percent of medicare; non-medicare codes at 100% of aetna ref for hmo...status: base document completed...can be easily changed to include direct component." (CX0585 at 1-2 [*capitalization, spacing, and incorrect ellipses are as in original*]).

376. Ultimately, Aetna capitulated to NTSP's terms. Aetna backed off of every rate it had offered in its initial offer: HMO, PPO, anesthesia, and HCPC. On December 19 it wrote to NTSP: "In follow-up to our recent discussion we are proposing the following: 1. Direct HMO reimbursement at 125% of current medicare; anesthesia at $43. . . . 3. PPO reimbursement at 140% of current medicare; anesthesia at $45 . . . . HCPC's at 100% of medicare. . .I look forward to talking to you following your polling the NTSP Board as well as physician member's [*sic*]." (CX0585 at 1).

377. The December 18-19 correspondence between Aetna and NTSP not only represented HMO and anesthesia fee negotiations, but also demonstrated that price negotiations had occurred regarding HCPCs – a set of coding technology used to describe drugs, durable medical equipment and medical supplies. Aetna's typical reimbursement methodology for these codes was its REF fee schedule that was lower than Medicare. Aetna tried to hold on to this position but eventually capitulated and accepted NTSP's position to pay at the higher Medicare rate. (Jagmin, Tr. 1084-1088; CX0591).

378. NTSP responded to Aetna on December 19th: "...ntsp Board members who I have been able to reach since we talked this morning all appreciate aetna's willingness to work with us and agree that your proposal is fair and a good faith effort. . . . 3. a notice will go out to our members today notifying them that the ppo and hmo direct portions have been completed within their messenger minimums...tommorrow [*sic*] they will be informed that they have the following contracting choices... 1. they can choose not to participate in any offering through ntsp. . . [*sic*] 2. they can choose to participate in the ppo and direct hmo offerings or 3. they can choose to participate in the ppo, direct hmo and delegated ipa hmo offering. . . [*sic*] this last choice is of course depndant [*sic*] on their accepting the new minimum for this product. . . which I believe the Board will be willing to recommend they do from my conversation with them today." (CX0589).

379. In a fax alert sent to NTSP member physicians the same day, NTSP notified its members that their joint strategy had been successful in raising the level of reimbursement. NTSP reported that Aetna and NTSP had reached a new contract and its "important provisions" are "1. PPO PRODUCT - 140% OF CURRENT MEDICARE; ANESTHESIA AT $45 PER UNIT. 2. DIRECT HMO 125% OF CURRENT MEDICARE; ANESTHESIA AT $43 PER UNIT." It concluded: "[a]s always, we appreciate our members' support regarding these matters." (*emphasis in original*) (CX0586 at 10).

380. NTSP forwarded the new contract to its members. (CX0597; CX0615 at 1). Ultimately, 188 NTSP member physicians signed the NTSP-Aetna contract. (Jagmin, Tr. 1088).

381. The rates in the 2000 Aetna-NTSP contracts were higher than rates from other IPAs providing similar services. (Roberts, Tr. 472-473).

8. For the Next Contracting Period, Aetna Attempted to Renegotiate a New Contract at Lower Rates

382. David Roberts is employed by Aetna Health, Inc., as a network vice-president. He has worked for Aetna Health, Inc. (or another subsidiary of the national company) since 1999, when Aetna acquired Prudential. Prior to 1999, he worked for Prudential. In May 2001, he assumed responsibility for contracting with physicians in the north Texas area. (Roberts, Tr. 468-470).

383. On July 10, 2001, Dr. Vance's practice group, Consultants in Cardiology, recorded the following from their Board of Directors Meeting, "Aetna is now offering a 95% of Medicare contracts for all commercial business. This contract was not presented to a solo practitioner, but to Texas Oncology, a very large corporate entity. This aggressive contracting by Aetna bodes ill for any small entities attempting to contract with Aetna this year. <u>NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term the entire NTSP network last year.</u> As I have argued for a number of years, physicians divided will be cannon fodder in this business. The hope that the Cardiology IPA will protect us from these gorillas is unrealistic. Even a 700 doctor organization such as NTSP may make only a ripple in the water in the coming days but is much more effective than any other organization at this time. Without NTSP's influence this last two years, our market level of reimbursement would be significantly below its present level." (*emphasis added*) (CX0256).

384. On August 10, 2001, NTSP submitted its proposal to Aetna for fee-for-service products. (CX0616; Roberts, Tr. 483-487).

385. NTSP proposed retaining the same rates of 125% for HMO and 140% for PPO for an additional three years, even though those rates were higher than those of similar IPAs, and even though the market had changed dramatically. (Roberts, Tr. 472-473, 488).

386. On September 28, 2001, Roberts wrote to NTSP, stating Aetna's intention to continue

discussions to finalize a mutually acceptable new agreement before the end of 2001, to commence on February 1, 2002. The letter terminated Aetna's existing agreement with NTSP effective January 31, 2002. (CX0644; Roberts, Tr. 489-490).

387. The renegotiation between Aetna and NTSP involved only non-risk components. (Roberts, Tr. 487).

388. On October 8, 2001, the NTSP Board reviewed Aetna's termination letter and decided to continue negotiations with Aetna. (CX0102 at 1-3).

389. Van Wagner informed the Board that Aetna's new proposed rates would be lower and that negotiations would be arduous. (CX0102 at 1-3).

390. On October 15, 2001, the NTSP Board received and accepted the results of NTSP's membership poll. The NTSP Board instructed NTSP staff to use the minimums of 125% HMO and 140% PPO of current Medicare. (CX0103 at 4-5).

391. On October 29, NTSP shared the poll results with its members by Fax Alert and at a general membership meeting at which members also received an update on the ongoing Aetna negotiations. (CX0186; CX0303).

392. On October 30, Aetna proposed a new contract with NTSP, under which NTSP members would be contracted at Aetna's "Market Based Fee Schedule" (85% 115% HMO and 95% 129% Non-HMO). The proposal included a 10% specialist incentive for "steerage," based on physician referrals, to preferred centers. (CX0629); Roberts, Tr. 492-493).

393. NTSP never distributed this offer to its membership, lacking Board authority to do so. *See* (Van Wagner, Tr. 1713-1714; Roberts, Tr. 495).

394. On November 5, NTSP's Board "reviewed Aetna's latest proposal along with NTSP's counter offer." (CX0104 at NTSP at 2-3).

9. During this Negotiation Process, Aetna Found NTSP's Efficiency Claims Not Credible

395. On November 1, 2001, NTSP sent utilization data to Aetna and in an attached letter advocated against a decrease in NTSP's current fee schedule. NTSP stated: "Although NTSP's current fee schedule is higher than that proposed by Aetna at the unit cost level, budget to actual PMPM [per member, per month] historical figures indicate that significant savings will accrue to Aetna given historical utilization patterns of NTSP physicians." (CX0553).

396. Aetna believed it was "critical to [their] organization" to determine if NTSP's efficiency claims were valid. Aetna believed that, "if, in fact, there were efficiencies and we couldn't come

to terms [with NTSP], then when those services went to other physicians in the marketplace, then the costs would actually go up. . . . so it was critical to us [Aetna] that we do an in-depth review of this data and try to determine if there were efficiencies and, if there were, to make sure this contract continued." (Roberts, Tr. 497).

397. In evaluating NTSP's efficiency claims, Aetna adjusted for between 10-25 variables, including age, sex, severity of illness, plan design, co-pays, and co-insurance. (Roberts, Tr. 502-503, 508).

398. Aetna spent approximately two months, from early September to early November 2001, analyzing NTSP's efficiency claims. For those two months, two Aetna employees, David Roberts and John McGinnes, each spent approximately 30 hours a week analyzing NTSP's claims. Other functional areas within Aetna also participated in the analysis. (Roberts, Tr. 503-504).

399. After its exhaustive analysis, Aetna could not validate NTSP's claims of clinical efficiencies. (Roberts, Tr. 504-505).

400. Aetna found that NTSP's efficiency claims failed to account for numerous variables, including severity of illness, age, sex, plan design, co-pays, co-insurance, and mental health services. (Roberts, Tr. 507, 505, 508-511).

401. The limited information NTSP provided to Aetna data derived from its risk contract with one health plan – PacifiCare, and it did not provide the underlying data. (Van Wagner, Tr. 1911-14; Roberts, Tr. 507, 520-521, 578-89).

402. NTSP never tried to cure the gaps in the data. (Roberts, Tr. 527).

403. Aetna based business decisions on its evaluation of NTSP's claims. Had Aetna found NTSP's claims to be valid, Aetna would have offered NTSP a higher rate. (Roberts, Tr. 506).

404. Aetna was confident in its final evaluation that there was no efficiencies justification to pay NTSP higher than market rates. (Roberts, Tr. 528).

405. In evaluating NTSP's efficiency claims, Aetna used the best data that was available to it. (Roberts, Tr. 581).

406. NTSP never gave Aetna data suggesting that NTSP performed at a higher level than the general community of Tarrant County physicians. (Roberts, Tr. 582, 513).

407. On other occasions Aetna has paid physicians a higher rate based on their performance. (Roberts, Tr. 519-520).

408. NTSP rejected Aetna's proposal for a 10% fee increase for some specialties solely because the reimbursement methodology would not be applied to all of NTSP's physicians. NTSP gave Aetna no data indicating that the specialties not offered a 10% increase merited the increase. (Roberts, Tr. 523-524).

409. On November 6, 2001, Aetna informed NTSP that the data NTSP presented as a stand-alone entity is not "credible" in actuarial terms. Aetna further informed NTSP that an analysis of its own data did not support NTSP's conclusions: "In light of this review of our data, we can not identify significant management objectives that would require any adjustment to proposed fee schedule. Based on your review of Aetna's proposal, the proposal produces an aggregate of 118% of Tarrant County Medicare for the HMO platform. We believe Aetna's reimbursement proposal is fair and is consistent with our overall objectives for 2002." (CX0501; Roberts, Tr. 502-503, 524-527).

410. On November 7, NTSP replied that although negotiations would proceed, "[t]o ask high performing physicians to take pay cuts because others have not done as well will be a difficult sell." NTSP also noted that Aetna would meet with the NTSP Board. (CX0502).

411. On November 12, John McGuinness and David Roberts from Aetna attended a NTSP Board meeting and addressed Aetna's proposal. Aetna offered an overall reimbursement average of 118% for the HMO product and 133% for the PPO contract. (CX0106). At that Board meeting, NTSP proposed a compromise between the parties at a rate level in the low 120s, which was below NTSP's offer of 125% but above to Aetna's offer of 118%. (Roberts, Tr. 537-539). At that same Board meeting, NTSP informed Aetna that NTSP had collected signed powers of attorney from it members. (Roberts, Tr. 540-541).

412. The NTSP Board alerted the membership that the Aetna contract was under advisement. (CX0106 at 3).

413. After this Board meeting, NTSP did not distribute Aetna's offer to its physicians. (CX0503; Roberts, Tr. 542-543).

414. On November 19, "The Board reviewed Aetna's latest proposal to NTSP. Dr. Van Wagner reported that it was essentially the same proposal which was less than the minimum that the membership has messengered as acceptable. The Board discussed NTSP's next steps are to request that Dr. Cheek and Blanford of Aetna meet with NTSP's Board to review their proposal." (CX0107 at 2-3).

415. On December 3, Aetna wrote to NTSP informing it that NTSP's current level of reimbursement was not competitive and termination of the Aetna-NTSP agreement would be effective on January, 31, 2002. (CX0640).

416. On December 7, 2001, NTSP informed its member physicians that Aetna's proposal fell

"below payment rates our members have messengered to NTSP as acceptable to continue negotiations." NTSP informed its members that they may contract directly with Aetna or request that Aetna re-open negotiations with NTSP. (CX0643).

IX. NTSP's Collective Fixing of Fee-for-Service Prices is Unrelated to the Achievement of Any Meaningful Efficiencies

417. NTSP engages in certain utilization and quality control efforts in connection with just two health plan agreements: its capitated contract with PacifiCare, and, to a lesser extent, its HMO contract, but not its PPO contract, with CIGNA, (Van Wagner, Tr. 1830-1854). Only with respect to the PacifiCare contract do NTSP physicians share risk and a measure of integration capable of causing material professional cooperation, collaboration, and interdependence. *See* findings 56, 401.

418. Of particular importance, although NTSP has argued that some efficiencies spill over from its risk panel to its fee-for-service panel, price-fixing plainly would not be necessary to the accomplishment of those claimed spill overs. (Deas, Tr. 2577 (asserted spillovers from NTSP's risk to fee-for-service contracts are "completely unrelated" to NTSP's setting of minimum contract prices); CX1196 (Van Wagner, 08.29.03 Dep. at 145-146) (asserting that NTSP's greater efficiency justified imposition of higher prices, rather than fee minimums being necessary to achieve clinical integration). Frech, Tr. 1347-1351 (concluding that NTSP lacks need for collective negotiation of fee-for-service contracts, and any spill-over is unrelated to setting of Board Minimums and joint negotiation. Also concluding that price-fixing of non-risk contracts is not only unnecessary to any efficiency make them artificially attractive to physicians and reduce interest in risk contracting.)).

419. NTSP admits that its information systems do not include data for patients under its fee-for-service contracts, (Van Wagner, Tr. 1837-1841; 1877; Deas, Tr. 2487- 2488); that NTSP cannot identify physician utilization outliers within its fee-for-service panel, (Van Wagner, Tr. 1849-1850); and that NTSP does not provide feedback to physicians concerning patient care under its fee-for-service contracts. (Lonergan, Tr. 2722-2723).

420. NTSP further admits that NTSP's medical director has no responsibility for controlling costs for patients under its fee-for-service contracts (Deas, Tr. 2553); that NTSP's medical management committee does not evaluate the care of patients under NTSP's fee-for-service contracts (Deas, Tr. 2550-2551); and that NTSP's hospital utilization management program does not apply to patients under its non-risk contracts. (Van Wagner, Tr. 1837-1838).

421. Dr. Lawrence Casalino, Complaint Counsel's rebuttal expert in physician organizations and efficiencies, has assessed NTSP's efficiency-related claims. Dr. Casalino, who has an M.S. in public health and a Ph.D. in health services research (Casalino, Tr. 2779-2780), formulated his opinion with care and applied his unquestionable expertise with rigor. His opinions are entitled to substantial weight and are uncontroverted by any other person with relevant expertise.

422. NTSP is not clinically integrated for patients under its non-risk contracts. (Van Wagner, Tr. 1877; Casalino, Tr. 2877; Frech, Tr. 1351-1352). Even under its risk contracts NTSP has placed greater emphasis on controlling costs than improving quality. (Casalino, Tr. 2808-2809, 2811).

423. NTSP physicians who do not participate in NTSP's shared risk contract are unlikely to learn and apply techniques to control costs and to improve quality that are developed or learned in the context of that risk-sharing arrangement. (Casalino, Tr. 2859- 2860). *See also*, (Frech, Tr. 1353-1354). For an IPA to achieve significant "spillover" benefits from its shared-risk patients to its non-risk patients, it would need to apply organized processes to its non-risk patients. (Casalino, Tr. 2864-2865). IPAs can implement some organized processes to improve quality for patients under fee-for-service contracts, (Casalino, Tr. 2870-2871), but NTSP has taken no collective action as an IPA, and has initiated no organized processes, to improve quality for patient under its fee-for-service contracts. (Casalino, Tr. 2816).

424. NTSP is hindered in implementing organized processes for patients under non-risk contracts because it lacks data for these patients. (Casalino, Tr. 2868-2869; Frech, Tr. 1352-1353). With respect to its fee-for-service physicians and patients, NTSP does not operate or refer patients to any disease management programs or patient registries which would improve health care quality for patients with specific, long-term conditions such as diabetes or congestive heart failure. (Casalino, Tr. 2812-2814; Van Wagner, Tr. 1834-1835). (Disease management programs typically include a nurse case manager who maintains regular contract with each patient; monitors indices of each patient's health; ensures that each patient takes prescribed medications; directs each patient to specialist physicians; and encourages each patient to participate in relevant patient education programs. (Casalino, Tr. 2812- 2813).

425. With respect to its fee-for-service physicians and patients, NTSP does not make effective use of clinical guidelines and protocols to improve quality. NTSP does not require adherence to its clinical guidelines and protocols. (Van Wagner, Tr. 1843-1844). Moreover, to be effective, clinical guidelines and protocols must be distributed in a manner to make them easily available to physicians; reminders must be provided at the point of care to employ them; and physicians' adherence to them must be monitored. (Casalino, Tr. 2837- 2838, 2840). NTSP does not do these things. (Casalino, Tr. 2838-2839; Van Wagner, Tr. 1843-1844). Moreover, NTSP's clinical guidelines and protocols tend to be too lengthy to be effective to improve quality, (Casalino, Tr. 2838- 2839), and it appears in any event that most of the clinical guidelines and protocols adopted by NTSP were not developed by NTSP itself, but rather by textbook authors and local hospitals. (Casalino, Tr. 2838-2839).

426. NTSP does not have an electronic medical records system for its physicians' patients, which prevents it from implementing an effective reminder system for patient care at the point of care. (Casalino, Tr. 2839).

427. NTSP does not engage in meaningful patient education. The patient education features of its web site were created in 2004 and are largely limited to links to other public web sites. (Casalino, Tr 2844-2848).

428. NTSP has not improved quality by improving coordination of patient care between primary care physicians and specialists. (Casalino, Tr. 2848). NTSP's coordination of primary care physicians and specialists has been hindered by the circumscribed participation of primary care physicians in NTSP, (Casalino, Tr. 2848-2849, 2851-2852), the ineffectiveness of NTSP's Primary Care Council in improving quality, which meets only 2 to 4 times per year with attendance at its meetings averaging only 6 to 10, and provides little information about its activities to other NTSP physicians. (Casalino, Tr. 2850-2851).

429. Further, NTSP's stated goal of enhancing teamwork among its physicians involves few organized processes applicable to fee-for-service medicine. (Casalino, Tr. 2856-2857) NTSP's goal of enhanced teamwork among its physicians is hindered by the lack of pediatricians, obstetricians, and cardiologists in NTSP, forcing NTSP patients needing the services of these core specialties to seek physicians outside NTSP. (Casalino, Tr. 2854-2856; Frech, Tr. 1432).

X. The Testimony of Respondent's Experts is Not Entitled to Any Weight

A. Dr. Wilensky

430. Dr. Wilensky is expert in matters of national health care policy. (Wilensky, Tr. 2155).

431. However, Dr. Wilensky has had little exposure to the workings of physician organizations in general and NTSP in particular, *see* findings 433-434; and has very limited familiarity with the relevant facts of this case. *See* findings 432-434.

432. Dr. Wilensky has selectively reviewed background materials in the evidentiary record and has read or skimmed only some of the depositions taken. (Wilensky, Tr. 2157).

433. She has acknowledged that she does not know or fully understand many details about how NTSP and its physicians go about their business, (Wilensky, Tr. 2158); and that she is relatively unclear as to what NTSP does within the fee-for-service context. (Wilensky, Tr. 2199-2200).

434. In particular, Dr. Wilensky acknowledged that she does not know whether NTSP enrolls fee-for-service patients in its palliative care program, (Wilensky, Tr. 2200); whether NTSP enrolls fee-for-service patients in any quality improvement-related program, (Wilensky, Tr. 2200); whether NTSP's medical management committee discusses high acute cases among non-risk patients, (Wilensky, Tr. 2200); whether NTSP has any programs to manage prescription drug utilization, (Wilensky, Tr. 2201), although such controls are important to controlling overall medical costs (Wilensky, Tr. 2201); whether NTSP's disease registry program applies to non-

risk patients, (Wilensky, Tr. 2202); and whether NTSP seeks to limit its fee-for-service business to offers that activate a significant portion of its risk panel. (Wilensky, Tr. 2159-2160).

435. Accordingly, Dr. Wilensky's opinions in this matter cannot be accorded substantial weight.

B. Dr. Maness

436. Dr. Maness' expertise is in industrial organization in general. (RX3119; Maness, Tr. 2107). He lacks particularized expertise applicable to organization capital or physician organizations. (Maness, Tr. 2095-2098 (his publications are unrelated to organization capital or physician organizations); 1983-1984 (expertise in other areas, not including organization capital or physician organizations)); and Dr. Maness acknowledged on cross-examination that organization capital is not a field in which experts have testified in court. (Maness, Tr. 2099 (nor is organization capital a "field of expertise"); 2106 (nor a "discipline")).

437. Dr. Maness often was evasive or uncooperative during cross examination. This Court found it necessary to strike Dr. Maness' unresponsive testimony and instruct him to answer the questions posed not fewer than 13 times. (Maness, Tr. 2108-2109; 2119; 2125-2127; 2252; 2260; 2261-2262; 2264; 2266-2267; 2282-2283; 2285-2286; 2301-2303; 2308-2309; 2315-2318.)

438. Dr. Maness frequently testified that alternative answers to clearly relevant fact questions would have absolutely no impact on his opinions or the intensity of them. *See e.g.*, findings 450, 456, 458, 459, 461, 463, 467, 473. (Maness, Tr. 2223; 2231-2237; 2266; 2309).

439. In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. *See* findings 440-474. *See also, e.g.*, (Maness, Tr. 2116-2117; 2131; 2220-2221; 2250-2251; 2294-2295; 2264-2265; 2274-2275; 2300-2301; Maness, Tr. 2127-2130; 2218-2219; 2099; 2121-2123 (lack of independent verification); 2228 (failed to consider the possibility of selection bias)).

440. Dr. Maness conducted only a limited document review in this matter. (Maness, Tr. 2215-2216).

441. In numerous instances, Dr. Maness relied solely on statements of Van Wagner, a person intimately associated with the challenged conduct and greatly interested in the outcome of this proceeding, where means of independent confirmation were reasonably available. *See* finding 66. *See* (Maness, Tr. 2123-2124 (in general data discovery); 2125-2128 (whether Fort Worth NTSP hospitals had recruited physicians); 2127-2128 (whether any Fort Worth employer generally had recruited physicians); 2128-2130 (whether any health plan had recruited physicians to Fort Worth); 2321-2322 (information about coding practices of NTSP physicians); 2232-2234 (whether NTSP's non-risk business acts as an incubator for the risk-sharing panel)).

442. Dr. Maness testified that maintaining a common "core" of physicians is key to NTSP's organization capital; but he acknowledged on cross-examination that he did not know what he meant by "core." (Maness, Tr. 2121-2124).

443. Dr. Maness acknowledged on cross-examination that he never "actually consider[ed] whether market power could be exercised if the Ft. Worth area was a relevant market," because he "never considered Ft. Worth to be a possible relevant market." (Maness, Tr. 2219).

444. Dr. Maness testified that he had applied the 5% test set out for market definition in the Merger Guidelines; but he acknowledged on cross-examination that he never talked to health plans, employers, brokers/consultants, or physicians, (Maness, Tr. 2224-2225), nor did he ask NTSP's counsel to propound relevant questions at any depositions. (Maness, Tr. 2237-2238).

445. Dr. Maness claimed to have "actually stud[ied] the question of whether Fort Worth area employers would substitute" Arlington for Fort Worth doctors in response to a 5% relative price increase; but he acknowledged on cross-examination that he conducted no "systematic" or "data" analysis of the matter, nor did he ask any health plan, employer, consultant, or broker about substitution in response to relative price increase. (Maness, Tr. 2232-2233).

446. Dr. Maness disregarded entirely and without adequate explanation health plans' testimony (*see e.g.*, testimony of Quirk, testimony of Jagmin) relating to purchasers' substitution in the event of a relative price increase, (Maness, Tr. 2233-2237), although he acknowledged on cross-examination that when employed in the Bureau of Economics at the FTC he did not feel free to disregard purchaser statements about substitutability at a 5% price increase. (Maness, Tr. 2225-2226).

447. Dr. Maness used data obtained from NTSP regarding three physician practices in support of his opinions, although he acknowledged on cross-examination that he did not know how the groups were selected and never considered the possibility of selection bias. (Maness, Tr. 2227-2228).

448. Dr. Maness testified that his assessment about ease of entry into physician service markets was based on "literature in general" and he also testified about his calculation of net inflow of physicians in Tarrant County; but he acknowledged on cross-examination that he didn't adjust his numbers for population change, had no idea whether entrants were economically effective, had no idea how long entry had been contemplated prior to any effective entry, had no information on scale of entry that would have to "take place to defeat a small but significant nontransitory" price increase, and had not considered entry with respect to Fort Worth, in particular, at all. (Maness, Tr. 2249-2251).

449. Dr. Maness testified that he was "fuzzy" on whether NTSP communicates its minimum contract prices to its physicians, but insisted that it would not matter to his analysis. (Maness, Tr.

2255-2256).

450. Dr. Maness testified that he relied in formulating his opinion on data/analysis in PacifiCare Southwest reports, but acknowledged on cross-examination that he lacked knowledge of how or why the data was gathered by PacifiCare or whether the results were statistically significant; none of this undermined the "data in any manner, shape, or form . . . as a basis for [his] opinions." (Maness, Tr. 2263-2265).

451. Dr. Maness testified that NTSP met or exceeded the scores of other physician organizations, but acknowledged on cross-examination that he did not know whether purported superiority of NTSP along clinical, service and administrative quality measures resulted from anything NTSP did other than judicious selection of member physicians. (Maness, Tr. 2316-2317).

452. Dr. Maness testified that comparative data reflecting lower NTSP physician cost per disease episode was evidence of NTSP's relative efficiency; but he acknowledged on cross-examination that he did not know what "disease episode" meant in any given instance or whether "disease episode" had a consistent meaning across his sample. (Maness, Tr. 2269).

453. Dr. Maness testified that he relied on United HealthCare data that "shows that generally NTSP's physicians were below United's overall average" in some performance measures; but he acknowledged on cross-examination that the data involved only 11 NTSP physicians (out of about 275 in the non-risk only panel) and he did not know how or why the 11 were chosen, who they were, or anything else about the report. (Maness, Tr. 2272-2276).

454. Dr. Maness asserted that there is a quality spillover from NTSP's risk physicians to its non-risk panel; but he acknowledged on cross-examination that he did not directly measure the quality of NTSP's non-risk physicians. (Maness, Tr. 2207).

455. Dr. Maness testified that in formulating his opinion he relied on the availability of "flat file" data to non-risk physicians, but acknowledged on cross-examination that he did nothing to assess the degree to which non-risk doctors have sought to access the data and did not know whether even one non-risk physician sought access to that data. (Maness, Tr. 2277-2278).

456. Dr. Maness asserted that NTSP's efficiencies resulted in important part from teamwork, including stable referral patterns, but he acknowledged on cross-examination that he did not systematically study referral patterns whether within NTSP or within any other IPA anywhere in the metroplex. (Maness, Tr. 2278-2279). He did not know whether NTSP requires in network referral for risk or otherwise, (Maness, Tr. 2280-2281), or whether there is a "stable core" or "specific cohort" of NTSP physicians that participate in substantially all contracts, and stated that the latter information would "not necessarily" be relevant to his assertions about stable referral patterns or teamwork. (Maness, Tr. 2281-2282).

457. Dr. Maness acknowledged on cross-examination that knowledge of how many physician outliers had been terminated or removed from NTSP potentially would be relevant to his inquiry, but that he had no knowledge of that number and did not inquire into it. (Maness, Tr. 2288-2289).

458. Dr. Maness testified that in formulating his opinion he "assumed" that a majority of NTSP Medical Directors' time was devoted to PacifiCare; but he acknowledged on cross-examination that he did not know if that was true for a "vast majority" of Medical Directors' time and that it did not matter. (Maness, Tr. 2293).

459. Dr. Maness acknowledged on cross-examination that, when he formulated his opinion, he did not know if he understood that NTSP Committee and Section meetings "not infrequently have been cancelled for want of a quorum;" but he asserted that the information was "not even relevant" to his opinion. (Maness, Tr. 2293-2294).

460. Dr. Maness testified that in formulating his opinion he relied on RX3129, which compared NTSP's capitated PacifiCare contract physicians with non-risk sharing, non-NTSP physicians (Maness, Tr. 2296); but on cross-examination, Dr. Maness acknowledged that he did not know whether the age or severity of illness of patients was the same for each group and that he made no effort to control for differences in plan design. (Maness, Tr. 2304-2308).

461. Dr. Maness was aware that many industry experts believe that valid comparisons can be made only by accounting for such variables as age, severity of illness, plan design, and numerous others; but on cross-examination, he asserted that this knowledge did not in the least undermine the validity or utility of his conclusions from RX3129, nor would lack of statistical significance of the delta undermine the validity or utility of his conclusions. (Maness, Tr. 2309-2310; 2310-2313 (impeachment about his understanding of need for demographic adjustment)).

462. But as Dr. Casalino emphasized, the quantitative analyses that purport to address NTSP's performance for controlling costs for patients under its fee-for-service contracts–and on which Dr. Maness relied–do not provide a reliable basis for reaching a conclusion on this question. (Casalino, Tr. 2816). Quantitative analyses that address an IPA's performance in controlling costs or improving quality cannot be relied upon unless patient populations are adjusted for "case mix," that is, the illness status of patients, (Casalino, Tr. 2827-2828), and none of NTSP's data from PacifiCare on cost control and quality improvement includes any adjustment for case mix (Casalino, Tr. 2827-2829); unless they include either all the IPA's specialty physicians or a random sample of the IPA's specialty physicians (which the Dr. Maness-sponsored studies did not include) (Casalino, Tr. 2827-2828); and unless they include the total cost of patient care, not merely the number of procedures (as was the case with some of Dr. Maness' comparisons). (Casalino, Tr. 2827-2829).

463. On cross-examination, Dr. Maness acknowledged, regarding his reliance on RX3129, that he could not explain how and why some year-to-year intra-group differences were much larger

than the between group differences that he deemed evidence of NTSP's relative efficiency (Maness, Tr. 2376-2381); but he asserted that, even if shown several such instances, it would not shake his confidence in his reliance on RX3129. (Maness, Tr. 2381).

464. Dr. Maness did not study or even inquire about the degree of clinical integration of any other metroplex IPA, although he acknowledged that it could be an important thing to know. (Maness, Tr. 2316-2317).

465. Dr. Maness opined that NTSP's clinical protocols were a source of NTSP's relative efficiency, but on cross-examination he acknowledged that, at the time he formulated his opinion, he did not know whether the clinical protocols numbered 10 or 10,000 nor whether they were merely derivatives of others' work. (Maness, Tr. 2317-2318).

466. Dr. Maness cited NTSP development and implementation of disease management programs as evidence of NTSP's integration/efficiency; but Dr. Maness evinced little understanding of the nature of NTSP's palliative care program, to which he referred illustratively. (Maness, Tr. 2318-2320).

467. Dr. Maness lacked understanding about whether NTSP did any disease management outside of the capitated PacifiCare contract context; but he testified that such understanding would not "influence . . . in the least" his opinion about the importance of NTSP's disease management. (Maness, Tr. 2318-2321).

468. Dr. Maness cited NTSP monitoring of/aiding with physician coding practices as an NTSP efficiency, but did not study coding practices of NTSP or other physicians nor did he consider physicians' personal incentives to code properly. (Maness, Tr. 2321-2322).

469. In formulating his opinion, Dr. Maness relied on RX3130 which purports to show that NTSP's capitated PacifiCare contract physicians tend to practice similarly outside of that context; but he knew nothing about the wellness or sickness of the patients served by the two groups of doctors compared and he made no effort to control for severity of illness or age, or to normalize for differences in plan design. (Maness, Tr. 2324-2330).

470. Dr. Maness testified that NTSP enjoyed positive reputational effects with Fort Worth health plans; but when challenged on cross-examination, he knew that to be true only of PacifiCare. (Maness, Tr. 2331-2332).

471. Dr. Maness testified that NTSP efficiencies were evidenced by NTSP's role in having dangerous pharmaceuticals removed from the market; but when challenged on cross-examination, he was only aware of NTSP's role with respect to the drug "Baycol." (Maness, Tr. 2332).

472. Dr. Maness testified that NTSP's non-risk panel of physicians was an incubator for its

risk-sharing panel; but he acknowledged on cross-examination that he did not study movement between panels. (Maness, Tr. 2332-2333).

473. Dr. Maness testified that his opinion about incubation would not be influenced in any manner by knowledge that "throughout NTSP's history some affiliate members of NTSP considered a great benefit to be that they can enjoy NTSP's higher rates without taking any risk," or that 75 or 80 physicians recently disassociated themselves from NTSP rather than agree to accept risk at some point in the future. (Maness, Tr. 2335-2336).

474. Finally, Dr. Maness' opinion is belied by the experience of the health plans. For example, Aetna, responding to ordinary commercial incentives, believed it was "critical" to determine if NTSP's efficiency claims were valid to decide how it could best control its own cost and compete with other health plans. (Roberts, Tr. 497). Had Aetna found NTSP's efficiency claims to be valid, Aetna would have offered NTSP a higher rate to obtain the benefit of those efficiencies. (Roberts, Tr. 506). Aetna reviewed the data NTSP presented regarding its efficiencies and found that it was not "credible" in actuarial terms. Aetna then conducted a further analysis of NTSP's efficiency claims using data from its own extensive data base, (Roberts, Tr. 528, 581), but concluded that the data simply did not support NTSP's assertions. (CX0501; Roberts, Tr 502-503; 504-505; 524-527).

475. Accordingly, Dr. Maness' opinions in this matter should not be accorded any weight.

XI. The Public is Injured By NTSP's Price-Fixing

476. The impact of NTSP price-fixing activity, even if only sometimes successful and then for limited periods of time, is substantial. Relatively small increases in fee-for-service prices translate to large additional costs that must be borne by purchasers. (Van Wagner, Tr. 1875-1876 (change from 125 percent of RBRVS to 130 percent of RBRVS can mean millions of dollars in additional physician reimbursement)).

477. Price increases immediately affect health plans and self-insured benefits plans, Frech, Tr. 1341; and fully-insured employer health plans are quickly affected–at the latest, when the health plan updates the premium. (Frech, Tr. 1341).

478. The effect is then felt by employers who can respond by increasing the co-payments, reducing the scope of the plans, increasing plan premiums, and may lead some to withdraw their sponsorship of health plans. (Jagmin Tr. 980; Frech, Tr. 1342). And the end result of higher prices for physician services is higher costs to consumers and less availability of insurance for consumers. (Frech, Tr. 1342).

XII. Need for Relief

479. NTSP's acts and practices for and with its participating physicians have and will continue

to restrain trade unreasonably, hindering competition in the provision of physician services in the Fort Worth area. *See* findings 105, 97-146, 476-478.

CERTIFICATE OF SERVICE

I, Sarah Croake, hereby certify that on June 16, 2004, I caused a copy of the Post - Trial Complaint Counsel's Proposed Findings of Fact to be served upon the following persons:

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