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

MOTION FOR LEAVE TO FILE OUT OF TIME A REDACTED PUBLIC VERSION OF COMPLAINT COUNSEL'S POST - TRIAL BRIEF

Complaint Counsel requests leave to file the attached redacted public version of its post - trial brief on July 6, 2004. Complaint Counsel had filed this post - trial pleading incorrectly with the Office of the Secretary on July 1, 2004, the court-ordered-cut-off for such pleadings. Previously, on June 16, 2004, Complaint Counsel had duly filed the non-public version of this pleading with the Office of the Secretary which was also served on Respondent at that time.

We request that the Court accept this filing, because there is no possibility that Respondent will suffer prejudice from this filing. As noted above, the complete, non-public version of this pleading was served on Respondent on June 16, 2004, which was the court-ordered deadline for such pleadings.

Respectfully submitted,

Michael J. Bloom / Carolyn A Cleveland

Michael J. Bloom

Attorney for Complaint Counsel

Date: July 6, 2004

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 BRIEF

Respectfully submitted,

Michael J. Bloom / Carolyn R Cleveland

Michael J. Bloom
Theodore Zang, Jr.
Mazor Matzkevich
Jonathan W. Platt
John P. Wiegand
Elvia P. Gastelo
Attorneys for Complaint Counsel

July 6, 2004

TABLE OF AUTHORITIES

Cases

Federal Trade Commission Orders

Statutes, Regulations and Guidelines

Other Authorities

F.T.C. News Release, Federal Trade Commission, Justice Department Revise Policy Statements on Health Care Antitrust Enforcement, Aug. 28, 1996 *(available at* http://www.ftc.gov/opa/1996/08/hlth3.htm)

John J. Miles, *Joint Venture Analysis and Provider-Controlled Health Care Networks*, 66 Antitrust L.J. 127 (1997)

Timothy J. Muris, *The Federal Trade Commission and the Rule of Reason: In Defense of Massachusetts Board*, 66 Antitrust L.J. 773 (1998)

TABLE OF CONTENTS

I. INTRODUCTION

The Federal Trade Commission ("Commission" or "FTC") initiated this suit to proscribe and remedy price-fixing and other anticompetitive acts and practices by competing physicians by, through, and with Respondent North Texas Speciality Physicians ("NTSP") in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45 ("FTC Act").

At trial, Complaint Counsel presented compelling documentary evidence–much of it in the form of Respondent's own writings–and convincing fact and expert testimony that establishes, by a preponderance of the evidence,[1] that NTSP and its otherwise competing physicians coordinated pricing activities and collectively negotiated prices applicable to fee-for-service medical practice in numerous medical specialties in the Forth Worth, Texas area. Complaint Counsel is entitled to relief because those concerted actions are of the kind that traditionally have been held illegal *per se*. *See U.S. v. Trans-Missouri Freight Ass'n*, 166 U.S. 290, 324 (1897), *U.S. v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223-4 n. 59. (1940).

It is incontrovertible that NTSP acts to affect member physicians' prices. In so doing it

---

[1] The preponderance of the evidence standard is applicable here. *See In re Adventist Health System/West, 117 F.T.C. 224, 297 (1994)* ("Each element of the case must be established by a preponderance of the evidence"), *F.T.C. v. Abbott Laboratories*, 853 F. Supp. 526, 535 (D.D.C. 1994) (government must show "by a preponderance of the evidence that [defendant's] action was the result of collusion with its competitors"). *See also Herman & MacLean v. Huddleston*, 459 U.S. 375, 387-91 (1983) (preponderance of the evidence standard applies to enforcement of antitrust laws), *Steadman v. SEC*, 450 U.S. 91, 95, 102 (1981) (APA establishes preponderance of the evidence standard of proof for formal administrative adjudicatory proceedings)."

acts as a horizontal combination. Moreover, NTSP's members, in reaching these price agreements, act in concert with one another by and through NTSP, further satisfying the "agreement" element of an antitrust law violation. That agreement was manifested through a variety of well-evidenced acts and practices including:

- NTSP's polling of its physicians as to their "minimum acceptable range of compensation," explicitly to be used "to establish Contracted Minimums" for physicians' services, and its sharing of the poll averages and NTSP's resulting minimum contract prices with its member physicians;
- the NTSP Board's establishing of "Board Minimums" for physicians' prices;
- NTSP's negotiating with health plans based on the Contracted Minimums set by the NTSP Board and by the polling; and
- NTSP's and its member physicians' adopting of various methods and anticompetitive practices, including concerted refusals to deal and terminations of dealings, designed to bolster their pricing power in those negotiations.

NTSP's concerted actions, taken separately and as a whole, *see In re High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d 651, 661 (7th Cir. 2002) (Posner, J.), are "inherently suspect" in that they can be expected to result in increased prices or decreased output unless they are ancillary to a countervailing efficient integration. *See In the Matter of Polygram Holding, Inc.*, No. 9298, at 47-48 (July 24, 2003), *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 9 (1979), *National Collective Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 98-103 (1984). Thus, NTSP bears the burden of coming forward to establish that its price-fixing and related activities are reasonably necessary to the accomplishment of cognizable and plausible efficiencies. *See, e.g., In the Matter of Polygram Holding, Inc.*, at 30-33, *Indiana Federation of Dentists*, 101 F.T.C. 57, 175 (1983), *vacated*, 745 F.2d 1124 (7th Cir. 1984), *rev'd*, 476 U.S. 447 (1986), *California*

Dental Ass'n v. F.T.C., 121 F.T.C. 191, 526 U.S. 756, 775 n.12 (1999). It has failed to do so. Its claimed efficiencies are not plausible, and its horizontal price-fixing is not necessary to the accomplishment of those claimed efficiencies. Its witnesses offered mere conjectures about speculative benefits in lieu of substantive evidence of efficiencies and ancillarity.

Further, although not obliged to come forward with additional evidence because Respondent did not successfully shift the burden of persuasion regarding efficient integration back to Complaint Counsel, Complaint Counsel presented witnesses who thoroughly debunked NTSP's efficiency claims. Thus, the evidence more than establishes that Respondent NTSP's horizontal price-fixing and related conduct is without cognizable justification or excuse and, therefore, is unambiguously harmful to competition and the public.

Having failed to put forward reliable evidence that its price-fixing and related conduct are ancillary to the accomplishment of cognizable countervailing efficiencies, Respondent seeks to convince this Court, against the greater weight of evidence, that price-fixing efforts by NTSP and its member physicians could not be effective. But, as Judge Posner recently noted in *Re High Fructose Corn Syrup*, even inefficacious price-fixing agreements are unlawful. *Id.* at 656. And NTSP's price-fixing certainly was not inefficacious; the testimony of several health plan witnesses, bolstered by NTSP's own documents, shows price increases and other market disruptions resulting directly from NTSP's and its member physicians' price-fixing and related conduct.

NTSP's price-fixing ultimately hurts consumers by increasing their cost of and reducing their access to medical care, and is condemned under the *Department of Justice and FTC Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153*

(August 28, 1996) ("*Health Care Statements*"), at 61, and relevant case law, *e.g., California Dental Ass'n, Michigan State Medical Society*, 101 F.T.C. 191 (1983), *F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986). It is likely to continue or recur unless this Court and the Commission issue a cease and desist order barring NTSP from engages in acts and practices like those that have given rise to this suit.

II. SUMMARY OF FACTS

NTSP is an IPA formed in 1995 by physicians in Fort Worth. Complaint Counsel Post-Trial Proposed Findings of Facts ("CPF") ¶¶ 6 by physicians associated with the Harris Methodist Hospital in Fort Worth. It was to be, among other things, a vehicle for physician risk sharing with respect to the Harris Methodist HMO. Over time, NTSP shifted its emphasis to fee-for-service contracting with a variety of health plans.

A. NTSP Collectively Sets Rates for Medical Services

The primary purpose and activity of NTSP is to engage in collective fee negotiations on behalf of its 600 member physicians. CPF ¶¶ 6-8, 53, 125-128. Evidence shows that NTSP engages in aggressive price negotiations with health plans to obtain supracompetitive prices in its non-risk contracts for its member physicians. These rate negotiations with health plans embody and reflect price-fixing agreements among otherwise-competing physicians, implemented by and through NTSP acting as their agent and representative. NTSP member physicians use NTSP as

an agent subject to their control, to establish fees for non-risk contracts and to jointly negotiate and execute such contracts. These actions constitute illegal price agreements among competitors.

NTSP ensures that its physicians will act "collectively" the moment they join the IPA. CPF ¶¶ 97-104, 143. A physician becomes an NTSP member by entering into a participation agreement with the IPA. Signatories to NTSP's participation agreement covenant that they will forward to NTSP any offers from health plans for further handling. CPF ¶ 98 Furthermore, they agree that they will refrain from pursuing any such offer until NTSP notifies the physician that it is permanently discontinuing negotiations with the health plan.[2] Thus, NTSP members agree to refrain from individual negotiations with health plans, deferring, instead, to NTSP.

NTSP also polls its member physicians for prospective prices to facilitate its price-fixing. NTSP polls its member physicians to determine what fees they would accept for current and future contracts with health plans. CPF ¶¶ 105-117. This data is used for a number of purposes. First, NTSP staff calculates the fees that would be acceptable to its "average" physician member (using "mean, median and mode" calculations). CPF ¶ 120. NTSP typically then disseminates the aggregated information to member physicians, relaying the prices their competitors, on average, will demand in the future. CPF ¶¶ 116, 120, 252. The dissemination of future pricing information encourages individual physicians to maintain a unified front through NTSP to

---

[2] Section 2.1 of the Participation Agreement provides that, subject to limited exceptions not pertinent to this discussion, "**NTSP** shall have the right to receive all Payor Offers made to **NTSP** or Physician . . . . Physician will promptly forward such Payor Offer to **NTSP** for further handling in accordance with the provisions of this Agreement." (Bolding, capitalization, and other emphases are as in original here and in subsequent quotations.) CX0311-008, Section 2.6 of the Participation Agreement provides that "[i]f **NTSP** rejects any Payor Offer and advises the Participating Physicians in writing that it is permanently discontinuing negotiations . . . then **NTSP** shall have no further responsibilities with respect thereto and any Participating Physician shall have the right to pursue such Payor Offer on its own behalf." CX0311-008. CPF ¶ 99.

achieve these "average" prices for all physicians, rather than sign individual contracts with health plans at lower fee levels, and is itself in unreasonable restraint of trade. CPF ¶¶ 121-124.

Second, the Board, which is made up entirely of doctors, also uses the poll results to establish "minimum" prices that it believes would be acceptable to most NTSP members. CPF¶¶ 108-109, 111-112, 114. Based on this minimum, NTSP affirmatively counter offers on price or rejects out of hand health plan offers that it considers too low priced. In so doing, it neither consults with its members or gives them an opportunity to "opt-in" to the health plan proposal. CPF ¶¶ 125-126, 170-181, 213, 270, 326. After NTSP rejects a health plan offer, the health plan sometimes submits a new proposal with higher fees that it thinks may be acceptable to NTSP. CPF ¶¶ 250, 252, 255-256, 361-362. This negotiation may continue until NTSP has obtained the fee levels it desires. Only when NTSP has obtained an acceptable fee agreement will it present the 'done-deal' to its member physicians.

To maintain and strengthen its bargaining power, NTSP encourages its physicians to abstain from negotiating direct contracts with health plans and to refer any health plan contacts to NTSP staff in accordance with their participation agreements;[3] and NTSP's physicians do in fact, refer health plans attempting to contract directly with them back to NTSP, with the knowledge that NTSP will reject offers below the collectively established minimum. CIGNA Healthcare ("CIGNA") for example, received 40 virtually identical letters from physicians directing it to contact NTSP rather than the physicians, because NTSP was acting as their agent in negotiating the non-risk sharing contract in question. CPF ¶¶ 260-262. When United Health Care Services Inc. ("United") approached NTSP's physicians to offer a direct contract, it also was referred to

---

[3] *See, e.g.*, CPF ¶¶ 98, 99, 133-134, 145, 362.

NTSP. CPF ¶¶ 219-220, 228-229.

To further strengthen its negotiating power with health plans, NTSP has at times acted on behalf of its members to terminate existing contractual relationships between a health plan and a significant number of NTSP's participating physicians.[4] In addition to the Participation Agreement, at various times, NTSP has collected "powers of attorney" from its member physicians, giving NTSP the right to negotiate contract terms– including price terms– on behalf of those members. CPF ¶¶ 135, 137-138, 146, 161, 222-224, 245, 318, 338-342, 345. NTSP has used these powers of attorney and other forms of agency agreements to strengthen its hand in negotiating fees with health plans. NTSP also has threatened to cancel existing NTSP agreements with United, Aetna and CIGNA unless the health plan accepted its demands for higher fees. CPF ¶¶ 140-141, 189, 271, 279, 281, 302-304, 364, 347-348. Actions such as these deliver a clear message to health plans that contracting individually with NTSP physicians will likely be met with stiff resistance by NTSP and its physicians and thus is not likely to be successful.

NTSP also approached a large employer–the City of Fort Worth–that had signed a contract with United, and warned this employer that NTSP physicians might not participate in United's network unless the City of Fort Worth "assisted" NTSP in obtaining higher fees from United. As a consequence, United was forced to offer higher fees to physicians to assuage the employer's concerns about the adequacy of its network to serve a Fort Worth-based employee

---

[4] For example, on or about November 7, 2000, NTSP terminated its member physicians' participation in the Aetna Inc.-Medical Select Management arrangements effective on or about December 7, 2000. CPF ¶ 347. *See* CX0546. *See also* termination of participation of NTSP member physicians from the HTPN-United contract, CPF ¶ 206, and as further discussed below.

population. CPF ¶¶ 188-189, 195-197, 203, 254, 257. NTSP's communications to brokers and employers also forced Aetna Inc. ("Aetna") to sign a deal with NTSP at higher prices than Aetna had offered, to appease employers' concerns at the end of the open enrollment season. CPF ¶¶ 347-351, 373, 377, 381.

As a result of all these activities NTSP has collectively set rates that have resulted in higher prices for health plans and consumers. CPF ¶¶ 118, 121, 123, 476-477.

As further discussed below, NTSP's conduct constitutes horizontal price-fixing, a category of conduct that traditionally has been condemned as *per se* unlawful. *See Trans-Missouri Freight Ass'n* at 324, *Socony-Vacuum* at 223- 224 n.59. Physicians' price-fixing by joint negotiating of price with health plans, by sharing of future price information among themselves or by setting joint rates is specifically condemned as *per se* illegal in *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 349-350 (1982), and in the *Health Care Statements*, at 117.[5] Such conduct, then, plainly is inherently suspect.

---

[5] The FTC and DOJ ("Agencies") *Health Care Statements* provide detailed guidance to health organizations on what types of conduct or transactions are likely to be anticompetitive and those that will not result in an antitrust investigation, absent extraordinary circumstances. The Health Care Statements consist of nine policy statements that provide a comprehensive explanation of how the Agencies apply basic principles and analysis under antitrust law to several types of collaborative activities among physicians, hospitals and other health care providers, and provide examples of such analysis using various factual situations. The goal of the Health Care Statements is to ensure that antitrust laws do not unnecessarily impede market developments and continue to prevent anticompetitive conduct that limits health care options available to consumers or leads to higher prices. *See* FTC News Release, Federal Trade Commission, Justice Department Revise Policy Statements on Health Care Antitrust Enforcement, August 28, 1996. *(available at* http://www.ftc.gov/opa/1996/08/hlth3.htm). Overall, they seek to provide a competitive marketplace in which consumers will have the benefit of high-quality, cost-effective health care and a variety of choices that expand consumer choice and increase competition. *Health Care Statements* at 2.

As an embodiment of antitrust law, several FTC and court cases have used the Health Care Statements as a guide in their analysis. *See, e.g., United States. v. Federation of Physicians*

B. NTSP's Anticompetitive Behavior Permeates its Dealings with Health Plans

The evidence shows that NTSP's physicians were able to successfully extract higher fees from the health plans by repeatedly engaging in price-fixing.

1. NTSP Jointly Negotiated Rates and Imposed Higher Rates on Aetna

Prior to 2000, many NTSP physicians served Aetna patients in the Fort Worth area through arrangements between NTSP's member physicians and Medical Select Management ("MSM"), a California-based IPA firm that was capitated by Aetna for HMO care. CPF ¶¶ 297-298. In 1999 and again in 2000, NTSP approached Aetna to obtain a direct NTSP-Aetna contract. Initially, the parties tried to negotiate a risk contract, but after those negotiations reached a dead end, in October 2000, the parties' negotiations shifted to non-risk, fee-for-service HMO and PPO products. CPF ¶¶ 299-319.

NTSP aggressively negotiated the prices for PPO, HMO, anesthesia, and other price components, taking advantage of the open enrollment season, the time when employees choose their health plans (or change their prior selections). CPF ¶¶ 316, 363. Disruption in a health plan's network at this time could have serious adverse consequences on the health plan's

---

and Dentists, Inc., 2002-2 Trade Cas. (CCH) ¶ 73,868 (D. Del. 2002) *(available at* http://www.usdoj.gov/atr/cases/indx26.htm), *U.S. v. Federation of Certified Surgeons and Specialists, Inc.*, Case No. 99-167-CIV-T-17F (M.D. Fla. filed Jan. 26, 1999) *(available at* http://www.usdoj.gov/atr/cases/f2200/2202.htm), *In the Matter of M.D. Physicians of S.W. Louisiana Inc.*, File No. 941-0095, C-3824, (June 19, 1998).

relationship with its customers, since the employer already has contracted with the health plans based on the more inclusive pre-disruption network of physicians.[6] CPF ¶ 317, 337, 363. NTSP rejected Aetna's initial price offer of its standard rate in the marketplace-approximately 125% for PPO, 111% for HMO and $40 for anesthesia - and countered with 140% for PPO, 125% for HMO and $46-$48 for anesthesia. CPF ¶¶ 321-322, 325-326, 327-329. In November 2000, Aetna, in response to NTSP's demands, agreed to raise its PPO offer to 140% and offered a higher HMO reimbursement rate of 116%. CPF ¶¶ 332, 334-336. NTSP accepted the offered PPO rates, but continued to insist on the higher rate of 125% for its HMO contract. CPF ¶¶ 353-354.

In the midst of negotiating the HMO and anesthesia rates with Aetna, NTSP decided to re-poll its members "on the acceptability of the present Aetna offering."[7] CPF ¶¶ 357-359. Soon thereafter, not surprisingly, NTSP announced that "the membership had held to a 125% minimum acceptable fee-for-service rate for the Aetna HMO product."[8] CPF ¶¶ 360, 362.

During these negotiations, Aetna was subjected to unusual pressure to reach an agreement with NTSP. NTSP had threatened the imminent departicipation of its member physicians from the Aetna-MSM arrangement–a threat of a concerted refusal to deal. Subsequently, that threat

---

[6] During the open enrollment season employees choose their health plans from several health plans available that were previously marketed to their employer. Both employees and employers base their decisions in part on the number and accessibility of physicians in their area. CPF ¶¶ 81-89. Employees also prefer a health plan that will assure them continued services from the same physicians. CPF ¶¶ 83.

[7] CX0565-001.

[8] CX0500.

was underscored by NTSP's amassing of some 180 powers of attorney from its member physicians, authorizing NTSP to act for those members in all transactions relating to MSM and to represent its member physicians in *any* negotiations with Aetna, regarding *any* term. CPF ¶¶ 318, 334, 338-345. Based on the authority provided by the powers of attorney, in November 2000, NTSP, making good on its threat, terminated its member physicians' participation in the Aetna-MSM arrangement.[9] CPF ¶ 347. Moreover, based on the plain language of the powers of attorney and other NTSP statements to Aetna, CPF ¶¶ 318, 340, Aetna believed that the viability of its Fort Worth area network was threatened because it could not negotiate directly with NTSP physicians. CPF ¶¶ 334, 344.

NTSP and its member physicians applied additional pressure on Aetna through a concerted campaign to convince employers and brokers in the Fort Worth area that Aetna's loss of NTSP member physicians was imminent and would be catastrophic due to network inadequacy and substantial patient disruption. CPF ¶¶ 363-365, 367. As a result, Aetna was subjected to pressure from employers and insurance brokers in the Fort Worth area that increased as the end of the open enrollment season approached. CPF ¶¶ 372-373, 363-368. These pressures eventually led Aetna to capitulate to NTSP's demands and to agree to NTSP's price terms, at a rate that was about 14 percent higher than Aetna's initial HMO proposal. CPF ¶¶ 325, 376, 379, 383, CX0256 ("NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term the entire NTSP network last year.").

In 2001, realizing that it was paying NTSP higher rates than it paid to any other IPA,

---

[9] *See* CX0546.

Aetna attempted to reduce the fees it paid to NTSP. CPF ¶¶ 381, 386-389. Aetna offered rates that it believed were more in line with the market, but in some aspects higher than its general fee schedule. CPF ¶ 392. NTSP did not present Aetna's rate proposal to its member physicians, arguing that NTSP's experience with practice management controls justified its member physicians' receipt of higher-than-market rates–the same rates they were paid under the above mentioned previously negotiated contract of 2000-2001. CPF ¶¶ 393, 395. After thoroughly analyzing patient and utilization data, Aetna concluded that there was no empirical justification to support NTSP's collectively set higher rates. CPF ¶¶ 396-407. Thus, since NTSP would neither accept nor present the new Aetna offer to its members, the Aetna-NTSP contract was terminated at the beginning of 2002. CPF ¶¶ 413, 415.

2. NTSP Jointly Negotiated Rates and Imposed Higher Rates on CIGNA

CIGNA purchased Healthsource Inc. ("Healthsource") in late 1997 and requested that the physicians in Healthsource's network assign their existing contracts with Healthsource to CIGNA. CPF ¶¶ 258-260. Instead, NTSP physicians who had contracts with Healthsource, at NTSP's direction, sent CIGNA 40 virtually identical letters, representing more than 50 doctors in separate practice groups, refusing assignment and stating that NTSP would be their representative and agent in negotiations with CIGNA[10] CPF ¶¶ 261-262. During these

[10] *See* CX0760 (not for truth, admitted as verbal act). The letters have a non-hearsay use in that they carry legal consequences or logical significance outside of their assertive context. Each letter contains and constitutes "verbal acts" signifying the rejection of an assignment offer and serving notice of the sender's appointment of an agent. The letters are of evidentiary value not for the declarant's subjective intent, but rather for "a kind of external meaning found 'on the

negotiations NTSP insisted that in order to obtain a contract with its members, CIGNA fee-for-service offers had to meet the fees established by NTSP. CPF ¶¶ 264-265. In 1999, as a result of NTSP's collective negotiations, CIGNA agreed to pay NTSP its offered price of 125% of 1998 RBRVS. CPF ¶ 264.

Over the next few years, NTSP frequently requested that CIGNA meet its changing demands for higher rates for the fee-for-service HMO and PPO contracts. CPF ¶¶ 266, 277-279. For example, in July 2000, the fee-for-service HMO rates were increased to 125% of 1999 RBRVS. CPF ¶ 266. This price was significantly higher–15 to 20 percent– than the price CIGNA was paying to individually contracted physicians. CPF ¶ 266. In addition, NTSP insisted and CIGNA acquiesced to a provision to the contract that insured the rate would be adjusted annually to maintain 125% of current year RBRVS. CPF ¶¶ 266.

When primary care physicians joined NTSP, NTSP demanded that CIGNA allow them to "opt-in" to the NTSP-CIGNA contract, even though CIGNA already had an adequate number of primary care physicians in its network. CPF ¶¶ 268, 273-275. CIGNA determined that if NTSP primary care physicians were allowed into CIGNA's network, its overall costs would increase significantly without any benefit to CIGNA, because NTSP contracts were at higher rates than CIGNA's other contracts. CPF ¶ 275. At times during the negotiations regarding the primary care physicians, NTSP threatened to terminate the NTSP-CIGNA contract, and at one point actually did terminate its CIGNA PPO contract, until CIGNA succumbed to NTSP's demands.

---

face' of the words . . . . What counts is the fact that the words were spoken or written, coupled with this external meaning." Mueller & Kirkpatrick, EVIDENCE, 3rd Edition, Aspen Publishers, at 731. It is well established in cases involving contract allegations that words are verbal acts when offered to prove terms of agreement, breach, waiver, estoppel, repudiation, and similar matters. *See* citations collected by Mueller & Kirkpatrick, *id.* at 730 n.2.

CPF ¶¶ 278-279, 281. [redacted] CPF ¶ 282. CIGNA was forced to allow NTSP's cardiologists into its network under similar circumstances. CPF ¶¶ 271-272, 282.

[redacted]

CPF ¶ 278, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*.}. In light of the pressure it was experiencing in the negotiations regarding NTSP's primary care physicians and cardiologists, CIGNA agreed to a more moderate increase, and adjusted the price to 2001 Dallas RBRVS. CPF ¶ 280.

In preparation for its negotiations with NTSP, and NTSP's demand for fees above the competitive level, CIGNA analyzed the importance of having NTSP's physicians in its Fort Worth area network. CIGNA determined that NTSP's physicians made up a high percentage of many specialty practices. CIGNA also frequently performed disruption analyses to determine the effect of losing access to NTSP's physicians. Based on these analyses, CIGNA concluded that a loss of NTSP physicians would have a significant negative impact on CIGNA's network in several crucial specialties, and that, therefore, it must have those physicians in its Fort Worth area network. CPF ¶¶ 267, 272. CIGNA further concluded as a result of factors such as its analysis of NTSP's strength and unity, the identical letters from NTSP's member physicians designating NTSP as their agent, and the threats by NTSP to terminate its contracts with CIGNA, that NTSP's physicians would only contract through NTSP and would not agree to contract individually with CIGNA. CPF ¶¶ 260-264, 267, 286.

Despite paying supracompetitive prices, CIGNA did not see any evidence that NTSP's

physicians were more efficient than other physicians who were not collecting NTSP's premium rates. [redacted] **CPF ¶¶ 287-288, 291, *in camera (See Grizzle, Tr. 752-754)*}.** CIGNA challenged NTSP to justify its significantly higher fees by demonstrating that its physicians were more efficient, but NTSP has not provided CIGNA with any such evidence. CPF ¶¶ 287-292.

3. NTSP Jointly Negotiated Rates and Imposed Higher Rates on United

In June of 1998, NTSP adopted a new strategic initiative in connection with its non-risk contracts, according to which NTSP would aggressively try to prevent any attempt to contract directly with its member physicians rather than through NTSP. CPF ¶¶ 98-99, 143, 157. In accordance with that policy, NTSP sought to negotiate on behalf of its membership with United, which was identified by NTSP as a potential major player in the market place. CPF ¶¶ 187. *See also* CX0211 ("NTSP has identified United Health Care as a re-negotiation target since the first of the year. They are quietly and quickly becoming a giant in the Fort Worth area."[*sic*]).

To that end, NTSP solicited powers of attorney from its member physicians and recommended that its members "refrain from responding to united healthcare [*sic*] while NTSP's request for agency status is being tabulated." CX1005, CPF ¶¶ 160, 222-223. The powers of attorney were not limited to non-economic terms. CPF ¶¶ 215, 218, 222, 245. In fact, Dr. Deas, currently NTSP's President, and on NTSP's Finance Committee at the time, explicitly authorized NTSP to negotiate price terms on his physicians group's behalf. CPF ¶ 161.

In the course of its negotiations with United, NTSP made fee proposals to United and repeatedly instructed its member physicians not to take any actions in regard to their United contract because NTSP was engaged in negotiations with United. CPF ¶ 163. Eventually, NTSP offered its membership access to United through its newly formed affiliation with a Dallas based IPA-Health Texas Provider Network ("HTPN").[11] CPF ¶ 169, 174.

In March 2001, NTSP approached United to reach a direct NTSP-United fee-for-service contract and divert its members to this contract. CPF ¶¶ 171-172. At that time, United already had contracts with approximately two-thirds of NTSP's member physicians, either directly or through other physician organizations such as HTPN. CPF ¶¶ 169, 174. Therefore, United concluded that there was no real *need* to enter into a contract with the remainder of the NTSP physicians through an NTSP group contract. CPF ¶¶ 174, 183, 201. Nevertheless, United offered NTSP its then standard rate in the Fort Worth area of 110% of 2001 Dallas RBRVS. CPF ¶¶ 177. Without presenting the offer to its member physicians, NTSP immediately informed United that the offer was unacceptable. CPF ¶¶ 178, 190. In a Fax Alert to the members, NTSP's Board acknowledged that the parties had agreed to fundamental non-economic terms, but deemed United's rate offer as at least 10 percent lower than NTSP's minimum price level. NTSP then rejected United's offer and advised member physicians that NTSP's Board had "authorized termination" of NTSP member physicians' participating in the HTPN-United contract. CX1042, CPF ¶¶ 192, 246. In effect, NTSP established a stratagem to cut off United's access to NTSP member physicians.

---

[11] HTPN, which is an affiliate IPA of Baylor Health Care System, was an organization of employed and contracted physicians covering primarily the Dallas area. CPF ¶ 175.

Following its rejection of the United offer, NTSP orchestrated its member physicians' opposition as well as a public relations campaign against United's price offer. This campaign was designed to make it appear that because of the rates United was paying physicians, United would be unable to attract an adequate number of physicians to provide health care services to City of Fort Worth employees, retirees and dependents. After NTSP found that United was negotiating for the City of Fort Worth's business, Board members were encouraged to "contact any city council members they know to let them know that United's panel is not adequate." CX0089 at 3, CPF ¶¶ 185. In July 2001, NTSP sent a letter to the Mayor of Fort Worth notifying him that United's reimbursement rates are "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 stated that "the City may experience significant network disruption once United officially begins their duties (up to 588 doctors no longer available)." CX1029, CPF ¶¶ 188. In a Fax Alert to its member physicians NTSP detailed a strategy it wished to apply to cause United to increase its offer to NTSP. NTSP informed its members that the City of Fort Worth was transitioning to United coverage, and recommended that they write Fort Worth's Mayor Barr and state: (1) that NTSP Board minimum prices are reasonable; (2) that "NTSP IS THE ONLY STABLE PHYSICIAN ORGANIZATION LEFT IN THE TARRANT COUNTY MARKET"; (3) that the United proposal "WILL NOT BE ACCEPTED"; and(4) that dire consequences to patients would result if an NTSP-United agreement could not be reached. (*emphasis in original*). CX1042 at 3, CPF ¶ 195. The NTSP Board decided that if this campaign to sway the City of Fort Worth did not cause United to capitulate, it would terminate all 108 NTSP physicians participating in United through HTPN. As the Fax Alert made clear, NTSP's

dispute with United was related only to price, NTSP deeming United's rate offer to be at least 10 percent lower than NTSP's minimum acceptable prices. CPF ¶ 192.

Such tactics successfully created concern among United's clients, particularly the City of Fort Worth, that NTSP physicians might drop out of United's network leaving an inadequate network of physicians to serve their Fort Worth-based employees. Based on these fears, the City of Fort Worth urged United to do what was necessary to preserve its network.[12] CPF ¶¶ 196-198.

Because it had the majority of NTSP physicians already under contract through HTPN, United initially did not yield to NTSP's of the summer of 2001. Realizing that it had to take tougher actions to weaken United's network in Fort Worth before United would capitulate, NTSP went forward and terminated all of its physicians' participation in United through HTPN. CPF ¶¶ 202, 206, 210. Further, NTSP was determined to make sure that United could not successfully pull an end-run around NTSP and go directly to NTSP members.

To gain further leverage in "all contracting activity" with United, NTSP informed its member physicians on August 9 that "[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, CPF ¶ 214. NTSP explained that to represent the members, a power of attorney would have to be executed between the physicians and NTSP that "will allow NTSP to represent [the physician] in all contracting activities regarding United Health Care." CX1062, CPF ¶ 215. The broad language of the power of attorney left no doubt that it would allow NTSP to negotiate price terms on behalf of the member physicians: "This power of

---

[12] NTSP employed similar tactics in seeking to induce fear and generate pressure to inflate physician fees from at least one other employer, Texas Christian University. CPF ¶¶ 139, 204, 216.

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." CX1062 at 3, CPF ¶¶ 215, 218, 222.

At some point, United learned about NTSP's efforts to solicit powers of attorney from its member physicians. CPF ¶¶ 217, 224. This new effort, in conjunction with NTSP's termination of 108 physicians participating in United via HTPN and the its concerted campaign to influence employers, forced United to change its network strategy for Tarrant County. CPF ¶ 217. As part of that new strategy, United tried to recruit the terminated NTSP member physicians individually. United offered those physicians the opportunity to come back to a United contract at the same reimbursement rates as they had received under the HTPN-United agreement prior to their termination by NTSP. CPF ¶¶ 219-220.

Continuing to discourage physicians from contracting with United directly, NTSP sent another Fax Alert to its member physicians in August 2001. In it, NTSP explained that it was receiving calls from member physicians regarding direct offers they had received from United; repeated its unfavorable assessment of the United offer; noted that it already had received 107 executed powers of attorney from its member physicians "to act on their behalf in regard to all contracting activity between themselves and United Healthcare"; invited the submission of executed powers of attorney by other members; and advised members who had already signed powers of attorney to inform United representatives that NTSP was their contracting agent and to instruct United "to contact NTSP directly." NTSP promised its members that it would continue to pursue a direct contract with United that "meets or exceeds" the fee schedule minimums set by

NTSP membership. CX1066, CPF ¶ 221. NTSP was successful in its efforts to discourage physicians from signing contracts directly with United. United's initial direct contract invitation attracted only a few physicians, though they were offered the precisely same rates they previously received through HTPN. CPF ¶¶ 225, 228-229. Some of these physicians explicitly referred United back to NTSP as their negotiating agent. CPF ¶ 229.

After receiving little interest in its initial direct offer to the terminated NTSP physicians, United tried to work through other Fort Worth IPAs or large medical groups. United offered 125% of 2001 Tarrant RBRVS for HMO and 130% of 2001 Tarrant RBRVS for PPO to ASIA and Medical Clinic of North Texas ("MCNT"). CPF ¶¶ 226-228, 234, 257. ASIA–another Fort Worth IPA at the time–included 113 of NTSP's member physicians. CPF ¶ 201, 226.

NTSP, still not satisfied, met with Gary Jackson, General Manager for the City of Fort Worth, and Jim Mosley, the City's consultant, to express its discontent regarding United's PPO rates. CPF ¶ 237. In addition, in a letter to Jackson, NTSP indicated 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, CPF ¶¶ 225, 239. The same information was relayed to NTSP member physicians. CPF ¶ 222.

NTSP's activities in the Fort Worth market turned United's network "upside down." CPF ¶ 250. In an effort to put an end to the contractual battles that NTSP imposed on United and its customers, United offered NTSP an increased rate of 125% of 2001 of Tarrant RBRVS for HMO and 130% of Tarrant RBRVS for PPO. Only after United had capitulated to NTSP's price demand was the 'done deal' contract sent out to the NTSP membership. CPF ¶¶ 250-257.

C. NTSP's Anticompetitive Conduct Raised Prices to Fort Worth Consumers

NTSP's illegal price-fixing has significantly increased the prices of medical services in the Fort Worth area by inflating its member physicians' fees. Moreover, NTSP admits that its contracted fee schedules, collectively negotiated, are at higher levels than its physicians received under direct contracts or contracts through other IPAs. As stated in the minutes of Dr. Vance's practice group, Consultants in Cardiology: "Without NTSP's influence this last two years, our market level of reimbursement would be significantly below its present level." CX0256 at 2, CPF ¶ 383.

Several health plans estimated that the price increases they incurred as a result of NTSP's price-fixing were substantial. Aetna estimated that NTSP's collectively-negotiated fees were higher than it paid other IPAs. CPF ¶¶ 381. Indeed, the Aetna-NTSP HMO contract was about 14 percent higher than Aetna's standard fee schedule at the time. CIGNA estimated that NTSP's price-fixing resulted in rates 15-20 percent higher than its standard HMO fee-for-service rates. CPF ¶ 266. [redacted]

[redacted] **CPF ¶ 284,** ***in camera (See Grizzle, Tr. 752-754).***} United also concluded that NTSP's collective rates were higher than its rates for individually contracted physicians. CPF ¶ 254.

In fact, NTSP itself acknowledged that it was able to obtain a large premium over the price health plans offered directly to its physicians. NTSP compared the rates its physicians were offered directly by the health plans to the rates it succeeded in obtaining from those health plans,

and concluded that NTSP's contract rates with Aetna were at least 15 percent higher for the PPO and the HMO, its contract rates with CIGNA were at least 12 percent higher for the HMO and 20 percent higher for the PPO, and its contract rates with United were 15 percent higher for the HMO. CPF ¶112.

The impact of NTSP's increasing prices to the health plans, even for limited periods of time, is substantial. Relatively small increases in fee-for-service prices translate into large additional costs. As admitted by NTSP, a five percent increase, from 125% RBRVS to 130% RBRVS can mean millions of dollars in additional physician reimbursement. CPF ¶¶ 476-478.

As the evidence shows, and as common sense dictates, this additional expense must be borne by purchasers. Price increases immediately affect health plans and self-funded employers and their workers. Fully-insured employers and their employees are also affected when health plans pass on premium increases. CPF ¶¶ 477-478. Employers respond by increasing co-payments, reducing the scope of coverage, increasing plan premiums, and, may, in some cases withdraw their sponsorship of health plans. CPF ¶¶ 478. The end result of higher prices for physician services is higher costs to consumers and less availability of health care for consumers. CPF ¶¶ 476-478.

D. The Facts Establish That the FTC Has Jurisdiction Over NTSP and its Conduct

1. NTSP Physicians Are "Members" of the Organization

The participating physicians of NTSP are in fact "members" of an association dedicated to advancing their business interests. The physicians pay dues, participate in association activities, and elect the Board of Directors. CPF ¶¶ 8, 59. They meet periodically in "general membership meetings" to discuss matters in the common interest of all physicians, which sometimes includes the negotiation of health plan contracts. CPF ¶¶ 8, 133. NTSP also regularly reports to its physician "members" by fax or mail or in meetings, including on matters relating to the business interests of the physicians (such as the price terms of health plans' contracts). CPF ¶¶ 63, 133.

The evidence shows that NTSP views itself as acting on behalf of its "members" in advancing their common economic interests. For example, NTSP has claimed to have, under its Physician Participation Agreement, "the exclusive right, on behalf of its *members*, to receive all payor offers delivered to NTSP or its members," and the exclusive right "on behalf of its *members*" to negotiate with health plans on the terms of risk contracts. *(Emphasis added).* CX0276 at 1. This Fax Alert informs "NTSP members" that "NTSP has also successfully represented you in at least one large non-risk contract dispute." The Fax Alert notes that members will see many risk and non-risk contracts, and asserts that "[i]t seems reasonable that NTSP should evaluate those contracts for its members."[13] In dealing with its individual

---

[13] *See, e.g,* CX0760 (not for truth, admitted as verbal acts), (letters from physicians to CIGNA designating NTSP as their agent), CPF ¶ 347 (NTSP terminating its member physicians' participation in the Aetna-MSM arrangements effective on or about December 7, 2000), CPF ¶¶ 213-214 (NTSP relaying the United-HTPN termination and soliciting powers of attorney for NTSP to represent the members in all negotiations and contracting with United), CX0910 (fax stated that the vast majority of the members asked NTSP to serve as their agent with Select for Harris/Pacificare lives at the general meeting).

participating members, NTSP thus regards and treats them as members of an organization engaged in activities directed at their common profit-making interests.

NTSP itself routinely refers to its physicians as "members" in its own internal communications. For example, the Fax Alerts that the Board or administrative staff of NTSP routinely sends to physicians are sent to "NTSP members."[14] *See also* CPF ¶ 8; CX0321 at 1 ("in order for NTSP to act on your behalf, we must first poll the membership to determine what rate would be acceptable to the majority of our members"); CX0611 ("NTSP is pleased to present two new NTSP contract offerings to all NTSP Members..."); CX0304 ("the two areas of financial interest for most NTSP members are...").

Moreover, NTSP witnesses while testifying in court referred to NTSP's member physicians as "members." CPF ¶ 8.

As further discussed below, in determining jurisdiction under the FTC Act, the courts and the Commission look to substance, rather than the form of incorporation. Moreover, words are presumed to be used in their "usual and well-settled sense," and understood according to "generally accepted definition[s]," *Community Blood Bank of Kansas City Area v. F.T.C.*, 405 F.2d 1011, 1016-1022 (8th Cir. 1969). Therefore, as further discussed below, NTSP "participating physicians" are its "members" within the meaning of the FTC Act, and the FTC has jurisdiction over NTSP.

2. A Substantial Part of NTSP's Activity Provides Pecuniary Benefits for its Members

---

[14] *See, e.g.*, CX0319, CX0321; CX0323.

The primary, if not only, function of NTSP is to enter into contracts with health plans. *See* CX1196 (Van Wagner, Dep. at 11 ("[w]e obviously have an objective to affiliate and do contracts, do contracting with other area HMOs and PPOs").[15] Indeed, NTSP was created for the purpose of negotiating contracts on behalf of its physicians. *See, e.g.,* CX1182 (Johnson, Dep. at 10-11) ("NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups to hopefully be able to secure contracts....it was to represent physicians...in obtaining contracts from businesses or insurance companies or in dealing with hospitals").[16] Such contracts set the level of physician fees that the participating physicians of NTSP receive for services provided by their own profit-making practices. Such NTSP-negotiated fee schedules by their very nature inevitably have more than a *de minimis* effect on the revenues and incomes of the individual physicians.

Indeed, in its communications to its member physicians, NTSP has expressed satisfaction about its success in negotiating the fees to be paid to them. For example, an October 9, 2000 "Open Letter to the Membership" from Dr. Vance (then-President of NTSP) notes that NTSP "started in an attempt to provide a seat at the table of medical business for the individual

---

[15] *See also* CPF ¶ 53 and CX0311 at 5, second recital: "WHEREAS, NTSP is in the business of contracting with health maintenance organizations, health care networks and other payors to provide health care services through physicians and physician groups who have contracted with NTSP to provide such health care services;" *Id.* at CX0311 at 8-10, provisions 2 through 2.6; *Id.* at CX0311 at 14, provision 4.1: "Marketing of NTSP. NTSP shall use its best efforts to market itself and its Participating Physicians to Payors and solicit Payor Offers for the provision of Covered Services by Participating Physicians."

[16] Dr. Johnson is a current member of NTSP's Board of Directors. CX1182 (Johnson, Dep. at 13-14). *See* CPF ¶¶ 6, 53, 127.

specialty physicians in Fort Worth," and goes on to report that "NTSP has provided a consistent premium fee-for-service reimbursement to the members." CX0350. On another occasion, Dr. Vance reported to members of his practice group that NTSP has "convinced CIGNA to utilize the NTSP network in a non-risk contract," even though CIGNA would be paying a higher price for NTSP doctors. CX0256 at 2.[17] Minutes of a 2001 Medical Executive Committee meeting (attended by 19 NTSP physicians as well as NTSP staff) recorded that the committee members were concerned about and contemplating action to avoid reductions in fees on non-risk contracts. CX0195 at 2.[18]

Furthermore, physicians who serve on the Board of NTSP recognize that the higher fees negotiated by NTSP increase their own incomes. *See* CX1174 (Deas, Dep. at 87 (when asked why NTSP pressed a health plan not to reduce its reimbursement rates, Deas replied: "I assume you would prefer that your salary not be reduced for services you render."))[19]

---

[17] *See also* CX0550 ("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."); CX0391; CX0295. *See also* CX0400 at 2 ("without help over the next three months it is likely NTSP will not be around the next time Aetna, CIGNA or United come to town with a 30% below market contract....").

[18] This document, dated April 28, 2001, expresses a desire to maintain NTSP's "contracting clout" and states that "NTSP wishes to avoid having its members experience a Florida fee-for-service meltdown."

[19] NTSP also terminated its member physicians' participation in the United HTPN arrangement because "[t]he proposed reimbursement rates for the HMO and PPO product had fallen significantly below Board approved minimums." *See* CX1062. *See also* CX0209 at 3, where the PCP Quarterly Forum Minutes state that "an attempt is being made to raise those [the Baylor contract available to NTSP physicians for the United products] rates."; CPF ¶¶176. The Complaint alleges that United increased its fee offer as a result of NTSP's actions. However, regardless of the actual effect, NTSP's actions were intended to have, and if successful would have had, more than a *de minimis* effect on the revenues of its physicians.

There is substantial additional documentary and testimonial evidence that NTSP has negotiated fees on behalf of its participating physicians with other health plans, in the course of which it sought the most favorable physician reimbursement rates for its members. CPF ¶ 127. *See, e.g.*, CX1177 (Grant, Dep. at 46).[20] For instance, as discussed above, NTSP often succeeded in obtaining substantial rate increases from health plans. These increased rates obviously resulted in increased revenues for NTSP member physicians.

The Commission has consistently held, and federal courts have agreed, that the FTC's jurisdiction extends to non-profit entities when a substantial part of the entities' total activities provides pecuniary benefits for its members. *See California Dental Ass'n at* 23, *American Medical Ass'n v. F.T.C.*, 94 F.T.C. 701, 994, (1979), *aff'd* as modified, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court,* 455 U.S. 676 (1982). Thus, as further discussed below, the Commission has jurisdiction over NTSP under Sections 5 and 4 of the FTC Act.

3. The Challenged Restraints Affect Interstate Commerce

a. Increases in Physicians' Fees in Fort Worth Affect Out-of-State Health Care Business

As the evidence shows, NTSP and its members have engaged in collective price negotiations and other price-related activities. CPF ¶ 127. *See, e.g.*, CX1177 (Grant, Dep. at

[20] Q - Does NTSP negotiate for more favorable market rates for the group as a whole? A - I presume that's what they do when they're doing their contract negotiations with the payors. I mean, that's one of the things you do when negotiating a contract.

46); CX1182 (Johnson, Dep. at 10-11). These actions have had a direct and predictable effect on the fees received by its member physicians, and thus inevitably affect interstate commerce. NTSP and/or its individual members contract or negotiate with numerous health plans doing business in the Fort Worth area. The three largest area health plans are United, Aetna and CIGNA, all of which are national health plans, headquartered outside Texas, that sell health care products throughout the United States. CPF ¶ 10. Any increase in physician fees paid by these health plans in Fort Worth eventually comes out of their multi-state pockets. Therefore rates paid in Texas affect the volume and destination of interstate health care payments.[21] *See Hospital Building Co. v. Trustees of Rex Hospital,* 425 U.S. 738, 741 (1976) (finding an effect on interstate commerce where a large portion of the hospital's revenue came from out-of-state insurance companies); and *Summit v. Pinhas,* 500 U.S. 322, 329-330 (1991) (the flow of revenue in interstate commerce is sufficient to establish that the elimination of the ophthalmological department in a single hospital affected interstate commerce).

These health plans sell their products to corporations or employees located in the Fort Worth area. Many of these employers are large national and multinational corporations with local operations in Fort Worth. For example, United's national employers include Raytheon Corporation and Home Depot Corporation.[22] Aetna's national employers include Bell Helicopter and Lockheed Martin, while CIGNA's national employers include Electronic Data Systems ("EDS") and Verizon.[23] Conduct by NTSP that has the effect of raising these employers' health

---

[21] CPF ¶ 10.

[22] CPF ¶ 10; Quirk, Tr. 253-254.

[23] CPF ¶ 10; Roberts, Tr. 476-477; Grizzle, Tr. 681-682.

care costs in Fort Worth could affect decisions with respect to the location of operations, the interstate movement of employees, and other competitive actions vis à vis other manufacturers throughout the United States. CPF ¶ 10.

b. NTSP Members Accept Payments from the Federal Government Through the Medicare and Medicaid Programs

Member physicians of NTSP routinely receive payments from out-of-state insurance companies, including the federal Medicare and Medicaid programs, which are by their very nature interstate in operation. CPF ¶ 9. *See, e.g., Hospital Building Co.,* at 741 (finding an effect on interstate commerce where a large portion of the hospital's revenue came from out-of-state sources, including the federal government, through Medicare and Medicaid), *Michigan State Medical Society,* at 250 (payments from Medicare and Medicaid, as well as the Federal Employees Health Benefits Program, held evidence of interstate commerce).

Dr. Grant, a member of NTSP's Board and Chairman of its Finance Committee, testified in his deposition that, like "the vast majority" of NTSP members, he accepts Medicare payments from the federal government, and also accepts Medicaid as a "secondary" source of payments.[24] CPF ¶ 9. Dr. Grant's testimony clearly shows the close interrelationship between private and federal insurance:

> A lot of people have two insurances. They'll have – a husband may be insured through one – Aetna, and then the wife is insured

---

[24] CX1177 (Grant, Dep. at 116-17); *see also* CX1178 (Hollander, Dep at 163); CX1187 (McCallum, Dep. at 165-66); CX1199 (Vance, Dep. at 298).

> through Cigna [*sic*] or something. And so then if you see the husband, his primary is Medicaid and the secondary is Cigna [*sic*]. Some people will have Medicaid as their secondary. They'll have Medicare as their primary and Medicaid as their secondary.

CX1177 (Grant, Dep. at 116-17); CPF ¶ 9. Thus, the increasing of physician fees to private health plans may result in some additional billing to the federally-funded Medicare and Medicaid programs.[25] This close link between federal and private health insurance (including private health insurance provided by national firms such as Aetna) clearly shows that the payments to health plans under contracts negotiated by NTSP are not strictly local in operation and effect.

c. NTSP Member Physicians Provide Medical Services to Patients from Outside the State of Texas

Individual member physicians of NTSP also treat patients from outside Texas. CPF ¶ 9. *See, e.g.*, CX1187 (McCallum, Dep. at 167-68); CX1199 (Vance, Dep. at 297). This is one of the factors that courts have cited in finding that the conduct of health care providers falls within the jurisdiction of the antitrust laws. *See, e.g., Oksanen v. Page Memorial Hospital,* 945 F.2d 696, 702 n.1, (4th Cir. 1991), *Miller v. Indiana Hospital,* 843 F.2d 139, 143 n.5 (3rd Cir. 1988), *cert. denied*, 488 U.S. 870 (1988). Further, NTSP member physicians sometimes seek to recruit physicians from outside Texas to join their own practices. *See* CX1199 (Vance, Dep. at 298).

---

[25] Though state-operated, a state's Medicaid program receives federal as well as state money.

Thus, the joint negotiation of physician fees by NTSP may affect the interstate movement of doctors from one market to another.

d. Both NTSP and its Member Physicians Make Substantial Purchases from Vendors Located Outside the State of Texas

In its answers to Complaint Counsel's Second Set of Interrogatories, NTSP provided a table showing its out-of-state vendor expenses from January 1, 1999 to December 22, 2003.[40] This data shows numerous purchases from outside of Texas, representing total expenditures of $1,047,820. For example, major vendors included the following:

Vendor	Purpose	Location	Payments
Aperture Credentialing	Consulting	Louisville, KY	$33,260
AT&T	Telephone	Omaha, NE	14,572
Avaya Financial Services	Equipment rental	Chicago, IL	18,099
Banco Popular	Supplies, etc	Baltimore, MD	22,995
Corporate Express	Supplies	Chicago, IL	27,700
Executive Risk	E&O insurance	Simsbury, CT	13,543
Federal Express	Delivery	Memphis, TN	3,690
Intl. Assoc. Of Administrative Profession	Dues, expenses	Kansas City, MO	3,886
Kelly Services, Inc.	Contract labor	Chicago, IL	19,934
Lucent Technologies	Equipment	Chicago, IL	19,934

[40] CX1203. *See also* CX1195 (Van Wagner, Dep. at 77 *et seq.)*

McPhee & Associates	Stop loss insurance	Lacanada, CA	457,373
Millman & Robertson	Consulting	Seattle, WA	38,611
Nextel Communications	Telephone	Los Angeles, CA	4,499
PBCC	Equipment	Louisville, KY	13,211
Principal Financial Group	Health/life insurance	Des Moines, IA	59,851
Standard Insurance Company	Health/life insurance	Portland, OR	36,155
The Hartford	Workman's comp.	Hartford, CT	5,404
Transamerica Occidendal Life	Health/life insurance	Atlanta, GA	17,907
UPAC	D&O insurance	Kansas City, MO	66,197
Watson Wyatt	Dues&subscriptions	Atlanta, GA	13,114
Xerox	Equipment	Chicago, IL	46,940

This uncontroverted evidence shows that the Respondent made substantial purchases from out-of-state vendors, including supplies, insurance, consulting fees, and dues for out-of-state organizations. Such evidence is sufficient to establish antitrust jurisdiction. *McLain v. Real Estate Bd. Of New Orleans*, 444 U.S., 232, 245-46 (1980), *Hospital Building Co.*, at 744. For example, in *Hospital Building Co.*, at 741, the Supreme Court noted that hospital spending of $112,000 in one year on purchases from out-of-state sellers satisfied the Sherman Act's "commerce" requirement.

The member physicians of NTSP likewise make purchases or use equipment manufactured or sold outside of Texas. For example, Dr. Jack McCallum, a neurosurgeon who has served as a Board member and Vice President of NTSP, testified in his deposition that he

prescribes diagnostic procedures that use equipment (such as CT and MRI scanners) made by General Electric, Siemens, and other non-Texas manufacturers. He also testified that he uses out-of-state malpractice insurers. CX1187 (McCallum, Dep. at 162-66). Likewise, Dr. Grant, also a Board member, testified in his deposition that he recently purchased a piece of X-ray equipment costing $170,000, made by Siemens, a German company. CX1177 (Grant, Dep. at 115-16). *See also* CX1199 (Vance, Dep. at 299-300) (purchases or lease of medical equipment from General Electric and Hewlett Packard). Dr. Vance, a former President of NTSP, also testified that he obtains malpractice insurance from a carrier located outside Texas. CX1199 (Vance, Dep. at 300-01).

E. NTSP Defenses Are Not Supported by Reliable Evidence

1. NTSP Has Created Minimal if Any Efficiencies in its Non-Risk Sharing Practices, and its Price-fixing Was Not Ancillary to Alleged Efficiencies

NTSP claims to have implemented many programs and procedures that have improved the quality and overall cost of medical care in its *risk-sharing* practices. CPF ¶ 70. However, half of NTSP's physicians do not participate in risk-sharing contracts at all, and practically all of NTSP's contracts are non-risk fee-for-service contracts. CPF ¶ 78. Currently, NTSP has only one risk-sharing contract covering fewer than 32,000 lives–a contract not at issue in this suit–while it has approximately 20 fee-for-service contracts covering vastly more lives. CPF

¶57. Not surprisingly NTSP claims that efficiencies in risk-sharing practices have "spilled-over" into non-risk sharing practices. CPF ¶¶ 4, 18.

There is no evidence that this spillover has occurred, nor is there any economic or other learning that would suggest spillover from a group of risk-sharing physicians to *other* physicians who do not share risk. As expert witnesses for Complaint Counsel Dr. Harry Edward Frech and Dr. Lawrence Peter Casalino testified, physicians who share risk and learn techniques to control costs and improve quality under risk contracts may individually apply these techniques to patients they treat under non-risk contracts, thereby, providing patients under non-risk contracts with "spillover" benefits. But NTSP physicians who do not participate in NTSP's shared risk contracts–roughly half of the members–are unlikely to learn techniques under these contracts to control costs and to improve quality, and therefore are unlikely to apply these efficiency-enhancing techniques to their patients. CPF ¶¶ 423, 428.

NTSP physicians have not integrated financially through NTSP. For the non-risk contracts challenged here, NTSP's members do not share the risk of financial loss. Non-risk contracts involve straight fee-for-service reimbursement, and therefore no risk.[41] Indeed, NTSP

---

[41] The primary method for sharing risk is for physicians to participate in "risk contracts" where the risk sharing involves accepting payment by capitation for the IPA as a whole. Capitation is a method of payment for medical care under which the capitated entity is paid a fixed amount (usually on a monthly basis) for each patient for whose care the entity is responsible, regardless of the actual number or nature of services provided to the patient. When physicians share capitated risk (the risk that the services provided will outstrip the capitation fees paid), through an IPA for example, that creates interdependence among physicians and provides incentives for the doctors to deliver services efficiently. Where individual physicians (or individual integrated physician practices) take but do not share capitated risk, no such interdependence or mutual incentives for efficient care delivery are created. Capitation stands in contrast to the more traditional "fee-for-service" practice of medicine, under which physicians are paid for the actual services they give a patient (and thus bear no risk). *See* CPF ¶¶ 32-49.

does not even claim any degree of financial integration from its non-risk contracts. Respondent has not proffered any reliable evidence to demonstrate that NTSP's *non-risk* physicians perform better than non-NTSP physicians with regard to higher quality and lower overall costs and utilization. NTSP's efficiencies claims were presented to health plans in the past to support its demand for higher-than-market prices. The health plans Aetna and CIGNA, testified that they did not believe–and did not experience–any efficiencies derived from NTSP's non-risk network that spilled over from the risk sharing arrangements. CIGNA has never paid anything to NTSP for meeting CIGNA's quality service incentives in the contract, CPF ¶ 292, and Aetna, despite its belief that it was "critical" to its own operations to determine if NTSP's efficiency claims were valid, found no support for these claims. CPF ¶ 396-399, 409, 424.

As testified by Dr. Casalino, NTSP lacks a basic component to establish and measure any degree of efficiency in its non-risk business–patients' data. CPF ¶ 424. Moreover, although, as Dr. Casalino testified, IPAs can implement some organized processes to improve quality for patients under non-risk contracts, NTSP has taken no action as an IPA to organize processes for the purpose of improving quality of care for patients under its non-risk contracts. CPF ¶ 423. Further, Dr. Casalino testified that the limited information provided by NTSP, upon which it bases its efficiency argument, is not a reliable basis for reaching a conclusion on this issue. CPF ¶ 462.

Faced with a total dearth of evidence necessary to meet its evidentiary burden, Respondent relies on general concepts of group teamwork and communication to support the proposition that its non-risk sharing physicians have benefitted from NTSP's risk-sharing practices. Respondent asserts that, to maintain "continuity of the team," CPF ¶¶ 442; Maness,

Tr. 2121, it must negotiate a fee that will attract a substantial number, or critical mass, of physicians. NTSP, however, offers no evidence or analysis to support the proposition that a certain number or type of NTSP physicians actually comes together to form such a critical mass. Nor does Respondent offer any guidance for determining the nature or structure of such a critical mass of physicians. In fact, the number and identity of NTSP physicians who participate in each non-risk contract varies markedly[42].

NTSP does not even have the 'right team' to support its team theory. As the expert witnesses testified, NTSP's goal of enhanced teamwork among its physicians is hindered by poor attendance of its physicians at divisional and general meetings and the lack of certain core specialties, forcing NTSP patients to seek physicians outside NTSP. CPF ¶ 249. Dr. Casalino concluded that NTSP teamwork was not sufficient to improve quality, even in NTSP's shared risk contracts, let alone its non-risk contracts. CPF ¶ 429.

Ironically, economics teaches that NTSP's joint negotiations and price-fixing creates inefficiency in the market, rather than efficiency. As Dr. Frech testified, the negative effect of NTSP's price-fixing is not limited to the direct effect of imposing higher prices on consumers, as discussed above, but also makes non-risk contracts artificially attractive to physicians. CPF ¶ 418.

In sum, Respondent cannot show that non-risk sharing physicians, and more importantly, their patients, have realized any efficiencies as a result of NTSP's organizational structure or programs. Moreover, as Dr. Frech testified, and supported by Dr. Deas' testimony, even assuming *arguendo* that NTSP's conduct results in some efficiencies, these alleged efficiencies

---

[42] RX13.

are simply unrelated to NTSP physicians' joint setting of medical service fees, CPF ¶ 418, the evidence simply does not support the argument that NTSP's anticompetitive conduct was *ancillary* to the production of efficiencies in its non-risk business.

As further discussed below, even if Your Honor were not to summarily condemn NTSP's conduct as *per se* illegal, because the described conduct is "inherently suspect," as defined *In the Matter of Polygram Holding, Inc.,* at 35, the Respondent has the burden of showing plausible and cognizable procompetitive effects. *Id.* at 30, 33. The Respondent has failed to show credible evidence of plausible and valid efficiencies in its non-risk contract. Furthermore, the Respondent did not show that the price-fixing was reasonably necessary to create those alleged efficiencies, as required in *Polygram Holding, Inc.,* at 47-48. *See also Broadcast Music, Inc. v. CBS*, at 9; *NCAA v. Board of Regents*, at 98-103, Hence, NTSP's price-fixing conduct should be condemned.

2. Health Plans Must Have Access to Fort Worth Physicians to Serve Fort Worth-based Clients

As the evidence shows, health plans need primary care physicians and specialists from the Fort Worth area to market their plans in Fort Worth, and they would not substitute physicians whose services are available in other areas such as Dallas County or the Mid-Cities area to avoid a small but significant Fort Worth area price increase. CPF ¶ 82, 90. Employers and consumers in Fort Worth require that their health plans offer a broad array of physician services in Forth Worth because they do not want covered persons to have to travel outside of that area on

regularly congested roads to visit a physician. CPF ¶ 81. For this reason, employers in Fort Worth, including the City of Fort Worth, emphasized the importance of having Fort Worth doctors in a network. CPF ¶¶ 81-84. Health plans testified that they would not be able to effectively market their products to Fort Worth employers, nor would they even try, without a sufficient number of Fort Worth physicians covering various fields of practice in their network. CPF ¶ 89. Health plans also testified that, even if the price of Fort Worth area physician services increased by five percent or greater, they would still need to have various kinds of Fort Worth area physicians in their provider panels to serve Fort Worth employers and consumers. CPF ¶ 89. There is also abundant evidence that NTSP recognizes that it serves the Fort Worth area. CPF ¶ 88.[43] Because of the necessity of having Fort Worth area physicians serve employers and consumers in that city, health plans could not switch to Dallas County physicians to avoid anticompetitive behavior by Fort Worth area physicians. CPF ¶ 89, 90.

_____3. NTSP Physicians Are an Integral Part of a Fort Worth Network

---

[43] For example, Karen Van Wagner wrote to a physician in Euless, which is in Tarrant County to the Northeast of Fort Worth, refusing an application to join NTSP, saying that Euless was outside of NTSP's "service area"; Van Wagner wrote in an email in connection with NTSP's United contract: "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 are not using the downtown doctors as their preferred choice any more...can we share this with united and see if we have a case on geographic access...kvw"; (*sic*) and Dr. Jack McCallum testified regarding NTSP's market: Q. As a member of the board of NTSP, did you regard Health Texas as a competitor? A. No. Q. Why not? A. Different market. Q. How so? A. I would get very few patients from Dallas. CX0269; CX1110; CX1187 (McCallum, Depo. at 59).

NTSP has approximately 600 member physicians, of which about 130 are primary care physicians and the remainder specialists. CPF ¶ 51.[44] The vast majority of NTSP physicians are located in the Fort Worth area of Tarrant County. CPF ¶ 52. Many of the primary care physicians and specialists who practice in the Fort Worth area are among NTSP's participating physicians. NTSP physicians make up a large percentage of Tarrant County practitioners in many medical specialties: pulmonary disease (80 percent); cardiovascular disease (59 percent); and urology (69 percent). CPF ¶ 91.

Moreover, health plans and employers believe that Harris Methodist Hospital is critical in a health plan's network. NTSP physicians are the majority of physicians who admit to this hospital. CPF ¶¶ 92-95. Health plans need to include in their networks the physicians who admit and practice at those hospitals. CPF ¶¶ 92-95.

Because NTSP has a substantial percentage of Fort Worth area physicians in many specialties, health plans recognized that they need NTSP's physicians to provide complete medical coverage in the Fort Worth area. Accordingly, health plans testified that NTSP's membership included several critical groups of specialists in the Fort Worth area, and that the marketability of their networks would be severely compromised if they could not contract with these physicians. CPF ¶ 91. As discussed above, CIGNA conducted an independent analysis of the importance of NTSP physicians to its Fort Worth area health plan. This analysis revealed that without NTSP physicians there would be substantial coverage holes in the Fort Worth area in several areas of specialization, including endocrinology, nephrology, and colo-rectal surgery. CPF ¶ 91. Not surprisingly, CIGNA agreed to NTSP's demands rather than risk the loss of so

---

[44] CX1196 (Van Wagner, Dep. at 12).

many crucial physicians. In fact, the evidence shows that health plans typically give into NTSP's contractual demands as a result of NTSP's ability to cripple the health plans' Fort Worth area networks.

As previously discussed above, NTSP is fully aware of its leverage over Forth Worth area health plans and uses this leverage to obtain higher fees from the health plans. CPF ¶ 140, 142, 176.[45]

F. The Complaint Is Supported by Reliable Witnesses; Not So the Defense

The evidentiary record contains overwhelming proof that Respondent's conduct is in violation of the antitrust laws. Much of the record consists of NTSP's own documents: NTSP's communication with its member physicians; NTSP Board meetings minutes; NTSP's internal discussions; and NTSP's correspondence with health plans and others, describing NTSP's and its member physicians' joint price-fixing and rate negotiations.

Complaint Counsel also introduced substantial testimony of third party witnesses who were credible, candid and clear. Jim C. Mosley, City of Fort Worth consultant, Thomas J. Quirk and David C. Beaty of United, Dr. Chris Jagmin and David Roberts of Aetna, Rickey Joe Grizzle of CIGNA, and rebuttal witness Rick Haddock of Blue Cross Blue Shield of Texas ("BCBS")–all recounted their interactions with Respondent and explained the competitive impact of Respondent's conduct. Further, their testimony is fully consistent both with the predictions of

---

[45] CX0209 ("NTSP has become a "gorilla network" with 124 PCP's ... and 528 specialists.").

economic theory and NTSP's own admissions. Though each health plan's story stands by itself to support the complaint, together they provide all the more compelling evidence of NTSP's price-fixing.

The testimony introduced by Complaint Counsel's expert witnesses, Dr. H.E. Frech and Dr. Lawrence Casalino, is credible, reliable and well founded.

In contrast, NTSP based most of its defense on: the often noncredible testimony of Karen Van Wagner, Executive Director of NTSP; the factually ungrounded testimony of Dr. Gail Wilensky, who had little exposure to the workings of physician organizations in general and NTSP in particular; and the testimony of Dr. Maness, which is remarkable, among other things, for its lack of analytical rigor.[46]

1. Complaint Counsel's Expert Witnesses - Dr. Frech and Dr. Casalino

Dr. Frech and Dr. Casalino are credible, reliable and well grounded expert witnesses. Not only do they possess outstanding credentials and expertise, but they also spent considerable time objectively analyzing information regarding NTSP and its conduct.

Unlike Respondent's expert, Dr. Frech has well-recognized expertise in healthcare economics and with respect to physician organizations in particular. Dr. Frech is a professor of economics at the University of California, Santa Barbara, where he researches the application of the principles of industrial organization to the health care industry. CPF ¶¶ 12-13. Dr. Frech has

---

[46] *See* discussion following in text and Appendix A hereto. Dr. Maness principally testified about organization capital in connection with NTSP, though he lacks particularized expertise applicable to organization capital or physician organizations.

published numerous articles relating to the industrial organization of health care in peer-reviewed journals and has testified as an expert in previous health care antitrust cases, for both plaintiffs and defendants. CPF ¶ 13.

In his analysis of NTSP, Dr. Frech focused on the competitive implications of NTSP's contracting behavior. Dr. Frech also reviewed documents produced by NTSP and third parties; interviewed health plans; and read deposition transcripts and expert reports. CPF ¶ 16. Dr. Frech used standard research methodologies in his analysis of NSTP, except, as he explained in court, to the extent that litigation gives more documentary access than does academic research. CPF ¶ 16.

Dr. Casalino has considerable experience relating to the application of organized processes to physician organizations to achieve utilization and quality improvements. In fact, Dr. Casalino's Ph.D. dissertation researched how medical groups and IPAs affect the quality and cost of physician services. CPF ¶ 19. During the 20 years he practiced medicine, Dr. Casalino managed his own medical group of between five and nine physicians, and served on the board of directors of one of the IPAs in which his medical group participated. CPF ¶ 20.

Presently, as a professor in the Department of Health Studies in the University of Chicago Medical School, Dr. Casalino concentrates his research on how the various forms of physician organizations affect the quality and cost of physician services. CPF ¶ 21. 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. CPF ¶ 22.

In his analysis of NTSP, Dr. Casalino focused on NTSP's claimed objectives of clinical integration, quality improvement, and cost control, and the question of whether or not it is reasonably necessary for NTSP to negotiate collectively prices with health plans to achieve these objectives. To complete his analysis, Dr. Casalino also reviewed documents produced by NTSP and third parties; conducted electronic searches through these documents; and read deposition transcripts, expert reports, and trial transcripts. CPF ¶ 23. Dr. Casalino used standard research methodologies in his analysis of NTSP, except to the extent that litigation gives more documentary access than does academic research. CPF ¶ 23.

2. Assessment of Respondent's Expert Witnesses

NTSP's counsel, in his opening statement, told this Court that NTSP would offer the testimony of three expert witnesses in support of its defense. For reasons sufficient to itself (and not known to the rest of us), NTSP did not do so, declining to have Dr. Edward F. X. Hughes, a medical doctor and holder of a Masters degree in Public Health, take the stand. Instead, NTSP offered this Court only the testimony of its two Ph.D. economists, Gail Wilensky and Robert Maness.

Complaint Counsel respectfully suggests that the testimony of Dr. Wilensky is entitled to very little weight because, as we explain, her testimony was only marginally connected to NTSP and the record in this matter. With respect to Dr. Maness, we urge Your Honor to accord no weight whatsoever to his testimony. Dr. Maness may be qualified to testify in general as to matters of industrial organization (though not, we conclude as to either organization capital or

physician organizations specifically). However, as we explain below, Dr. Maness' testimony is of doubtful credibility, and he utterly failed to bring appropriate intellectual rigor to his inquiry and analysis in this matter. His conclusions sit precariously atop a pile of errors of omission and commission, and, therefore, should be rejected as incapable of assisting this Court and the Commission in resolving this suit. Complaint Counsel's critique of Dr. Maness' testimony, while summarized in this brief, is extensive, and therefore is elaborated in full in an attached Appendix.

a. The Testimony of Robert Maness, Ph.D. Is Entitled to No Weight.

As explained here, Complaint Counsel asks that Your Honor give no weight to Dr. Maness testimony.

Dr. Maness' expertise is in industrial organization in general. CPF ¶ 436. Although he testified about organization capital in connection with NTSP, Dr. Maness lacks particularized expertise applicable to organization capital or physician organizations. CPF ¶ 436. Indeed, Dr. Maness acknowledged on cross-examination that organization capital is not a field in which persons previously have testified as experts in courts, nor is it even "a discipline." CPF ¶ 436.

Dr. Maness often was evasive or uncooperative during cross examination. CPF ¶ 437. The Court not fewer than 13 *times* was required to strike unresponsive testimony of Dr. Maness and instruct him to answer questions posed that clearly were answerable as asked. CPF ¶ 437.

Moreover, the record reflects a stubborn determination of Dr. Maness to avoid any truth potentially harmful to Respondent, CPF ¶ 438, and Dr. Maness' opinions seemed oddly

impervious to change when he was asked to consider the import of additional information or alternative putative fact statements. CPF ¶ 438. The triumph of partisanship over objectivity and candor is represented in Dr. Maness' inquiry and testimony.

Further, Dr. Maness' testimony at times appeared to affirmatively mislead. For example, on two occasions Dr. Maness was impeached for using plurals to convey that he was aware of numerous instances of an occurrence that he reckoned to the benefit of Respondent, when in fact he was aware of but a single instance. CPF ¶¶ 470-471. For example, on cross-examination Dr. Maness was asked whether NTSP enjoyed "a reputation as a particularly effective and efficient physician organization . . . with [any] health plans participating in the Ft. Worth community." He replied: "Some," while in fact, when asked in cross-examination, he testified that he could not identify more than one health plan. Maness, Tr. 2331:6-2332:3. CPF ¶ 470. The same misleading pattern recurred when Dr. Maness testified in direct examination that NTSP had been, at least in important part, responsible for dangerous pharmaceuticals, being removed from the market. In cross-examination he testified he knew about only one incident, and to Complaint Counsel's question in this matter he replied: "If you want to call it [another] fictitious [plural], that's fine." Maness, Tr. 2332:5-19. CPF ¶ 471.

Even were Your Honor to assume that Dr. Maness sought to convey the whole truth as he understood it, Dr. Maness' testimony should be given no weight because in formulating his opinion in this matter, Dr. Maness often failed egregiously to apply the care and rigor that this Court should expect from a competent expert economist. CPF ¶ 439. Dr. Maness conducted only a limited document review in this matter. CPF ¶ 440. 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. CPF ¶ 441. Therefore, all of his information about NTSP, except for the documents and testimony he reviewed, came from one highly interested and biased source – Karen Van Wagner. Dr. Maness' abject failure of care and rigor infects the entirety of his testimony. CPF ¶¶ 439-474.

In light of all that, as further detailed in Appendix A to this pleading, we ask your Honor to give no weight to Dr. Maness' testimony.

b. The Testimony of Gail Wilensky, Ph.D. Is Entitled to Very Little Weight

Without question, Dr. Wilensky is an expert in matters of national health care policy. CPF ¶ 430. She has, however, had little exposure to the workings of physician organizations in general and NTSP in particular. CPF ¶ 431.

Further, Dr. Wilensky has very limited familiarity with the relevant facts of this case. CPF ¶ 431. As Dr. Wilensky testified at trial, in formulating her opinions she selectively reviewed background materials, participated in some discussion with NTSP personnel, and "read or skimmed" only some of the depositions taken. CPF ¶ 432.

As a result, at trial Dr. Wilensky acknowledged that she does not know or fully understand many details about how NTSP and its physicians go about their business. CPF ¶ 433. Specifically, Dr. Wilensky acknowledged that she is unclear as to what NTSP does within the fee-for-service context. CPF ¶ 433. This is a particularly serious failure of knowledge and understanding in that the Commission's complaint centers around NTSP's and its physicians'

conduct with respect to those very fee-for-service contracts; and it is a particularly serious failure of knowledge and understanding in that NTSP's defense has centered on its assertion that efficiency-inducing NTSP practices and procedures spill over from its shared-risk PacifiCare contract to its fee-for-service contracts.

Accordingly, it is no small matter that, in addition to the above, Dr. Wilensky acknowledged at trial that she does not know whether NTSP enrolls fee-for-service patients in its palliative care program, CPF ¶ 434; that she does not know whether NTSP enrolls fee-for-service patients in any quality improvement-related program, CPF ¶ 434 ; that she does not know whether NTSP's medical management committee discusses high acuity cases among fee-for-service patients, CPF ¶ 434; and that she does not know whether NTSP's disease registry program applies to fee-for-service patients. CPF ¶ 434.

We acknowledge the care that Dr. Wilensky generally took to maintain her testimony at a level of abstraction appropriate to her expertise. At the same time, her exercise of that expertise had precious little grounding in an understanding of NTSP and the facts of this litigation. Accordingly, we respectfully urge Your Honor to find that Dr. Wilensky's opinions in this matter cannot be accorded substantial weight.

3. The Testimony of Karen Van Wagner Is Entitled to Little or No Weight

The credibility of NTSP's main witness, Karen Van Wagner, is unreliable because the evidence shows that Van Wagner is intimately associated with the challenged conduct and is greatly interested in the outcome of this proceeding. *See* CPF ¶¶ 66-73.

Van Wagner's credibility is dubious given what she stands to lose if NTSP loses this case

– the continuation of the benefits that she receives from NTSP may be substantially dependent on NTSP's continuation under its present "business model." Van Wagner's current base salary as NTSP's Executive Director is approximately $270,000. CPF ¶ 66. In addition to her salary, Van Wagner regularly receives a bonus for her work with NTSP, including in calendar year 2003, when it totaled over $40,000. CPF ¶ 66.

Van Wagner's credibility is also doubtful given her husband's stake in this case. 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 only after Van Wagner became NTSP's Executive Director. CPF ¶ 66.

Moreover, since most of the conduct questioned in these proceedings was done or at least supervised by Van Wagner, her testimony should be carefully scrutinized alongside the other evidence. Such examination of the evidence shows that Van Wagner was often less than candid on direct examination. CPF ¶ 67.

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. CPF ¶ 70.

Van Wagner evasively testified that she did not have the authority to send out to members ("to messenger") Aetna's proposal in late 2001, CPF ¶ 69, 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 4, 10-11) and CPF ¶ 69, as did Dr. Grant, another NTSP Board member, CX1177 (Grant, Dep. at 3, 12).

Van Wagner's credibility is also dubious with respect to her testimony about NTSP's negotiations with BCBS. Van Wagner testified at trial that NTSP did not propose to BCBS a fee-for-service arrangement with PPO prices at 145% of current Medicare. CPF ¶ 72. She sought to characterize a document suggesting the contrary, CX0085, as a typographical error. Asked again in cross-examination if she was certain that the error was merely typographical and that she did not in fact discuss a 145% price with BCBS, she expressed her certainty that 145%, which was more than NTSP's minimum price in effect at that time, had never been mentioned to BCBS. CPF ¶ 72. She subsequently was impeached on this point by the testimony of BCBS' 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. CPF ¶ 72.

Van Wagner's testimony regarding Aetna is also suspect. Van Wagner denies that she made a proposal on PPO rates to Aetna. However, she clearly wrote "proposal" in an e-mail to Aetna, and did not deny doing this in her testimony. CPF ¶ 71.

In her testimony, Van Wagner evasively sought to repudiate her prior characterization, in her business documents, of NTSP price offers that clearly pertained to fee-for-service contracts as ongoing "negotiations" and "NTSP proposals." CPF ¶ 71.

However, Dr. Grant testified that he had assumed that NTSP staff were negotiating price terms and negotiating for more favorable rates for NTSP physicians as a whole. CPF ¶ 127; CX1177 (Grant, Dep. At 3). Also, David Roberts from Aetna attended an NTSP Board meeting in November 2001. At that Board meeting, attended by Van Wagner, NTSP attempted to negotiate rates by mentioning the possibility of a rate level in the low 120s, which was below NTSP's prior offer of 125 and above Aetna's offer of 118. CPF ¶¶ 127, 411; CX0106).

Van Wagner has also given conflicting testimony in this case. For example, 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. CPF ¶ 68.

In the Matter of Schering-Plough Corporation, No. 9297 (F.T.C. Dec. 18, 2003), the Commission was faced with testimony by the parties that contradicted contemporaneous business records. *Id* at 43. The Commission emphasized that although self serving testimony is not subject to "automatic discount" as such, "when the trial testimony of a strongly self interested witness conflicts with the same witness's earlier testimony in a more unguarded moment, with contemporaneous documents or with statements of less interested witnesses, it is necessary to take account of these alternative versions of the facts." *Id.* Indeed, the Commission held that the prior documents regarding business negotiations were more credible than subsequent contradictory, self serving witness testimony. *Id.* at 73.

For all of the above reasons, Van Wagner's testimony cannot be relied upon, 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.

III. ARGUMENT

A. NTSP Violated the FTC Act by Acting as and Coordinating a Price-Fixing

Conspiracy among Otherwise Competing Physicians

A violation of Section 5 of the FTC Act, 15 U.S.C. §45, is established if the Court finds: (1) the existence of a contract, combination, or conspiracy among two or more separate entities, (2) which are subject to the antitrust law, that (3) unreasonably restrains trade, and (3) the acts or practices are in or affecting interstate or foreign commerce.[47]

1. NTSP Is a Combination of Competitors Subject to the Antitrust Laws and the FTC Has Jurisdiction over it

Trade and professional associations, including NTSP, are "by definition, [an] organization[ ] of competitors, [that] automatically satisf[ies] the combination requirements of §1 of the Sherman Act."[48] As a result, trade associations are subject to the antitrust laws when those associations attempt to restrain competition.[49] When competitors in such organizations band together to jointly set terms, including price terms, upon which they will deal with customers, they are vehicles for price-fixing.

---

47 *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 431 n. 8 (1990).

48 *Alvord-Polk, Inc. v. Schumacher & Co.*, 37 F.3d 996, 1009 n.11 (3d Cir. 1994) ("a trade association, in and of itself, is a unit of joint action sufficient to constitute a section 1 combination."). *See also Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 500 (1988) (holding unlawful certain conduct by a standards-setting organization, and observing that: "There is no doubt that the members of such associations often have economic incentives to restrain competition" and that their actions "have a serious potential for anticompetitive harm.")

49 *Addino v. Genesee Valley Med. Care, Inc.*, 593 F. Supp. 892, 896-97 (W.D. N.Y. 1984).

NTSP is not a single entity with a "complete unity of interest," thus incapable of conspiring with itself.[50] Rather, it is an association of individual competing physicians, or competing group practices, who have not integrated their practices into a collective whole, and thus, have separate economic interests. When addressing a similar issue, in *Addino* the court held that the defendant organization "is merely a vehicle for the member MDs to fix prices charged by those MDs as well as other health care providers. . . . It is not sufficient to assert, as defendants do, that a corporation cannot conspire with itself. We must look at substance rather than form."[51]

2. The FTC Has Jurisdiction over NTSP Because it is a Corporation Organized to Carry on Business for the Profit of its Members

Under Section 5 of the FTC Act, the Commission has jurisdiction to prevent "corporations" from using unfair methods of competition, 15 U.S.C. § 45(a)(2). Section 4 of the Act defines "corporation" as "any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that

---

50 *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 771 (1984).

51 *Addino*, at 896-97. *See also Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022, 1030 (9th Cir. 1989) (denying summary judgment where plaintiff produced evidence demonstrating that the defendant was an organization of physicians). Similarly, in recent years the Commission has authorized complaints against trade associations that engage in anticompetitive conduct. For example, *In the Matter of Fair Allocation System*, 126 F.T.C. 626, 3 (1998), the Commission charged an incorporated association of franchised automobile dealerships with acting "in agreement, combination or conspiracy with some of its members to restrain trade . . . by threatening to boycott particular models." *See also U.S. v. General Motors Corp.*, 384 U.S. 127, 143 (1966) (noting that car dealers "collaborated, through the [trade] associations and otherwise, among themselves and with General Motors").

of its members," 15 U.S.C. §44.

a. NTSP Physicians Are "Members" of the Organization Within the Meaning of the FTC Act

NTSP is incorporated under Texas law as a non-profit entity with no members.[52] Thus, the participating physicians of NTSP are not "members" as a matter of Texas corporation law–though they are commonly referred to by NTSP as "members," and are treated in the same manner as any other trade association or professional organization treats its members. In determining jurisdiction under the Federal Trade Commission Act, the courts and the Commission look to substance, rather than organizational form. This same principal–the priority of substance over form–should be applied in defining NTSP's "members," as that term is used in the FTC Act. This Court should look to the practical operation of NTSP, not the narrow technicalities of Texas corporation law, and recognize the participating physicians of NTSP as "members" in the common sense, generally accepted usage of that word.

As discussed above, and further detailed in CPF, the evidence in this case shows that NTSP physicians are in fact "members" of an association dedicated to advancing their business interests. NTSP physicians are referred to as "members" by NTSP, participate in "General Membership meetings" and are involved in and served by NTSP as members.

---

[52] NTSP was organized as a memberless non-profit corporation under Section 5/01(a) of the Texas Medical Practice Act. The Texas Non-Profit Corporation Act defines "member" as "one having membership rights in accordance with the provisions of its Articles of Incorporation or its by-laws." Tex. Rev. Civ. Stat. Ann. Art. 1396-1.02(A)(6) (West 2001).

Though we are unaware of any judicial constructions of the term "member," there is precedent in judicial interpretations of the word "profit" (as used in the FTC Act's definition of "corporation"). In *Community Blood Bank of Kansas City Area,* the Eighth Circuit applied the principle "that Congress will be presumed to have used a word in its usual and well-settled sense," and looked to the "generally accepted definition" of "profit" in assessing whether the respondent "engages in business for profit within the traditional and generally accepted meaning of that word." *Id.* at 1015, 1022.[53] Thus, there is precedent for this Court to define NTSP participating physicians as members by looking to the traditional and generally accepted meaning of the word rather than the technicalities of Texas corporation law.

---

[53] The court was at pains to emphasize that its ruling that the association there was not acting for its own profit was based on "reality" rather than "the mere form of incorporation:"

> In making this ad hoc determination, we do not mean to hold or even suggest that the charter of a corporation and its statutory source are alone controlling. Indeed, the corporate petitioners, with candor, recognize that the mere form of incorporation does not put them outside the jurisdiction of the Commission. Their position, with which we agree, is that the reality of their being in law and in fact charitable organizations places them beyond the reach of the Act.

Community Blood Bank of Kansas City Area, at 1018-19. As authority, the court cited "instances where corporations organized under nonprofit laws have actually engaged in profit-making or other activities. When this occurs they may lose their charter through quo warranto proceedings." *Id.* at 1019 n.15. The court went on to note that

> "There is no contention that any of the corporate respondents is a device or instrumentality of individuals or firms who seek monetary gain through the nonprofit corporation."

Id. at 1019. This is precisely the nature of Complaint Counsel's allegations against NTSP, supported by the substantial evidence discussed in the previous section.

b. A Substantial Part of NTSP's Activities Provide Pecuniary Benefits for its Members

The Commission has consistently held, and federal courts have agreed, that Section 4 extends to a non-profit entity when a substantial part of the entity's total activities provides pecuniary benefits for its members. *See California Dental Ass'n.*, at 766-68. *See also American Medical Ass'n*, at 983-84. The evidence discussed above demonstrates that NTSP is a non-profit association created and operated for the main purpose of engendering pecuniary benefits to its members. As such, it is a "corporation" within the meaning of Section 4.

The Supreme Court set forth the test for finding Commission jurisdiction over a nonprofit organization in *California Dental Ass'n*, where the Court affirmed the Commission's holding that a non-profit professional association which confers pecuniary benefits to its members through a substantial part of its activities is a corporation under Section 4 of the FTC Act.[54] The Court noted that FTC jurisdiction over a non-profit entity does not require that the entity "devote itself single-mindedly to the profit of others:"

> Nonprofit entities organized on behalf of for-profit members have the same capacity and derivatively, at least, the same incentives as

---

[54] Though the association was organized as a non-profit corporation under state law and was exempt from federal taxes, the Commission found that services such as offering professional liability insurance, business and personal insurance, and practice management seminars are sufficient to satisfy the jurisdictional threshold of the Act. *See California Dental Ass'n.*, at 765-66. The Ninth Circuit affirmed, holding that it would not exclude from the FTC's reach "the many nonprofit corporations that conduct substantial commercial and related activities," and that the "FTC's approach of looking at whether the organization provides tangible, pecuniary benefits to its members as a surrogate for 'profit' is a proper way of deciding which nonprofit organizations are subject to its jurisdiction." *California Dental*, 128 F.3d 720, 726 (1997).

> for-profit organizations to engage in unfair methods of competition or unfair and deceptive acts.

Id. at 766, 768. Enumerating a list of activities, the Court concluded that "an entity organized to carry on activities that will confer greater than *de minimis* or presumed economic benefits on profit-seeking members certainly falls within the Commission's jurisdiction." *Id.* at 768 n.6.

The test for finding antitrust jurisdiction over a non-profit entity was first laid out in *Community Blood Bank of Kansas City Area*, where the Eighth Circuit rejected the notion that a corporation's non-profit organizational form places it beyond the Commission's jurisdiction. An examination of the legislative history of the FTC Act led the court to conclude that "Congress did not intend to provide a blanket exclusion of all non-profit corporations, for it was also aware that corporations ostensibly organized not-for-profit, such as trade associations, were merely vehicles through which a pecuniary profit could be realized for themselves or their members." *Community Blood Bank of Kansas City Area,* at 1017. *See also F.T.C. v. Nat'l Comm'n on Egg Nutrition,* 517 F.2d 485, 487-88 (7th Cir. 1975), *cert. denied,* 426 U.S. 919 (1976).

Although the court in *Community Blood Bank of Kansas City Area* eventually found that the association in question was a true non-profit corporation, not subject to the Commission's jurisdiction, it nonetheless held that:

> Under § 4 the Commission is vested with jurisdiction over nonprofit corporations....which 'carry on business for (their) own profit or that of [their] members,' within the traditional and generally accepted definition of the quoted phrase.

Id. at 1022.

This standard was amplified in *American Medical Ass'n*, ("AMA"), where the Commission found that AMA had violated Section 5 of the FTC Act by restricting advertising and solicitation by its members. In finding jurisdiction, the Commission rejected the argument

that the term "profit" is limited to direct gains distributed to its members. Instead, the Commission agreed with the Administrative Law Judge ("ALJ"), who ruled that the FTC can "assert jurisdiction over nonprofit organizations whose activities engender a pecuniary benefit to its members if [those] activit[ies are] a substantial part of the total activities of the organization, rather than merely incidental to some non-commercial activity." *American Medical Ass'n.*, at 983.[55]

Since *AMA*, the FTC has adhered to the standards above to find that it has jurisdiction over non-profit corporations. For example, in *Michigan State Medical Society*, the Commission found jurisdiction over a non-profit medical society that engaged in lobbying that affected physicians' pecuniary interests and operated a for-profit malpractice insurance carrier. Likewise, in *College Football Association,* 117 F.T.C. 971, 1000-8 (1994), the Commission asserted that a "finding that a substantial part of an association's activities engenders pecuniary benefits for profit-seeking members is sufficient to establish that the association is organized to carry on business 'for the profit' of its members."[56] Under the standards set forth by the Supreme Court in

---

[55] Close examination of AMA's activities, including its dealings and contracting practices with third-party payers and insurance carriers on behalf of its members, led the ALJ to conclude that many of AMA's activities revealed "a clear, direct economic purpose and effect." *Id.* at 925. The ALJ further noted that while the organization engaged in educational, scientific and public health activities, a "significant part of [its] time and resources [was] devoted to obtaining, protecting and furthering the economic interests of [its] members." *Id.* at 926. The Commission agreed, and also pointed to founding documents and promotional literature indicating that one of AMA's goals was to serve the "material interests" of the medical profession and provide "tangible benefits and services to its members," such as insurance programs, a retirement plan, a physician placement service, publications, authoritative legal information, and practice management programs. *Id.* at 986-87.

[56] Finding substantial tangible activities engendering pecuniary benefits is not always required. Courts have also deemed sufficient that a non-profit corporation promotes "the general interests" of an industry. *See Nat'l Comm'n on Egg Nutrition*, at 487-88, where the court found sufficient that "NCEN was organized for the profit of the egg industry, even though it

California Dental Ass'n, at 766-67, the contributions of NTSP's conduct "to the profits of its individual members are proximate and apparent," and its conduct "fall[s] within the object of enhancing its members' 'profits.'" Moreover, in *California Dental Ass'n*, the Court of Appeals in finding FTC jurisdiction noted that certain "activities, such as continuing education and financing assistance, indirectly make members' practices more efficient and reduce their costs." *Id.* at 726. NTSP likewise contends that its activities allegedly have lowered the total cost of its members' services, thus justifying a premium price. *See* CX1199 (Vance, Dep. at 312-13, 317-19).[57] Such activities are thus undertaken for the pecuniary benefit of its members. CPF ¶ 53. *See, e.g.* CPF ¶ 227.

As discussed above, and further detailed in CPF, the evidence in this case demonstrates that NTSP acts in its members pecuniary benefit. NTSP's primary function is to enter into contracts with health plans, thus providing business and income to its members. In fact, by fixing prices and jointly negotiating non-risk contracts, NTSP has succeeded in increasing its members' rates and revenues. Therefore, the FTC has jurisdiction over NTSP because it is a corporation organized to carry on business for the profit of its members.

3. The Challenged Restraints Are Unreasonable Restraints of Trade and Are Presumptively Anticompetitive

---

pursued that profit indirectly," and thus came within the scope of Section 4 of the Act.

[57] *See also* CX1174 (Deas, Dep. at 97): "Our argument was that our total health care cost was still lower than the metroplex average or other physician groups and that that didn't justify a reduction in compensation for the network on the existing contract." and CX1174 (Deas, Dep. at 58, 62).

Horizontal price restraints fall within the category of conduct that traditionally has been condemned as *per se* unlawful.[58] As shown by "past judicial experience and current economic learning," *per se* unlawful conduct warrants "summary condemnation" due to its "likely tendency to suppress competition."[59] Price restraints by professionals, such as physicians, are subject to the same standard, *i.e.*, they have been subject to *per se* condemnation by the courts.[60] Similarly, the Commission also condemns horizontal price restraints in the health care field: "[T]here have been arrangements among physicians that have taken the form of networks, but which in purpose and effect were little more than efforts by their participants to prevent or impede competitive forces from operating in the market. . . . Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are per se illegal."[61]

As discussed above and further detailed in CPF, documents and testimony demonstrate that NTSP has successfully obtained higher prices for physician services due to NTSP's illegal agreements. The evidence shows that NTSP and its member physicians agreed to directly restrain price competition among its member physicians with regard to fee-for-service medicine by

- polling and disseminating averaged data on future prices, and collectively setting and sharing minimum contract prices based thereon,

---

58 *Trans-Missouri Freight Ass'n*, at 324, *Socony-Vacuum Oil Co.*, at 223, 224 n. 59.

59 *In the Matter of Polygram Holding, Inc.*, at 29.

60 *Arizona v. Maricopa County Medical Soc'y*, at 348-49. *See also Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (lawyers' price-fixing illegal).

61 *Health Care Statements* at 73-74. *See also Health Care Statements* at 89-92 (illustrative example finding "per se unlawful" a physician network where, *inter alia*, "physicians' purpose in forming network "is to increase their bargaining power with payers," notwithstanding physicians contribution of capital.)

- negotiating prices with health plans on behalf of members,
- collecting of powers of attorney from members,
- campaigning among member physicians to press employers to assist NTSP in negotiating higher physician fees with health plans, and
- threatening to terminate and terminating existing contracts with health plans.

The totality of this evidence demonstrates that NTSP entered into a "contract, combination or conspiracy" to implement and enforce price and related agreements, engaging in the same type of conduct struck down as *per se* illegal in *Arizona v. Maricopa County Medical Soc'y.*[62] Thus, because NTSP's acts and practices fit squarely within the conduct traditionally condemned as *per se* illegal, there is no need to engage in an extensive or elaborate analysis of market definition and competitive effects. *In the Matter of Polygram Holding, Inc.*, at 2, *see also Dagher v. Saudi Refining, Inc.*, 2004 WL 1191941 (9th Cir. June 1, 2004) (it is unnecessary and even inappropriate to assess market power in a price-fixing matter). Moreover, irrespective of the standard of analysis applied, indirect evidence of respondent's market power, such as a high market share within a defined market, is unnecessary where, as here, there is direct evidence of price-fixing among competitors.[63]

---

[62] *Arizona v. Maricopa County Medical Soc'y*, a physicians' association sought to jointly set prices in contracting with insurers. The Court held that the horizontal price-fixing was per se illegal: "The fee agreements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely into the horizontal price-fixing mold." At 357.

[63] *See Todd v. Exxon Corp.*, 275 F3d 191, 206 (2d Cir. 2001) ("actual adverse effect on competition . . .arguably is more direct evidence of market power than calculations of elusive market share figures"); *Re/Max International, Inc. v. Realty One, Inc.*, 173 F3d 995, 1018 (6th Cir. 1999) ("an antitrust plaintiff is not required to rely on indirect evidence of a defendant's monopoly power, such as a high market share within a defined market, when there is direct evidence that the defendant has actually set prices or excluded competition").

Although horizontal price agreements historically have been labeled *per se* illegal and condemned summarily, Your Honor may choose to examine the conduct at issue here along an "analytical continuum." *California Dental Ass'n*, at 780-81. As the Commission explained recently, "the evaluation of horizontal restraints takes place along an analytical continuum in which a challenged practice is examined in the detail necessary to understand its competitive effect analyses." *In the Matter of Polygram Holding, Inc.*, at 22. This analysis, nevertheless, will find NTSP's conduct unlawful.

The evidence here demonstrates that "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question have an anticompetitive effect on customers and markets." *California Dental Ass'n*, 526 U.S. at 770. The setting of prices by competitors and the use of those prices in joint negotiations with customers (health plans) "are of a sort that generally pose significant competitive hazards," and are thus inherently suspect.[64] NTSP set prices among otherwise competing physicians by, among other things, establishing Board minimum acceptable prices, polling and disseminating the results, joint collectively terminating and threatening to terminate contracts, collecting of power of attorneys, rejecting offers below Board established minimum price and negotiating prices. The Court in *Indiana Federation of Dentists* held that "no elaborate industry analysis is required to demonstrate the anticompetitive character of" horizontal agreements, "absent some countervailing procompetitive virtues –such as, for example, the creation of efficiencies in the operation of a market or the

---

64 In *Indiana Federation of Dentists* the Court rejected the argument that the Commission erred in not making elaborate market power determinations, stating "the Commission's failure to engage in detailed market analysis is not fatal to its finding of a violation." *In the Matter of Indiana Federation of Dentists at 460.*

provision of goods and services."[65] Accordingly, we respectfully urge Your Honor to treat NTSP's restraints of trade as *per se* illegal or, at least, inherently suspect, requiring NTSP to put forth plausible and cognizable justifications.

4. The Challenged Restraints Affect Interstate Commerce and Are Subject to FTC Jurisdiction

It is settled law that even purely local activities are within federal antitrust jurisdiction if they have a "not insubstantial" effect on interstate commerce. *Hospital Building Co.,* at 745-746 (1976). The jurisdiction of the FTC is co-extensive with that of the Sherman Act, which has been held co-extensive with the federal power to regulate interstate commerce.[66] In finding jurisdiction under Section 5 of the FTC Act, the Commission has applied the same legal standards as the federal courts have applied under the Sherman Act. *See McLain v. Real Estate Bd. Of New Orleans,* at 241-42, *California Dental Ass'n*, at 762.

It is sufficient to prove potential, not actual, effect on commerce, and the effect need not be measurable; it is sufficient that "as a matter of practical economics" the conduct "could be expected" to affect the flow of commerce.[67] Under *McLain v. Real Estate Bd. Of New Orleans,*

---

65 In *Indiana Federation of Dentists, Id.* at 459, the Court found that a conspiracy among dentists to refuse to submit x-rays to dental insurers for use in benefits determinations constituted an unfair method of competition.

66 *See American Medical Ass'n,* at 983-984, and *Summit Health Ltd. v. Pinhas,* at 329, n.10. The Fifth Circuit has likewise held that under the Sherman Act "Congress exercised the full panoply of power authorized by the Commerce Clause." *Cowan v. Corley,* at 225.

67 *See Summit Health Ltd. Health Ltd. v. Pinhas,* at 330, *Goldfarb,* at 785, *Hospital Building Co.,* at 785. *See also U.S. v. Fischbach and Moore, Inc.*, 750 F.2d 1183, 1191-1192 (3rd

at 241-42, the antitrust requirement of a "not insubstantial" effect on commerce depends upon the nature of the restraint and its effect, not the amount of commerce involved. *See also, St. Bernard General Hospital v. Hospital Service Ann'n,* 712 F.2d 978, 984 (5th Cir. 1983).

Under *Summit Health Ltd. v. Pinhas* at 332, the Court may look at the conduct of all members of a conspiracy in assessing whether the restraints may affect commerce. Alternatively, it may be sufficient to prove that the *general business activities* of the respondent affect commerce. *McLain v. Real Estate Bd. Of New Orleans*, at 242-43. *See also, U.S. v. ORS, Inc.*, 997 F.2d 628, 629 n.4 (9th Cir. 1993). However, regardless of the standard applied, the facts discussed above demonstrate that the actions of NTSP and its members had a "substantial" or at the very least a "not insubstantial effect" on interstate commerce.

In *California Dental Association*, the actions of a medical association were found "as a matter of practical economics" to have had a substantial effect on interstate commerce, and its conduct thus was subject to the jurisdiction of the FTC. *Id.* at 262. Such activities included: the receipt by Association members of reimbursements that cross state lines for services provided under health insurance plans that affect the federal government; the purchase or lease of dental equipment from out-of-state manufacturers; competition between Association members and out-of-state dentists for patients; treatment of patients residing outside California; use of the U.S. Postal Service to enforce the Association's Code of Ethics; and the operation of subsidiaries that

---

Cir. 1984), where the court noted that the government "may prove the nexus between the interstate commerce and the challenged activity through either the activities of the target of the antitrust violation or the defendant's actions," and held that a local bid-rigging conspiracy by electrical contractors was in interstate commerce, based on evidence that both the contractors and the corporation that they served ordered substantial amounts of materials from out of state.

provide insurance and other services to members through out-of-state companies.[68]

In *Hospital Building Co.*, involving allegations that a hospital had tried to block a rival's expansion to preserve its dominance in the Raleigh, NC market, the plaintiff alleged that the hospitals purchased medicines and supplies from out-of-state, derived revenues from out-of-state sources, and financed their construction through out-of-state lenders. In that case, the Court found that the combination of these factors was sufficient to establish a "substantial effect" on interstate commerce under the Sherman Act, *Id.* at 744. Furthermore, the Court stated that as long as the challenged acts and practices place "unreasonable burdens on the free and uninterrupted flow of interstate commerce, they are wholly adequate to state a claim." *Id.* at 746. The Fifth Circuit likewise has applied broad jurisdictional standards to the antitrust laws, holding that under the Sherman Act "Congress exercised the full panoply of power authorized by the Commerce Clause." *Cowan v. Corley* at 225. The court there held that the actions of an association of local wreckers, who were authorized to provide towing services from public property, came within the reach of the antitrust laws, finding that the provision of towing services to the interstate vehicular movement of goods and people through the county substantially affected interstate commerce.

In *U.S. v. Young Brothers, Inc.*, 728 F.2d 682, 687-88 (5th Cir. 1984), highway bid-rigging was found to affect commerce based on evidence that out-of-state vehicles used the roads in question and that equipment used in the construction was purchased and delivered from out-

---

[68] The ALJ also cited the Commission's decision in *American Medical Ass'n*, at 993-996, in which "the Commission determined that it had jurisdiction over state and local medical societies which restricted advertising by health-care professionals because these activities, some of which were local in character, had a substantial effect on interstate commerce."

of-state sources. The court also found that the price-fixing affected interstate commerce "because equipment suppliers were forced to bargain with a contractor who, as a result of an unlawful conspiracy, possessed a monopolistic position as a buyer or lessee of heavy construction equipment." *See also Ancar v. Sara Plasma, Inc.*, 964 F.2d 465 (5th Cir. 1992); *Park v. El Paso Board of Realtors*, 764 F.2d 1053, 1063 (5th Cir. 1985) (boycott conspiracy among local brokers "had a significant effect on interstate commerce through the financing of real estate loans, the furnishing of title insurance, and the advertising of properties for sale").[69]

As discussed above, and further detailed in CPF, the evidence in this case demonstrates

---

[69] A wide variety of conduct by healthcare providers has been held to affect interstate commerce sufficiently to confer antitrust jurisdiction. In *St. Bernard General Hospital,* at 984, the Fifth Circuit, reversing the dismissal of antitrust claims following the close of plaintiff's case, applied *Hospital Building Co.*, and found sufficiently substantial effect on interstate commerce:

> Undisputed evidence in the record shows that St. Bernard purchases much of its supplies from out-of-state suppliers and from out-of-state manufacturers. The economic damage that St. Bernard alleges obviously affected these transactions, whether directly in terms of St. Bernard's ability to purchase supplies or indirectly in terms of its general economic strength and viability.

St. Bernard General Hospital, at 984 *See also Oksanen v. Page Memorial Hospital,* at 702 n.1, (antitrust jurisdiction in a peer review case established by evidence, *inter alia*, that the hospital purchased supplies and received payments from out of state and treated out-of-state patients); *Miller v. Indiana Hospital,* at 143 n.5 ("a hospital's treatment of out-of-state patients, purchase of medical supplies from out-of-state, and receipt of money from out-of-state, including federal funds, satisfies the requirement of affecting interstate commerce"); *U.S. v. North Dakota Hosp.*, 640 F. Supp. 1028, 1035-1036 (D.N.D. 1986), (jurisdiction based on evidence of payments to local hospitals by an out-of-state federal agency.) *See also BCB Anesthesia Care v. The Passavant Memorial Area Hospital* Ass'n, 36 F.3d 664 (7th Cir. 1994) (nurse anesthesiologists and hospitals treated out-of-state patients, generated revenue from out-of-state, and received reimbursement through Medicare and Medicaid), *Marrese v. Interqual, Inc.*, 748 F.2d 373, 382-83 (3rd Cir. 1984) (denial of motion to dismiss based on allegations of treatment of out-of-state patients, purchases from out-of-state suppliers, revenues from Medicare, Medicaid, and out-of-state insurers, and payments to out-of state consultants).

that NTSP and its member physicians acted in interstate commerce, and shows that their anticompetitive conduct would unquestionably have affected interstate commerce. NTSP's collective price negotiation activities have had a direct and predictable effect on the fees received by its member physicians, and thus inevitably affect interstate commerce. NTSP and/or its individual members contract or negotiate with numerous health plans doing business in the Fort Worth area. At least four of them are national insurers, headquartered outside Texas, who sell policies throughout the United States. Any artificial increase in physician fees in Fort Worth may be expected to affect the volume and destination of health care payments.[70] These health plans in turn, sell insurance policies to corporations or employees located in the Fort Worth area. Many of these employers are large national and multinational corporations, with local operations in Fort Worth. Conduct by NTSP that has the effect of raising these employers' health care costs in Fort Worth could affect decisions with respect to the location of operations, the interstate movement of employees, or other competitive actions vis a vis other manufacturers throughout the United States and the world.

In addition, member physicians of NTSP routinely receive payments from out-of-state insurance companies, including the federal Medicare and Medicaid programs, which are by their very nature interstate in operation.[71] An increase in physician fees to private health plans may

---

[70] *See Hospital Building Co.*, 741, where the Supreme Court noted that a large portion of the hospital's revenue came from out-of-state insurance companies. *See also Summit Health Ltd. v. Pinhas,* at 329-30, where the Supreme Court held that the flow of revenue in interstate commerce was sufficient to establish that the elimination of the opthalmological department in a single hospital affected interstate commerce.

[71] *See, e.g., Hospital Building Co.*, at 741, where the Supreme Court noted that a large portion of the hospital's revenue came from out-of-state sources including the Federal Government (through Medicare and Medicaid), *see also In the Matter of Michigan State Medical Society,* at 250, payments from Medicare and Medicaid, as well as the Federal

result in some additional billing to the federally-funded Medicare and Medicaid programs, as private coverage is reduced or made more costly, shifting demand at the margin to publicly funded programs.[72] Moreover, NTSP member physicians treat patients from outside Texas and as the evidence shows, both NTSP and its member physicians make substantial purchases from vendors located outside the state of Texas. Thus the evidence is more than sufficient to meet the standards for finding antitrust jurisdiction, as set forth in the authorities cited above.

B. An Efficiency Justification Must Be Both Plausible and Valid

When a respondent has engaged in "inherently suspect" conduct, such as price-fixing, if the court declines to apply a *per se* rule and summarily condemn the conduct, the burden of going forward shifts to the respondent who must advance "a legitimate justification" for the challenged practices in order to avoid summary condemnation.[73] Moreover, to shift this burden back to

---

Employees Health Benefits Program, held evidence of interstate commerce.

[72] Though state-operated, a state's Medicaid program receives federal as well as state money.

[73] "If the plaintiff satisfies its initial burden of showing that the practices in question are inherently suspect, then the defendant must come forward with a substantial reason why there are offsetting procompetitive benefits. If the defendant articulates a legitimate (i.e., cognizable and plausible) justification, then the plaintiff must address the justification, and provide the tribunal with sufficient evidence to show that anticompetitive effects are in fact likely, before the evidentiary burden shifts to the defendant." *In the Matter of Polygram Holding, Inc.*, at 33. *See also In the Matter of Schering-Plough Corporation, et al.*, at 8: "once Complaint Counsel have demonstrated anticompetitive effects under the standard we apply, Respondents must demonstrate that the challenged provisions are justified by procompetitive benefits that are both cognizable and plausible." *See Id.* at 38: "However, once Complaint Counsel have made out a *prima facie* case of actual anticompetitive effects, Respondents must do more than suggest hypothetical benefits."

Complaint Counsel, a respondent must present evidence that its anticompetitive conduct did *in fact* promote efficiency. Hypothetical and vague argument will not suffice:

> We note at the outset that the burden of proving sufficient justification for restraints which have been shown substantially to harm competition rests with respondents. Such justifications cannot be speculation only but must be established by record evidence in order to be considered an adequate justification for otherwise anticompetitive behavior.

Indiana Federation of Dentists, at 175. *See also, California Dental Ass'n* at 775 n. 12 (under abbreviated rule of reason analysis, defendant has "the burden to show empirical evidence of procompetitive effects").[74] Respondent NTSP has not produced evidence to validate its proffered efficiency defense and thus the burden was not shifted back. Therefore, condemnation of NTSP's conduct is appropriate.

Respondent's justification must be "both cognizable under the antitrust laws and at least facially plausible." *In the Matter of Polygram Holding, Inc.*, at 30. To be "cognizable," the justification must be compatible with the competition-enhancing goal of the antitrust laws. To be "plausible," the justification must "create or improve competition" and the defendant must articulate a "specific link between the challenged restraint and the purported justification."[75]

---

[74] *See also* Timothy J. Muris, *The Federal Trade Commission and the Rule of Reason: In Defense of Massachusetts Board*, 66 Antitrust L.J. 773 (1998) 773, 778-79 (1998) ("Compared to the plausibility stage inquiry, the court must delve more deeply into the factual assertions of the parties to determine whether (1) the claimed efficiency benefits are real, and (2) the restraint is reasonably necessary to achieve them. If a proffered explanation fails on either count, then the court should declare the challenged restraint unlawful under the abbreviated rule of reason.")

[75] *Id.* at 31-32. *See also, e.g., U.S. v. Addyston Pipe & Steel Co.*, 85 F. 271, 281-282 (6th Cir. 1898); *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, at 20-24, *National Collegiate Athletic Ass'n. v. Board of Regents of the University of Oklahoma*, at 100-102. *See also, Arizona v. Maricopa County Medical Soc'y*, at 356-57 (distinguishing *per se* illegal price-fixing agreements among the physicians in that case from "partnerships or

It is possible that under certain limited circumstances, price-fixing may be plausibly related to an efficiency-enhancing joint venture. In the context of physician IPAs, for example, the Commission has said that a collective fee negotiation by physicians acting through a physician organization is *per se* illegal *unless* it is reasonably ancillary to an efficient integration. The Commission has recognized the potential efficiency benefits of two non-exclusive examples of integration: (1) financial integration through some form of sharing of risk of financial loss or potential gain; and (2) clinical integration among otherwise competing health care providers interdependently providing their services in a more efficient and effective manner.[76] To avoid the dangers embodied in price-fixing, the clinical integration must be achieved "prior to [the network] contracting on behalf of competing doctors."[77] The presence of substantial risk-sharing "generally establishes an overall efficiency goal for the venture and the incentives for physicians to meet that goal. The setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason." *Health Care Statements* at 20.

Other kinds of integration among the members of a physician venture also may be likely to produce significant efficiencies, and, if present, similarly would warrant application of the rule of reason to an evaluation of the venture. *Id.* "Such integration can be evidenced by the network

---

other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit.").

[76] *See Health Care Statements* at 70-74, 107-112. *See also* Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, F.T.C., to John J. Miles, Ober, Kaler, Grimes, Shriver (Feb. 19, 2002) (*available at* http://www.ftc.gov/bc/adops/medsouth.htm), John J. Miles, *Joint Venture Analysis and Provider-Controlled Health Care Networks*, 66 Antitrust L.J. 127 (1997)

[77] *See Health Care Statements* at 86 (competitive analysis of Statement 8, Example 1, regarding "Physician Network Joint Venture Involving Clinical Integration").

implementing an active and ongoing program to evaluate and modify practice patterns by the network's physicians and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." *Id.* Such a program might include the establishment of cost/quality monitoring and control mechanisms, the selective choice of network physicians to further the efficiency objectives, and the investment of significant capital in infrastructure to realize the efficiency objectives. *Id.* Only to the extent that price agreements are reasonably necessary to the accomplishment of the efficiencies, however, will they escape the condemnation. *Id.*

As discussed above, NTSP has not integrated financially for the non-risk contracts challenged here. NTSP's non-risk contracts involve straight fee-for-service reimbursement and, therefore, no financial risk is shared by NTSP member physicians in providing these services. Moreover, roughly half of NTSP member physicians–including most of its primary care physicians–do not engage in any risk-sharing. Those who do share risk do so with respect only to the HMO components of one of the 21 contracts to which NTSP is a party. CPF ¶¶ 56-57. In contrast, substantially all of NTSP's member physicians participate in its fee-for-service PPO arrangements. The evidence indicates that the risk arrangement does not produce significant efficiencies that carry over to the fee-for-service arrangements.[78] Further, NTSP member physicians are not clinically or otherwise integrated in providing fee-for-service medicine. Such clinical integration as is present in NTSP is tied to management of its capitated risk arrangement,

---

[78] *Health Care Statements* at 88 suggests that application of the rule of reason will be appropriate where "[t]he IPA's procedures for managing the provision of care under its capitation contracts and its related fee schedules produce significant efficiencies" and "those same procedures and fees are used for the PPO contracts and result in similar utilization patterns."

with little or no application to or impact on NTSP's fee-for-service arrangements. Even if, for purposes of argument, NTSP *might* effectively manage its few risk-sharing arrangements, there is no credible evidence–and, as discussed above, health plans did not believe–that efficiencies spilled over to the fee-for-service arrangements. CPF ¶¶ 284-292, 395-416, 417-429, 474.

C. In Every Event, Price-Fixing Must be Ancillary to the Claimed Efficiency

Finally, even if NTSP's conduct results in some efficiencies, these supposed efficiencies are legally insufficient to justify the horizontal price-fixing agreements. Even a fully integrated joint venture will be found guilty of *per se* unlawful price-fixing if the price-fixing is not ancillary to the integrative purposes of the joint venture. *Dagher v. Saudi Refining, Inc.*, 2004 WL 1191941 (9th Cir. June 1, 2004). There is no reliable evidence to demonstrate that NTSP must set prices collectively to accomplish any of its claimed efficiencies, NTSP's efficiencies claims are at best linked to its limited risk-sharing activities and are not ancillary to its separate and distinct fee-for-service contracts; hence, these efficiencies claims are not recognized by law in connection with fixing the prices of those fee-for-service contracts. *In the Matter of Polygram Holding, Inc.*, at 47-48, *Broadcast Music, Inc. v. CBS*, at 9, *National Collegiate Athletic Ass'n. v. Board of Regents of the University of Oklahoma*, at 98-103.

Further, none of the specific clinical integrations and efficiencies claimed by NTSP, under any economic theory, *require* NTSP to engage in collective price negotiations or any of the

other price-related activity that is the subject of this lawsuit.[79] All of NTSP's alleged efficiencies applicable to the NTSP non-risk business could be accomplished equally well in a competitive environment. Thus, NTSP has failed to meet its burden of establishing that its claimed efficiencies are plausible or valid, and thus there is no legal justification for its price-fixing conduct.

IV. PROPOSED CONCLUSIONS OF LAW

1. The Commission has jurisdiction over the subject matter of this proceeding and over NTSP pursuant to Section 5 of the FTC Act, 15 U.S.C. 45.
2. NTSP is, and at all relevant times has been, a corporation as "corporation" is defined by Section 4 of the FTC Act, 15 U.S.C. § 44; and at all times relevant herein, NTSP has been, and is now, engaged in commerce as "commerce" is defined in the same provision.
3. Respondent NTSP, its members, officers and directors, are engaged in a continuing combination and conspiracy to fix prices charged by physicians for providing medical services for health plans' patients.
4. The challenged restraint of trade is in or affecting interstate commerce.
5. NTSP's horizontal price-fixing and related conduct is *per se* unlawful and "inherently suspect" and thus, is an unreasonable restraint of trade.
6. NTSP has not satisfied its burden of establishing that the challenged restraint of trade has

---

[79] Other physician organizations have been able to offer their members similar benefits without collectively negotiating prices.

a legitimate justification that is both cognizable under the antitrust laws and plausible. Moreover, the price-fixing was not ancillary to alleged efficiencies.

7. Therefore NTSP has violated Section 5 of the FTC Act.

8. Absent entry of a cease and desist order, it is likely that NTSP's acts and practices found unlawful here, or acts and practices substantially like them, will continue or recur.

9. The relief sought and discussed below sets forth provisions appropriate and warranted to remedy Respondent's unlawful activities.

V. REMEDY

The Commission has wide discretion in choosing remedies "adequate to cope with unlawful practices."[80] Commission-imposed remedial provisions are proper if they bear "a reasonable relationship to the unlawful practices found to exist."[81] This "reasonable relationship" requirement does not limit relief to prohibition only of the precise illegal practices found.[82] Rather, the Commission "must be allowed effectively to close all roads to the prohibited goal, so that its order may not be bypassed with impunity."[83] Accordingly, the Commission may

---

[80] *Jacob Seigel Co. v. F.T.C.*, 327 U.S. 608, 611 (1946). *See also F.T.C. v. National Lead*, 352 U.S. 419, 428-29 (1957); *F.T.C. v. Cement Institute*, 333 U.S. 683, 726 (1948); *F.T.C. v. Colgate-Palmolive Co.*, 380 U.S. 374, 392 (1965).

[81] *Jacob Seigel Co. v. F.T.C.*, 327 U.S. at 613.

[82] *Removatron Int'l Corp. v. F.T.C.*, 884 F.2d 1489, 1499 (1st Cir. 1989); *F.T.C. v. Ruberoid*, 343 U.S. 470, 473 (1952). *Cf. National Soc'y of Prof'l Eng'r v. U.S. v.*, 435 U.S. 679, 698 (1978) (it is "entirely appropriate" that a remedy for antitrust law violation go "beyond" a simple proscription of the conduct previously pursued").

[83] *F.T.C. v. Ruberoid*, 343 U.S. 470, 473 (1952).

properly enjoin practices "like and related" to those found to be unlawful in the matter at bar.[84] Moreover, these "like and related" practices that the Commission may enjoin include practices that would not, of themselves, violate the law.[85] As the Supreme Court has said, having been found to have violated the law, a respondent "must expect some fencing in."[86]

The proposed order, which appears at Appendix B of this brief, is designed to remedy respondent's violations of the law and to prevent it from engaging in similar unlawful conduct in the future. We first address the need for the order and then explain its provisions.

A. An Order Is Needed to Prevent Further Unlawful Conduct

The need for entry of an order containing prospective relief is established by a showing of a "cognizable danger" of a respondent's repeated violation of the law.[87] Moreover, the initial law violation is itself potent evidence of cognizable risk of recurrence.[88] The risk of recurrence need not be with respect to the precise conduct found unlawful; rather the question is whether there is a danger that the respondent will engage in conduct of the same type.[89]

The facts here amply demonstrate the need for entry of an order against NTSP containing

---

84 *F.T.C. v. National Lead Co.*, 352 U.S. at 431.

85 *F.T.C. v. Mandel Bros., Inc.*, 359 U.S. 385, 393 (1959); *see, e.g., Amrep Corp. v. F.T.C.*, 768 F.2d 1171 (10th Cir. 1985).

86 *F.T.C. v. National Lead Co.*, 352 U.S. at 431.

87 *U.S. v. W.T. Grant*, 345 U.S. 629, 633 (1953); *SCM Corp. v. F.T.C.*, 565 F.2d 807, 812-13 (2nd Cir. 1977).

88 *U.S. v. W.T. Grant*, at 633, *SCM Corp.* at 812-13 ("the violation is itself the best evidence of the possibility of future such occurrences").

89 *See TRW, Inc. v. F.T.C.*, 647 F.2d 942, 953 (9th Cir. 1981).

prospective relief. NTSP's conduct strongly evinces a cognizable danger of recurrent price-fixing and related behaviors. NTSP and its member physicians have openly flouted competition law principles. NTSP has barely, if at all, concealed its horizontal price-fixing under linguistic deceptions, such as its claim to operate as a messenger model IPA, and gauzy rationalizations, such as its entirely misplaced reliance on the *Colgate* doctrine. NTSP's own documents–its physician agreements, powers of attorney, Fax Alerts, and meeting minutes–make plain that NTSP, acting for and with its physicians, knowingly and willfully sought to extract, and at times extracted, supra-normal prices from health plans. Neither NTSP nor its leaders have disavowed that conduct. Not only has NTSP not abandoned its horizontal price-fixing; it continues to insist on a right to refuse to messenger to physicians health plan offers that NTSP and some number of its physicians deem "below market" or otherwise inadequate.

Further, there have been no changes in market conditions that would eliminate NTSP's incentives or abilities to engage in future similar misconduct.[90] Indeed, with the withdrawal from the market of several other area IPAs, NTSP may be in a stronger position than ever before to fix or facilitate the fixing of physician prices. Accordingly, we turn to the text of our proposed order.

---

[90] Questions about the need for an order arise most often when a respondent claims to have abandoned the challenged conduct (though abandonment by itself rarely will obviate the need for prospective relief), *see, e.g., American Medical Ass'n v. F.T.C.*, 638 F.2d 443, 451 (2nd Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982) (rejecting claim of abandonment), or where there are changes in market conditions that make future violations unlikely. *See e.g., International Harvester*, 104 F.T.C. 949, 1070 (1984) (changes in tractor technology made recurrence of violation unlikely). *See also TRW*, 647 F.2d at 954 (no danger of recurrent violation where TRW terminated interlocking directorate before issuance of complaint "and arguably before notice of the FTC's investigation"; the violation was not a blatant one; and TRW had implemented a compliance program the effectiveness of which was not in question).

B. The Proposed Order

Complaint Counsel's proposed order is designed to prevent recurrence of the illegal concerted actions established in this proceeding. It is closely modeled on the Commission's proposed consent order in *Southeastern New Mexico Physicians IPA* ("*SENM*"), just issued for publication.[91] *SENM*, just like *NTSP* involves price-fixing among doctors through an IPA. The *SENM* order, in turn, is closely modeled on numerous other orders involving IPA price-fixing.[92] Accordingly, the Commission has over time evolved a form of order in cases involving IPA price-fixing that it apparently has concluded is warranted and workable, and that is the form of order we propose be entered here.

Paragraph I. contains definitions of key terms later used in the order.

Paragraph II.A would prohibit respondent from maintaining, entering into, or facilitating any agreement: (1) to negotiate for the provision of physician services on behalf of any physician with any health plan or other payor; (2) to deal, refuse to deal, or threaten to refuse to deal with any health plan or other payor; (3) regarding any condition on which any physician will deal with any health plan or other payor; and (4) not to deal individually, or not to deal other than through respondent, with any health plan or other payor.

---

[91] File No. 0310134 (consent order issued for public comment June 7, 2004).

[92] *See, e.g., Memorial Herman Health Network,* (031-0001) (consent order issued January 13, 2004); *Maine Health Alliance,* C-4095 (consent order issued August 29, 2003); *System Health Providers,* C-4064 (consent order issued October 24, 2002).

Paragraph II.B would prohibit respondent from exchanging or facilitating the exchange or transfer of information among physicians concerning any physician's willingness to deal with a payor, or the terms on which the physician is willing to deal.

Paragraph II.C would prohibit respondent from attempting to engage in any action prohibited by Paragraphs II.A or II.B.

Paragraph II.D would prohibit respondent from suggesting, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C.

Paragraph II contains a customary proviso to permit respondent to engage in conduct that is reasonably necessary to the formation or furtherance of a "qualified risk-sharing joint arrangement" or a "qualified clinically-integrated joint arrangement," where such arrangement does not restrict the ability, or facilitate the refusal, of physicians who participate in it to deal with health plans or other payors individually or through any other arrangement. Thus, insofar as NTSP in the future integrates economically or clinically and thereby brings significant efficiencies to the market, it may engage in reasonably ancillary pricing activities.

Paragraph II intentionally is broad so as to preclude respondents from engaging both in the precise conduct found unlawful in this action and "like and related" conduct. Without appropriately broad fencing-in, there is a substantial risk that respondent would again engage in

price-fixing and related behaviors under cover of one or another pretext. We emphasize again that the Commission repeatedly has imposed comparable relief in IPA price-fixing cases, apparently finding it warranted and workable. With regard to this relief, NTSP has not established any principled difference between itself and its physicians and the other IPA/physician price-fixers subjected to Commission orders to warrant lesser protections of the public.

Paragraph III would require for three years that NTSP give notice to the Commission at least 60 days before entering into any arrangement pursuant to which it will act as a messenger or agent on behalf of any physicians regarding contracting with health plans or other payors. As in *SENM*, this provision is included because respondent purported to, but did not in fact, operate in the manner of a messenger model IPA. Mere receipt by the Commission of any such notice would not be construed as a determination that any action described in the notification complies with the order or any law enforced by the Commission.

Paragraph IV.A would require respondent to provide specified persons with copies of the complaint and order in this manner. Paragraph IV.B. would require NTSP to terminate, without penalty, contracts with health plans and other payors entered into during the collusive period at the earlier of a payor's request or the termination or renewal date of such contract. This provision is intended to eliminate the ongoing effects of respondents' concerted actions.

The remaining provisions of the proposed order would impose obligations on respondent

with respect to distribution of the complaint and order to NTSP's member physicians, the making of reports to the Commission detailing order compliance, and other commonplace provisions to facilitate order enforcement.

The order would terminate 20 years from the date of issuance.

Respectfully submitted,

Michael J. Bloom / Carolyn L Cleveland

Michael J. Bloom
Mazor Matzkevich

Attorneys for Complaint Counsel
Federal Trade Commission
Northeast Region
One Bowling Green, Suite 318
New York, NY 10004
(212) 607-2829
(212) 607-2822 (facsimile)

Dated: July 6, 2004

UNITED STATES OF AMERICA

BEFORE FEDERAL TRADE COMMISSION

Public Version

In the Matter of NORTH TEXAS SPECIALITY PHYSICIANS, a corporation.	Docket No. 9312

COMPLAINT COUNSEL'S POST-TRIAL BRIEF

APPENDIX A

THE TESTIMONY OF ROBERT MANESS, PH.D. IS ENTITLED TO NO WEIGHT

Appendix A

The Testimony of Robert Maness, Ph.D. Is Entitled to No Weight

Dr. Maness' expertise is in industrial organization in general. CPF ¶ 436. Although he testified about organizational capital in connection with NTSP, Dr. Maness lacks particularized expertise applicable to organizational capital or physician organizations. CPF ¶ 436. Indeed, Dr. Maness acknowledged on cross-examination that organizational capital is not a field in which persons previously have testified as experts in courts, nor is it even "a discipline." CPF ¶ 436.

Dr. Maness often was evasive or uncooperative during cross examination. CPF ¶ 437. The Court not fewer than 13 times was required to strike unresponsive testimony of Dr. Maness and instruct him to answer questions posed that clearly were answerable as asked. CPF ¶ 437. A single quotation from the trial record will suffice for present purposes:

> Q Do you believe it's appropriate for NTSP physicians to fix prices in order to obtain the efficiencies that you believe they obtained through NTSP?
>
> A Well, I'm not comfortable with the term "fix prices." I'm comfortable with the term "a high enough price to get a certain level of participation." And if you want to call that fixing prices, then with the caveat that what I'm looking at is high enough prices to get a certain level of participation, I would agree. I'm comfortable with that, that NTSP feels the need, appropriately so in my view, to do that.
>
> MR. BLOOM: Move to strike and move that the witness be instructed to answer the question that was posed or indicate that he cannot answer the question that was posed.

JUDGE CHAPPELL: I'm sustaining that. I'll disregard the answer. As I told you before, and I don't want to have to say this again, you answer these questions, sir, yes or no or you tell the questioner what part of that question you don't agree with, what it's assuming that you won't agree with. Let's go.

Q Do you have any knowledge of the purpose for which the data was gathered?

A I have no direct knowledge. I do know it was distributed to NTSP.
MR. BLOOM: Your Honor, move to strike the last portion of that answer as responsive--as unresponsive.

JUDGE CHAPPELL: Sustained.

Q If you were to learn that that was not gathered from NTSP's files and that Dr. Van Wagner didn't know how that data was gathered or whether any tests of statistical significance had been applied to it, would you continue to rely on it?

A I -- I have the raw data.

JUDGE CHAPPELL: Sir, you didn't just answer that question, did you? Did you?

THE WITNESS: I would continue to rely on it, yes.

JUDGE CHAPPELL: You didn't answer that question.

THE WITNESS: No, you're right, you're right. I --

Q Does it matter how the data was gathered?

A It matters. It -- and what I'm suggesting to you is I have the data in its raw form.

JUDGE CHAPPELL: Hold on, hold on. That was a yes or no. That question required a yes or no. I don't want to hear any more explanations. Do you understand me, sir? I want to be sure. Look at me. Do you understand me?

THE WITNESS: Yes, sir.

Maness, Tr. 2261:11-2267:18.

And several colloquies with Complaint Counsel reflect a stubborn determination to avoid any truth potentially harmful to respondent. Consider, for example, the following:

> Q Did you actually study the question of whether Ft. Worth area employers would substitute Arlington for Ft. Worth doctors in response to a 5% relative price increase?
>
> A Yes, I think I have evidence.
>
> Q You actually studied that?
>
> A Well, I studied with the record -- I studied the record with regard to that question, yes.
>
> Q What studies did you do?
>
> A I looked at the record, the record in this case.
>
> Q The record? Is there anything in particular you can point to as a study that you conducted? A systematic analysis?
>
> A By "systematic analysis," you mean data analysis?
>
> Q That would be nice.
>
> A I haven't done a data analysis.

Maness, Tr. 2232:13-2233:8. CPF ¶ 445. And another colloquy:

> Q You do not purport to have empirical evidence of the spillover from NTSP's risk-sharing physicians to its nonrisk-sharing physicians, correct?
>
> A What do you mean by "empirical evidence" in this regard?
>
> Q As an economist, do you have an understanding of the term "empirical evidence"?
>
> A Yes.
>
> Q What does it mean to an economist?

A It would encompass more than data in my view, it would encompass the facts in this case, real observations.

Q Well, let's set aside armchair empiricism and look at data. You do not purport to have provided nonarmchair empirical evidence of spillover from NTSP's risk-sharing physicians to its nonrisk-sharing physicians, correct?

* * *

A I believe there is some data cited in my report in that regard, yes.

Q You believe there is data cited in your report that establishes spillover from NTSP's risk-sharing physicians to its nonrisk-sharing physicians?

A I take that back. In -- in the way you phrase the question, I would agree, I don't have data.

Maness, Tr. 2269:22-2271:10.

Further, Dr. Maness' opinions seemed oddly impervious to change when asked to consider the import of additional information or alternative putative fact statements. For example, Dr. Maness opined that between group differences in the data in RX 3129 evidenced NTSP's relative efficiency. He acknowledged on cross-examination, however, that he cannot explain how and why some year-to-year intra-group differences are much larger than those between group differences. Consider, if you will, the following exchange during cross-examination:

Q Knowing that you can't account even for changes within out-of-network over as short a span of one year, does that give you any pause about the strength of the conclusions you've reached based on this document, RX3129?

A I don't believe so, no.

Q What if I showed you other comparisons that adequately showed greater change, greater differences across in-network or out-of-network than between in-network or out-of-network? Would that shake your confidence?
A No.

Maness, Tr. 2376:2-2381:17. CPF ¶ 463. The unavoidable truth, however, is that such a showing should shake one's confidence.

Nor is this an isolated example. Dr. Maness testified that, importantly, NTSP's non-risk physician panel served as "an incubator" for its risk-sharing panel. On cross-examination his opinion regarding incubation would not be influenced in any manner by knowledge that "throughout NTSP's history some affiliate members of NTSP considered a great benefit of NTSP 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. CPF ¶ 473. Complaint Counsel's exchange with Dr. Maness was so enlightening at numerous levels that we present it in detail:

Q You state in substance that NTSP's nonrisk business is an incubator, has acted and acts as an incubator for the risk-sharing panel, is that correct?

A Yes.

Q Did you learn that from Dr. Van Wagner?

A Among others, yes.

Q And who would the others be?

A Among other places, I'm sorry, I didn't mean other individuals.

Q Did you systematically study movement from the nonrisk panel into the risk panel over time?

A No.

* * *

Q You have no idea how many doctors started out in the risk -- in the nonrisk-only panel and subsequently went into the risk panel and took risk?

A I don't know specifically.

Q But you accept NTSP's assertion that its nonrisk panel is an incubator for its risk panel?

A Yes.

Q There are things you could have done to test that proposition, aren't there?

A I suppose so.

Q Do you suppose or do you know?

A I suppose so.

Q You don't know there are?

A I don't know.

Q Well, let's see if we can help. Could you have taken a look at the role of the nonrisk physicians and chart over time how many of them moved across into the role of the risk physicians?

A Yes.

Q So you do know there were things you could have done to test that proposition?

A Yes, I suppose so.

Q You suppose you know?

A I suppose I could have done what you said.

Maness, Tr. 2335:2-2336:14.

These incidents, and numerous others like it, *see, e.g.*, CPF ¶¶ 449, 459-460, 464-465, 467, 470, 473, reflect the triumph of partisanship over objectivity and candor in Dr. Maness' inquiry and testimony.

Indeed, Dr. Maness' testimony at times appeared to affirmatively mislead, for example on two occasions Dr. Maness was impeached for using plurals to convey that he was aware of numerous instances of an occurrence that he reckoned to the benefit of respondent, when in fact he was aware of but a single instance. CPF ¶¶ 458, 471. For example, on cross-examination Dr. Maness was asked whether NTSP enjoyed "a reputation as a particularly effective and efficient physician organization . . . with the health plans participating in the Fort Worth community." He replied: "Some."

Q Some?

A Yes.

A Other than PacifiCare, can you identify one where you know for a fact that it enjoys that reputation?

A No.

Q That's not some, is it, that's one, correct?

A Yes.

Maness, Tr. 2331:6-2332:3. *See* CPF ¶ 470. The exchange continued:

Q While we're on the subject of number, you also testified, did you not, that NTSP had been, at least in important part, responsible for

pharmaceuticals, for dangerous pharmaceuticals, plural, being removed from the market, is that correct?

A Yes.

Q Other than Baycol, what pharmaceuticals was NTSP responsible for having removed from the market?

A That's the only one I'm aware of.

Q So again we have a fictitious plural, correct?

A If you want to call it fictitious, that's fine.

Maness, Tr. 2332:5-19. *See* CPF ¶ 471.

Even were Your Honor to assume that Dr. Maness sought to convey the whole truth as he understood it, Dr. Maness' testimony should be given no weight because in formulating his opinion in this matter, Dr. Maness often failed egregiously to apply the care and rigor that this Court should expect from a competent expert economist. *See* CPF ¶ 439.

Dr. Maness conducted only a limited document review in this matter. CPF ¶ 440. In numerous instances Dr. Maness relied solely on statements of Dr. 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. CPF ¶ 441. Therefore, all of his information about NTSP, except for the documents and testimony he reviewed, came from one highly interested and biased source–Van Wagner. Dr. Maness' abject failure of care and rigor infects the entirety of his testimony.

For example, regarding NTSP's policies, practices, and procedures:

- 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. CPF ¶ 449.

- Dr. Maness acknowledged on cross-examination that he doesn't know if he understood when he formulated his opinion that NTSP Committee and Section meetings "not infrequently have been cancelled for want of a quorum" (but he asserted that the information is "not even relevant" to his opinion). CPF ¶ 459.
- Dr. Maness did not study, or even inquire about, the degree of clinical integration of any other metroplex IPA, although acknowledging that that could be an important thing to know. CPF ¶ 464.
- Dr. Maness opined that NTSP's clinical protocols were a source of NTSP's relative efficiency, but on cross-examination he acknowledged that he did not know at the time he formulated his opinion whether they numbered 10 or 10,000 nor whether they were merely derivative of others' work. CPF ¶ 465.
- Dr. Maness lacks understanding that NTSP does no disease management outside of the capitated Pacificare contract context (although he testified that such understanding would not "influence . . . in the least" his opinion about the importance of NTSP's disease management). *See* Maness, Tr. 2318:6-2321:6. CPF ¶ 467.
- Dr. Maness cited NTSP development and implementation of disease management programs as evidencing its integration/efficiency; but Dr. Maness evinced little understanding of the nature of NTSP's palliative care program, to which he referred illustratively. CPF ¶ 466.

- 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 doesn't know if that was true of the "vast majority" of Medical Directors' time, and that it didn't matter. CPF ¶ 458.
- Dr. Maness testified that the maintaining of a common "core" of physicians is key to NTSP's organizational capital; but acknowledged on cross-examination that he did not know what he meant by "core." CPF ¶ 442.

Q So it does matter, does it not, that it be the very same physicians at the core of this time in and time out for organization capital to be present?

A At the core, at the core, yeah.

Q What's the core?

A I don't know. I mean, that's NTSP's decision, quite frankly, about what the core is.

Q You studied this, didn't you?

A Yes.

Q You don't know what the core is?

A I don't know who they consider to be the core physicians, what I know is they consider there to be core physicians.

Q Dr. Maness, you're here as an expert purporting to have studied organization capital within NTSP and you refer me back to NTSP to find out what the source of the organization capital is, is that correct?

A It's NTSP's organizational capital, yes.

Q So you don't know independent of what they told you constitutes their organization capital?

A I don't know beyond what's in the record of this case.

Maness, Tr. 2122:6-2123:6.

- 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; does not know whether NTSP requires in network referral for risk or otherwise; or whether a "stable core" or "specific cohort" of NTSP physicians participate in substantially all contracts (and Dr. Maness states that the latter information would "not necessarily" be relevant to his teamwork assertions). CPF ¶ 456.
- 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 does not know whether even one non-risk physician sought access to that data. CPF ¶ 455.
- 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 has no knowledge of that number and did not inquire into it. CPF ¶ 457.

See also findings CPF ¶¶ 450-454, 460-464, 467-474.

For example, regarding relevant market/competitive effects:

- Dr. Maness acknowledged on cross-examination that he never "actually consider[ed] whether market power could be exercised if the Fort Worth area was a relevant market, " because he "never considered Fort Worth to be a possible relevant market." CPF ¶ 443.
- 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, nor did he ask NTSP's counsel to propound relevant questions at any depositions. CPF ¶ 444.
- Dr. Maness disregarded entirely and without adequate explanation health plans' testimony *(e.g.*, the testimony of Mr. Quirk and of Dr. Jagmin) relating to purchasers' substitution in the event of a relative price change, although he acknowledged on cross-examination that when employed in the Bureau of Economics of the FTC he did not feel free to disregard purchaser statements regarding substitutability at a 5% price increase. CPF ¶ 446.
- Dr. Maness testified to ease of entry based on "literature in general" and his calculation of net inflow of physicians in Tarrant County; but he acknowledged on cross-examination that he did not 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 did not

consider entry in Fort Worth, in particular, at all. CPF ¶ 448.

See also CPF ¶¶ 445, 447.

For example, regarding asserted NTSP efficiencies:

- Dr. Maness obtained through NTSP and later used data from three physician practices in support of his opinions, though he acknowledged on cross-examination that he did not know how the groups were selected and never considered the possibility of selection bias. CPF ¶ 447.
- Dr. Maness testified that he relied in formulating his opinion on data/analysis in PacifiCare Southwest reports; but acknowledged on cross-examination that he lacks knowledge of how or why the data was gathered by PacifiCare or whether the results were statistically significant (though none of this undermines the "data in any manner, shape, or form . . . as a basis for [his] opinions)," *See* Maness, Tr. 2263:24-2265:5. CPF ¶ 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 does not know whether the purported superiority of NTSP along clinical, service, and administrative quality measures results from anything NTSP does other than judicious selection of member physicians. Maness, Tr. 2316:4-17. CPF ¶ 451.
- Dr. Maness testified that comparative data of lower NTSP physician cost per disease episode evidenced 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. CPF ¶ 452.

- 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 that data involved only 11 NTSP physicians (out of about 275 in the non-risk only panel) and that he did not know how or why the 11 were chosen, who they were, or anything else about the report. *See* Maness, Tr. 2272:10-2276:2. CPF ¶ 453.
- 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. CPF ¶ 454.
- 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. CPF ¶ 468.
- Dr. Maness relied in formulating his opinion on RX 3130, which purports to show that NTSP's capitated Pacificare contract physicians tend to practice similarly outside of that context; but he knows nothing about the wellness or sickness of the patient served by the two groups of doctors compared and made no effort to control for severity of illness, or age, or to normalize for

differences in plan design. CPF ¶ 469.

- Dr. Maness testified that NTSP's non-risk panel of physicians is an incubator for its risk-sharing panel; but he acknowledged on cross-examination that he did not study movement between panels. CPF ¶ 472.

See also CPF ¶¶ 455-456, 458, 460-462, 464-465.

In conclusion, Dr. Maness' formulation of his testimony was wanting in the ordinary care and rigor to be expected of an expert economist, and his testimony was wanting in candor. For each of these reasons, Dr. Maness' testimony cannot provide this Court or the Commission with material assistance in resolving the issues before them. Accordingly, we respectfully urge Your Honor to find that Dr. Maness' testimony is entitle to no weight.

UNITED STATES OF AMERICA

BEFORE FEDERAL TRADE COMMISSION

Public Version

In the Matter of NORTH TEXAS SPECIALITY PHYSICIANS, a corporation.	Docket No. 9312

COMPLAINT COUNSEL'S POST-TRIAL BRIEF

APPENDIX B

PROPOSED ORDER

UNITED STATES OF AMERICA

BEFORE FEDERAL TRADE COMMISSION

COMMISSIONERS: Timothy J. Muris, Chairman
Mozelle W. Thompson
Orson Swindle
Thomas B. Leary
Pamela Jones Harbour

In the Matter of	)	
	)	Docket No. 9312
North Texas Specialty Physicians, a corporation	)	

PROPOSED ORDER

I.

IT IS ORDERED that, as used in this Order, the following definitions shall apply:

A. "Respondent" means North Texas Specialty Physicians ("NTSP"), its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by North Texas Specialty Physicians, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.

B. "Medical group practice" means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, members, or employees, or in which only one physician practices medicine.

C. "Participate" in an entity means (1) to be a partner, shareholder, owner, member, or employee of such entity, or (2) to provide services, agree to provide services, or offer to provide services, to a payor through such entity. This definition also applies to all tenses and forms of the word "participate," including, but not limited to, "participating," "participated," and "participation."

D. "Payor" means any person that pays, or arranges for the payment, for all or any part of any physician services for itself or for any other person. Payor includes any person that develops, leases, or sells access to networks of physicians.

E. "Person" means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.

F. "Physician" means a doctor of allopathic medicine ("M.D.") or a doctor of osteopathic medicine ("D.O.").

G. "Preexisting contract" means a contract that was in effect on the date of the receipt by a payor that is a party to such contract of notice sent by Respondent, pursuant to Paragraph V.A.3 of this Order, of such payor's right to terminate such contract.

H. "Principal address" means either (1) primary business address, if there is a business address, or (2) primary residential address, if there is no business address.

I. "Qualified clinically-integrated joint arrangement" means an arrangement to provide physician services in which:

1. all physicians that participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the physicians who participate in the

arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and

2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

J. "Qualified risk-sharing joint arrangement" means an arrangement to provide physician services in which:

1. all physicians who participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the physicians who participate jointly to control costs and improve quality by managing the provision of physician services, such as risk-sharing involving:

a. the provision of physician services for a capitated rate from payors;

b. the provision of physician services for a predetermined percentage of premium or revenue from payors;

c. the use of significant financial incentives (*e.g.*, substantial withholds) for physicians who participate to achieve, as a group, specified cost-containment goals; or

d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; and

2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

II.

IT IS FURTHER ORDERED that Respondent, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting commerce, as "commerce" is defined in Section 4 of the

Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

A. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians:

1. to negotiate on behalf of any physician with any payor,

2. to deal, refuse to deal, or threaten to refuse to deal with any payor,

3. regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms, or

4. not to deal individually with any payor, or not to deal with any payor through any arrangement other than Respondent;

B. Exchanging or facilitating in any manner the exchange or transfer of information among physicians concerning any physician's willingness to deal with a payor, or the terms or conditions, including price terms, on which the physician is willing to deal;

C. Attempting to engage in any action prohibited by Paragraph II.A or II.B, above; and

D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C above.

PROVIDED, HOWEVER, that nothing in Paragraph II of this Order shall prohibit any agreement involving or conduct by Respondent that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or qualified clinically-integrated joint arrangement, so long as the arrangement does not restrict the ability, or facilitate the refusal, of physicians who participate in it to deal with payors on an individual basis or through any other arrangement.

III.

IT IS FURTHER ORDERED that, for three (3) years from the date this Order becomes final, Respondent shall notify the Secretary of the Commission in writing ("Notification") at least sixty (60) days prior to entering into any arrangement with any physicians under which Respondent would act as a messenger, or as an agent on behalf of those physicians, with payors regarding contracts. The Notification shall include the identity of each proposed physician participant; the

proposed geographic area in which the proposed arrangement will operate; a copy of any proposed physician participation agreement; a description of the proposed arrangement's purpose and function; a description of any resulting efficiencies expected to be obtained through the arrangement; and a description of procedures to be implemented to limit possible anticompetitive effects, such as those prohibited by this Order. Notification is not required for Respondent' subsequent acts as a messenger pursuant to an arrangement for which this Notification has been given. Receipt by the Commission from Respondent of any Notification, pursuant to this Paragraph III, is not to be construed as a determination by the Commission that any action described in such Notification does or does not violate this Order or any law enforced by the Commission.

IV.

IT IS FURTHER ORDERED that Respondent shall:

A. Within thirty (30) days after the date on which this Order becomes final, send by first-class mail, return receipt requested, a copy of this Order and the Complaint to:

1. each physician who participates, or has participated, in Respondent since January 1, 2000;

2. each officer, director, manager, and employee of Respondent; and

3. the chief executive officer of each payor with which Respondent has a record of having been in contact since January 1, 2000, regarding contracting for the provision of physician services, and include in such mailing the notice specified in Appendix A to this Order;

B. Terminate, without penalty or charge, and in compliance with any applicable laws, any preexisting contract with any payor for the provision of physician services, at the earlier of: (1) receipt by Respondent of a written request from a payor to terminate such contract, or (2) the earliest termination or renewal date (including any automatic renewal date) of such contract; *provided, however*, a preexisting contract may extend beyond any such termination or renewal date no later than one (1) year after the date on which the Order becomes final, if prior to such termination or renewal date, (a) the payor submits to Respondent a written request to extend such contract to a specific date no later than one (1) year after the date this Order becomes final, and (b) Respondent has determined not to exercise any right to terminate; *provided further*, that any payor making such request to extend a contract retains the right, pursuant to part (1) of Paragraph IV.B of this Order, to terminate the contract at any time;

C. Within ten (10) days after receiving a written request from a payor, pursuant to Paragraph IV.B(1) of this Order, distribute, by first-class mail, return receipt requested, a copy of that request to each physician participating in Respondent as of the date Respondent receives such request;

D. For a period of three (3) years after the date this Order becomes final:

1. distribute by first-class mail, return receipt requested, a copy of this Order and the Complaint to:

a. each physician who begins participating in Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such participation begins;

b. each payor who contracts with Respondent for the provision of physician services, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such payor enters into such contract;

c. each person who becomes an officer, director, manager, or

employee of Respondent and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that he or she assumes such responsibility with Respondent;

2. annually publish a copy of this Order and the Complaint in an official annual report or newsletter sent to all physicians who participate in Respondent, with such prominence as is given to regularly featured articles;

E. File a verified written report within sixty (60) days after the date this Order becomes final, annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each such report shall include:

1. a detailed description of the manner and form in which Respondent has complied and is complying with this Order; and

2. copies of the return receipts required by Paragraphs IV.A, IV.C, and IV.D of this Order; and

F. Notify the Commission at least thirty (30) days prior to any proposed change

in Respondent, such as dissolution, assignment, sale resulting in the emergence of a successor company or corporation, the creation or dissolution of subsidiaries, or any other change in Respondent that may affect compliance obligations arising out of this Order.

V.

IT IS FURTHER ORDERED that Respondent shall notify the Commission of any change in its principal address within twenty (20) days of such change in address.

VI.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, Respondent shall permit any duly authorized representative of the Commission:

A. Access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in its possession, or under its control, relating to any matter contained in this Order; and

B. Upon five (5) days' notice to Respondent, and in the presence of counsel, and

without restraint or interference from it, to interview Respondent or employees of Respondent.

VII.

IT IS FURTHER ORDERED that this Order shall terminate twenty (20) years from the date it is issued.

By the Commission.

Donald S. Clark

Secretary

SEAL

ISSUED:

PUBLIC

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of NORTH TEXAS SPECIALITY PHYSICIANS, a corporation.	Docket No. 9312

POST - TRIAL COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT

APPENDIX C

IN CAMERA ATTACHMENT

Appendix C

In Camera Attachment

Please notify the following individual of the Commissions intent to disclose in a final decision any of the *in camera* information in the document:

Outside Counsel for CIGNA:
Bevin Newman, Esq.
Jones Day
51 Louisiana Avenue, NW
Washington, DC 20001-2113
bnewman@jonesday.com
(202) 879-3833 Work
(202) 626-1700 Fax

Pages with *In Camera* Information:

P. 14
P. 15
P. 21

CPF ¶¶ 278-279, 281. [redacted] CPF ¶ 282. CIGNA was forced to allow NTSP's cardiologists into its network under similar circumstances. CPF ¶¶ 271-272, 282.

[redacted]

CPF ¶ 278, ***in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04).***}. In light of the pressure it was experiencing in the negotiations regarding NTSP's primary care physicians and cardiologists, CIGNA agreed to a more moderate increase, and adjusted the price to 2001 Dallas RBRVS. CPF ¶ 280.

In preparation for its negotiations with NTSP, and NTSP's demand for fees above the competitive level, CIGNA analyzed the importance of having NTSP's physicians in its Fort Worth area network. CIGNA determined that NTSP's physicians made up a high percentage of many specialty practices. CIGNA also frequently performed disruption analyses to determine the effect of losing access to NTSP's physicians. Based on these analyses, CIGNA concluded that a loss of NTSP physicians would have a significant negative impact on CIGNA's network in several crucial specialties, and that, therefore, it must have those physicians in its Fort Worth area network. CPF ¶¶ 267, 272. CIGNA further concluded as a result of factors such as its analysis of NTSP's strength and unity, the identical letters from NTSP's member physicians designating NTSP as their agent, and the threats by NTSP to terminate its contracts with CIGNA, that NTSP's physicians would only contract through NTSP and would not agree to contract individually with CIGNA. CPF ¶¶ 260-264, 267, 286.

Despite paying supracompetitive prices, CIGNA did not see any evidence that NTSP's

physicians were more efficient than other physicians who were not collecting NTSP's premium rates. [redacted] **CPF ¶¶ 287-288, 291, *in camera (See Grizzle, Tr. 752-754)*}.** CIGNA challenged NTSP to justify its significantly higher fees by demonstrating that its physicians were more efficient, but NTSP has not provided CIGNA with any such evidence. CPF ¶¶ 287-292.

3. NTSP Jointly Negotiated Rates and Imposed Higher Rates on United

In June of 1998, NTSP adopted a new strategic initiative in connection with its non-risk contracts, according to which NTSP would aggressively try to prevent any attempt to contract directly with its member physicians rather than through NTSP. CPF ¶¶ 98-99, 143, 157. In accordance with that policy, NTSP sought to negotiate on behalf of its membership with United, which was identified by NTSP as a potential major player in the market place. CPF ¶¶ 187. *See also* CX0211 ("NTSP has identified United Health Care as a re-negotiation target since the first of the year. They are quietly and quickly becoming a giant in the Fort Worth area."[*sic*]).

To that end, NTSP solicited powers of attorney from its member physicians and recommended that its members "refrain from responding to united healthcare [*sic*] while NTSP's request for agency status is being tabulated." CX1005, CPF ¶¶ 160, 222-223. The powers of attorney were not limited to non-economic terms. CPF ¶¶ 215, 218, 222, 245. In fact, Dr. Deas, currently NTSP's President, and on NTSP's Finance Committee at the time, explicitly authorized NTSP to negotiate price terms on his physicians group's behalf. CPF ¶ 161.

C. NTSP's Anticompetitive Conduct Raised Prices to Fort Worth Consumers

NTSP's illegal price-fixing has significantly increased the prices of medical services in the Fort Worth area by inflating its member physicians' fees. Moreover, NTSP admits that its contracted fee schedules, collectively negotiated, are at higher levels than its physicians received under direct contracts or contracts through other IPAs. As stated in the minutes of Dr. Vance's practice group, Consultants in Cardiology: "Without NTSP's influence this last two years, our market level of reimbursement would be significantly below its present level." CX0256 at 2, CPF ¶ 383.

Several health plans estimated that the price increases they incurred as a result of NTSP's price-fixing were substantial. Aetna estimated that NTSP's collectively-negotiated fees were higher than it paid other IPAs. CPF ¶¶ 381. Indeed, the Aetna-NTSP HMO contract was about 14 percent higher than Aetna's standard fee schedule at the time. CIGNA estimated that NTSP's price-fixing resulted in rates 15-20 percent higher than its standard HMO fee-for-service rates. CPF ¶ 266. [redacted]

[redacted] **CPF ¶ 284, *in camera (See Grizzle, Tr. 752-754).*}** United also concluded that NTSP's collective rates were higher than its rates for individually contracted physicians. CPF ¶ 254.

In fact, NTSP itself acknowledged that it was able to obtain a large premium over the price health plans offered directly to its physicians. NTSP compared the rates its physicians were offered directly by the health plans to the rates it succeeded in obtaining from those health plans,

CERTIFICATE OF SERVICE

I, Carolyn Cleveland hereby certify that on July 6, 2004, I caused a copy of the foregoing document to be served upon the following persons:

Office of the Secretary
Federal Trade Commission
Room H-159
600 Pennsylvania Avenue, NW
Washington, D. 20580

Hon. D. Michael Chappell
Administrative Law Judge
Federal Trade Commission
Room H-104
600 Pennsylvania Avenue, NW
Washington, D.C 20580

Gregory S. C. Huffman, Esq.
Thompson & Knight, LLP
1700 Pacific Avenue, Suite 3300
Dallas, Texas 75201-4693

and by email upon the following: Gregory S. C. Huffman (gregory.huffman@tklaw.com), William Katz (William.Katz@tklaw.com), and Gregory Binns (gregory.binns@tklaw.com).

Carolyn L Cleveland
Carolyn Cleveland