PUBLIC

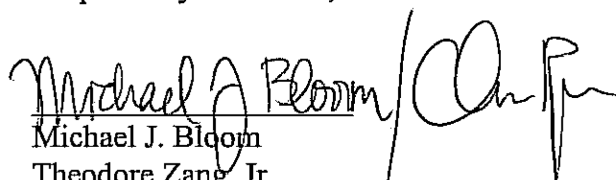
UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

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

To: The Honorable D. Michael Chappell
Administrative Law Judge

COMPLAINT COUNSEL'S RESPONSE TO
NTSP'S POST-TRIAL BRIEF

Respectfully submitted,



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I. INTRODUCTION AND SUMMARY OF ARGUMENT

In our Post-Trial Brief, Complaint Counsel provided the Court with a detailed discussion, supported by citations to the factual record, of continuous and substantial collective price-fixing conduct by NTSP and its participating member physicians–conduct which was designed to raise, and in many instances succeeded in raising, the fees charged by NTSP's physicians. As detailed in Complaint Counsel's Post-Trial Brief, NTSP accomplished this through the setting of minimum acceptable prices on a collective basis, collective price negotiations, and various kinds of exclusionary and coercive conduct designed and used to strengthen NTSP's collective bargaining power. This showing by Complaint Counsel established sufficient evidence of *per se* unlawful or inherently suspect conduct by NTSP and its physicians, and shifted the burden to NTSP to justify its price-fixing conduct as necessary or ancillary to the achievement of procompetitive efficiencies. Respondent has completely failed to satisfy this burden.

Respondent in its Post-Trial Brief presents a sanitized and revisionist version of the facts that fails utterly to address the overwhelming evidence presented at trial while at the same time urging the application of the wrong legal standard, and maintaining–unbelievably–that its conduct has actually been condoned by FTC staff. Respondent falsely tries to portray itself as an organization with little or no role in determining fees for non-risk contracts–although the evidence is clear that NTSP was formed and operates precisely as a vehicle for collective fee negotiations with risk <u>and non-risk</u> health plans on behalf of its 600 member physicians. Respondent argues: (1) that only a full blown rule of reason analysis will suffice as the appropriate standard of proof; (2) that its conduct–which it claims does not amount to price-fixing of any sort–was justified by certain claimed efficiencies or procompetitive benefits

generated through its unique "business model"; (3) that NTSP's own actions were the "unilateral" acts of a single entity, and that Complaint Counsel has not proven "collusion" through direct evidence of agreements among individual physicians; and (4) that its conduct actually fits within certain parameters detailed by FTC staff in advisory opinion letters to other IPAs.

Respondent's arguments misstate both the applicable law and the factual record, as we demonstrate below. While Respondent actually does admit that NTSP established minimum prices and communicated with health plans and its member physicians concerning those minimums (RPF 140-141; RPB at 6-7), it otherwise largely ignores the most egregious examples of its own conduct, including:

- soliciting powers of attorney from its participating physicians;
- warning health plans that NTSP had exclusive bargaining rights on behalf of its physicians;
- urging members to refrain from contracting with health plans directly;
- collectively terminating existing contracts on behalf of its physicians; and
- pressuring employers to support NTSP's demands for higher prices by threatening disruption of provider networks.

Rather than address the factual record, Respondent contents itself with lengthy discussions of irrelevant or peripheral "facts," combined with misleading assertions that Complaint Counsel's expert, Dr. Frech, did not cite evidence of certain kinds of direct price agreements among specific physicians on specific contracts. In fact, Dr. Frech testified that based on his economic analysis of the entire factual record, NTSP's conduct was anticompetitive and resulted in higher prices.

Respondent ignores clear law holding that NTSP's conduct is *per se* unlawful or inherently suspect, and that no detailed market analysis is required, especially where (as here) this conduct has been proven to have led to higher prices in its actual effect. Respondent's efficiency defense is unavailing, consisting largely of after-the-fact rationalizations of past conduct and use of empty phrases like "unique business model" to describe simple price-fixing activity. NTSP has failed to prove that its alleged efficiencies are real, has made no effort to demonstrate that its price-related conduct was ancillary to or reasonably necessary to achieve such efficiencies, and has not attempted to quantify any efficiencies to show that they might outweigh the admitted costs of the higher prices that it extracted from health plans and consumers.

Finally, Respondent's attempt to cloak its naked price-fixing conduct in the protective shroud of FTC advisory opinion letters misses the mark badly. As we demonstrate below, these precedents, which recognize that physician organizations may, under certain limited circumstances and with appropriate safeguards, exchange historical price information, are totally inapplicable here. Respondent's invocation of purported legalistic "standards of review," and its strained attempts to analogize its conduct to precedents with far different factual predicates, cannot conceal the simple fact that there is no court or Commission precedent that would justify NTSP's efforts to increase future prices for non-integrated physicians through concerted and coercive conduct. Wherever the line between lawful conduct and illegal price-fixing may be drawn in theory, there can be no doubt that NTSP's coercive efforts to impose its collectively-set prices went well beyond that line.

II. ARGUMENTS AND AUTHORITIES

A. NTSP's Conduct Unlawfully Restrained Competition Under Any Legal Standard

In urging the Court to adhere to various formulaic and static categories of legal analysis, Respondent attempts to obscure the overwhelming evidence in the record, which establishes that NTSP and its member physicians engaged in anticompetitive practices that–in their actual effect–restrained price competition among its member physicians and resulted in higher prices for health plans and consumers. (CPF 254-257, 279-282, 376-381). Respondent claims that its conduct "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition,"[1] though it offers no cognizable and plausible efficiency justifications for the challenged conduct. Respondent's efforts to cloak naked price-fixing on its numerous non-risk contracts under the guise of "spillover" from its single risk contract is fanciful and false, as we demonstrate in detail below.

Collective price-setting activity by a physician group is unlawful under leading court decisions–indeed, it has been expressly condemned by the Supreme Court for more than 20 years, *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 349-50 (1982)–and is condemned by the Commission's own *Health Care Statements*.[2] It does not require a prolonged or detailed analysis to identify its anticompetitive nature and effects. *California Dental*, 526 U.S. at 781 ("What is required, rather, is an enquiry meet for the case, looking to the circumstances, details

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[1] *See* RPB at 8 (*quoting California Dental Ass'n v. FTC*, 526 U.S. 756, 771 (1999)).

[2] *U.S. Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care* (August 28, 1996), *available at* http://www.ftc.gov/reports/hlth3s.htm. [hereinafter *Health Care Statements*].

and logic of a restraint"); *Michigan State Med. Soc'y*, 101 F.T.C. 191 (1983) (finding that a physician medical society designed to pressure third party payors to accept changes in reimbursement policies was a "clear threat to competition" and an unreasonable restraint on trade in violation of § 5 of the FTC Act); *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) (holding 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); *Health Care Statements*, Statement 8(B)(1) ("there have been arrangements among physicians that have taken the form of networks but which in purpose or effect were little more than efforts by their participants to prevent or impede competitive forces from operating in the market. These arrangements are not likely to produce significant procompetitive efficiencies. Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are *per se* illegal").

1. NTSP's price-fixing on non-risk contracts is *per se* illegal or inherently suspect

Without citing to any evidence, and misconstruing Complaint Counsel's arguments, Respondent incorrectly asserts that *per se* rules do not apply in this case and that only a full blown rule of reason analysis is the appropriate standard. (RPB at 9). Respondent ignores the fact that its conduct and the effects of that conduct are transparent and measurable as anticompetitive in nature and impact. The evidence set forth in Complaint Counsel's Post-Trial Brief and Proposed Findings demonstrate that the actions of NTSP and its members unlawfully restrained price competition among physicians with regard to fee-for-service medicine. (CPB at 4-20). These actions included: polling and disseminating averaged data on future prices;

collectively setting and sharing minimum contract prices based on the polls; negotiating prices with health plans on behalf of members; collecting 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. As a result of all of these activities, NTSP has collectively set rates that have resulted in higher prices for health plans and consumers. (CPF 118, 121, 123, 476-477).

Undeniably, these acts and practices constitute horizontal price-fixing, a category of conduct that traditionally has been condemned as *per se* unlawful. *See United States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290, 324 (1897), *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223-24 n.59 (1940). 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." *Polygram Holding, Inc.*, F.T.C. Docket No. 9298, at 29 (July 24, 2003), *available at* http://www.ftc.gov/os/adjpro/d9298/030724commoppinionandfinalorder.pdf. The Supreme Court has held that an agreement among competitors to obtain higher prices for their services, implemented by a concerted refusal to deal with customers, is a "naked restraint" of trade and is *per se* unlawful. *FTC v. Superior Court Trial Lawyers Ass'n,* 493 U.S. 411, 422-23 (1990) ("*Trial Lawyers*"). 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 *Maricopa*, 457 U.S. at 349-50, and in the *Health Care Statements*, Statement 8(B)(1).

Assuming, *arguendo*, that the price-fixing conduct at issue here is not deemed *per se* illegal, NTSP's conduct would then be examined under an "analytical continuum" where the

focus is on "the circumstances, details, and logic of a restraint." *California Dental*, 526 U.S. at 780-81. As the Commission recently explained, "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." *Polygram Holding*, F.T.C. Docket No. 9298 at 22. Once a plaintiff has met its burden of showing that a practice is inherently suspect, the burden then shifts to the defendant to prove that its conduct was ancillary to legally cognizable efficiencies or procompetitive effects that offset any anticompetitive injury. *Id.* at 33.

Respondent's use of *California Dental* to support its contention that the Court must apply a full rule of reason analysis is disingenuous and betrays a total misunderstanding of the case and its implications. The issue in *California Dental* was not price-fixing, but rather whether limitations on advertisements obviously tended to limit competition in the delivery of dental services. 526 U.S. at 776. In reaching its conclusion, the Court found that the association's advertising restrictions arguably protected patients from misleading or irrelevant advertising, and, therefore, might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition. *Id.* at 771.

California Dental is thus a very different case from the instant matter. Unlike limits on false or misleading advertising, the joint setting of prices has been condemned summarily for decades, *see, e.g., Socony-Vacuum*, 310 U.S. at 223-24 n.59. NTSP's price-related conduct is so obviously anticompetitive that "[a]n observer with even a rudimentary understanding of economics could conclude that" NTSP's price-fixing conduct has "an anticompetitive effect on customers and markets." *California Dental*, 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. *Polygram Holding*, F.T.C. Docket No. 9298 at 29.

Moreover, the *California Dental* Court recognized, "not every case attacking a less obviously anticompetitive restraint is a candidate for plenary market examination." 526 U.S. at 779. Likewise, the Court in *Indiana Fed'n 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 provision of goods and services." 476 U.S. at 459. Where, as here, the conduct involves collective price negotiations by competitors, elaborate market analysis simply is a waste of public resources. Accordingly, Your Honor should treat NTSP's restraints of trade as *per se* illegal or, at least, inherently suspect, requiring NTSP to set forth plausible and cognizable efficiencies or procompetitive effects sufficient to justify its price-fixing conduct.

Respondent attempts to defend its price-fixing by citing to an FTC staff advisory opinion that recommended no law enforcement action against an IPA that used a 50% threshold for screening health plan offers.[3] (RPB at 7-8, and n.35). However, Respondent disingenuously fails to acknowledge that BAPP's 50% participation threshold applied only after an offer had been messengered to physicians for an opportunity to "opt in" to a proposed contract, whereas NTSP's participation threshold was a screening device for health plan offers that fell below the Board's minimum prices.

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[3] Letter from Jeffrey W. Brennan, *Assistant Director, Bureau of Competition, FTC*, to Martin J. Thompson, *Manatt, Phelps & Phillips, LLP* (Sept. 23, 2003) (regarding Bay Area Preferred Physicians, "BAPP"), *available at* http://www.ftc.gov/bc/adops/bapp030923.htm. [hereinafter *BAPP Opinion*].

Further, Respondent's citation to the *BAPP Opinion* conveniently leaves out a key phrase: "So long as payers have an effective opportunity to contract with physicians individually–*that is, BAPP's members do not explicitly or tacitly agree not to deal with payers with whom BAPP has not contracted*–BAPP's refusal to administer contracts to which fewer than half its members subscribe is less likely to have anticompetitive effects"[4] [Italics indicate omitted phrase]. As noted in the *BAPP Opinion* (at 2-3 and 6), BAPP's arrangement provided that:

- (1) "[t]he messenger will not negotiate price or price-related terms on behalf of physician members";
- (2) "the messenger will not coordinate or facilitate horizontal agreements among the physicians in responding to the payer's offer";
- (3) "BAPP will prohibit [its] employees from disclosing physician price [minimums requirement] information to any BAPP physicians";
- (4) "BAPP will not . . . require or persuade members not to deal with any payer"; and
- (5) "[t]he BAPP messenger will . . . notify those physicians whose minimum payment demand exceeds the offer that they have one opportunity to 'opt in' to a contract containing the payer's offer."

NTSP's so-called messenger model is inconsistent with the *BAPP Opinion* standards in several ways. First, there is ample evidence that NTSP negotiated prices on behalf of its members. (CPF 125-128). For example, NTSP negotiated PPO, HMO, and anaesthesia rates with Aetna, rejecting initial price offers that were standard rates in the marketplace. (CPF 321-322, 325-326, 327-329). BAPP did not propose to do this. Second, NTSP's Physician Participation Agreement, dissemination of future pricing information and collection of "powers of attorney"[5] encouraged physicians to maintain a united front and, thus, facilitated and

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4 *BAPP Opinion* at 7.

5 CPF 97-104 (Participation Agreement); CPF 121-124 (dissemination of future pricing information); CPF 135, 137-138, 146, 161, 222-224, 245, 318, 338-342, 345 (powers of attorney).

coordinated horizontal agreements among the physicians. BAPP did not propose to do this. Third, NTSP disseminated poll results which contained physicians' minimum reimbursement rates to other member physicians as a means of establishing consensus prices. (CPF 105-117). BAPP did not propose to do this. [redacted] **(CPF 98, 99, 133-134, 145, 162), *in camera (Order on CIGNA's Motion for In Camera Treatment, 06.29.04)***}. BAPP did not propose to do this. Finally, whereas BAPP messengered all contracts, NTSP failed to messenger several non-risk offers to its participating physicians. (CPF 177-181, 327-328, 325-326, 392-394).

A proper reading of the *BAPP Opinion* focuses on the standards which FTC staff applies in determining whether the operation of a "messenger model" raises anticompetitive concerns, regardless of percentage thresholds or procedural frameworks:[6] "The central competitive question is whether the organization, *in practice*, creates or facilitates price-related agreements or other anticompetitive conduct among its members."[7] (emphasis added).

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[6] *See also BAPP Opinion* at n.8: "The Commission's recent complaint in . . . NTSP . . . provides an illustrative contrast regarding messenger arrangements. According to the complaint, NTSP engaged in numerous practices that facilitated or constituted unlawful collective behavior and agreements among its participating physicians–including negotiating payer contracts on the physicians' collective behalf, collecting the physicians' price requirements and using their averages as a floor in negotiating contracts, reporting the group's prospective price information back to the physicians, organizing collective refusals to deal with payers to extract higher prices, and other acts. *In such circumstances, the staff would view the messenger's refusal to administer contracts to which half the members do not agree as a device for furthering anticompetitive goals.*" (emphasis added).

[7] *BAPP Opinion* at 5.

Respondent cites a second FTC staff advisory opinion to support its contention that collection and dissemination of price information is consistent with competition.[8] However, as with the *BAPP Opinion*, respondent fails to acknowledge significant differences between the MGMA arrangement and NTSP. First, MGMA did "not act in a representative capacity with health plans on behalf of any physician group."[9] NTSP, on the other hand, as the evidence demonstrates, indeed acted in a "representative capacity" through its negotiation of prices on behalf of its member physicians and collection of powers of attorney. (CPF 125-128, 338-342). Further, MGMA did "not provide advice or suggestions to practices about proper pricing."[10] NTSP, by contrast, utilized its fax alerts to express its unfavorable assessments of health plan offers and provided members with model letters complaining about "below benchmark rates." (CPF 185-188, 221).

Respondent also neglects to mention that the *MGMA Opinion* expressed concern about the dangers of anticompetitive behavior: "A price survey such as MGMA proposes to undertake could restrain competition by resulting in physicians' concertedly or interdependently modifying their pricing or contracting behavior relative to insurers."[11] Here, NTSP's polls and fax alerts encourage its physicians to comply with the disseminated average prices, and to refrain from

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[8] Letter from Jeffrey W. Brennan, *Assistant Director, Bureau of Competition, FTC*, to Gerald Niederman, *Faegre & Benson* (Nov. 3, 2003) (regarding Medical Group Management Association, "MGMA"), *available at* http://www.ftc.gov/bc/adops/mgma031104.pdf. [hereinafter *MGMA Opinion*]. *See* RPB at 20-21, and n.110.

[9] *See MGMA Opinion* at 5.

[10] *See Id.*

[11] *MGMA Opinion* at 4.

entering into direct contracts with health plans at lower rates. (CPF 121-124). Significantly, MGMA's surveys involved member physicians' *past* fees, while NTSP polls its members for *prospective* prices to determine what fees they think should be the target price of the collective physician group. (CPF 114-116). This is a crucial distinction which NTSP conveniently ignores. The exchange of future price information is a very dangerous practice and paves the way for collective rate-setting. Finally, the MGMA model provided that price information, when published, will be at least 90 days old. This procedural safeguard, lacking in the NTSP model, reduces the likelihood that a consensus on fees can be achieved through polling of members.[12]

2. The conduct of NTSP has unreasonably restrained trade

As explained above, under a *per se* or inherently suspect standard of review, a plaintiff may prevail without a full analysis of the competitive effects of a restraint, because the nature of the restraint is inherently likely to be anticompetitive in effect. It is thus not necessary to prove that an anticompetitive agreement has been successful in accomplishing its anticompetitive aim. Notwithstanding this, Complaint Counsel has introduced substantial evidence that demonstrates that the actual effect of the price-fixing and coercive practices of NTSP has been to raise prices to health plans and patients. There is extensive testimony from health plans and other evidence showing that NTSP told them it had established minimum acceptable prices for all NTSP physicians, demanded fees that met or exceeded those minimums, and refused to offer its physicians an opportunity to participate in a plan that it considered to be too low. (CPF 106; RPF 124, 133, 140). There is testimony that NTSP claimed to have exclusive bargaining power for

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[12] *See Health Care Statements*, Statement 6(A) (price information provided by survey participants must be no more than 3 months old in order to fall within the antitrust safety zone).

many of its members, and led health plans to believe that they would not be able to get those physicians in their network unless they agreed to NTSP's price terms. (CPF 135, 137, 146, 214-215, 218, 222-224, 342-345). There is testimony that during a negotiating impasse with United, NTSP terminated a pre-existing contract through another IPA that had the effect of causing the simultaneous departicipation of 108 doctors from United's network. (CPF 206). There is testimony that, simultaneously, NTSP tried to pressure certain large employers that contracted with United, including the City of Fort Worth, warning them that the networks used by their employees would be disrupted unless they supported NTSP's demands that United raise its fees to NTSP. (CPF 185-190, 194-200, 203-204, 206, 209-210, 213, 217, 244, 250, 254, 257).

The record is clear that the actions of NTSP caused several major health plans to offer NTSP higher prices than they had previously offered, higher prices than they paid other Fort Worth physicians, and higher prices than they were already paying many of the same NTSP physicians under their non-NTSP contract arrangements. (*See, e.g.,* CPF 254, 266, 381). There can be no doubt from the testimony that these higher prices were due to the price-fixing and related coercive practices of NTSP. Under any legal standard, the Court should find that the conduct of NTSP caused an unlawful restraint of trade.

3. Though detailed market definition is not required, there is substantial evidence that the market here consists of the services of physicians, or certain types of physicians, in Fort Worth

Respondent incorrectly contends that Complaint Counsel has failed to prove relevant markets. Respondent ignores clear authority establishing that it is unnecessary to define markets

or assess market power when conduct is clearly anticompetitive, especially if (as here) there is direct evidence of actual anticompetitive effects (higher prices) as a result of the conduct.[13]

As noted above, NTSP's conduct fits squarely within the type of price-related activity that courts and the Commission have summarily condemned as *per se* illegal, without need for further proof or analysis of product or geographic markets. *See Maricopa,* 457 U.S. at 345. The Commission and courts have further held that once a defendant has been proven to have engaged in "inherently suspect" conduct, there is no need to engage in an extensive or elaborate analysis of market definition and competitive effects. *Polygram Holding*, F.T.C. Docket No. 9298 at 29; *see also Dagher v. Saudi Refining, Inc.,* 369 F.3d 1108 (9th Cir. 2004) (it is unnecessary and even inappropriate to assess market power in a price-fixing matter). Moreover, in *Polygram Holding*, the Commission held that it was not necessary to examine evidence of respondent's market power, such as a high market share within a defined market, where there is direct evidence of price-fixing among competitors.[14] *Id.* at 20 n.26.

The record here provides ample evidence that NTSP's illegal price-fixing indeed significantly increased the prices of medical services in the Fort Worth area by inflating its

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13 Extensive market analysis is not required when there is proof of actual anticompetitive effects. *Todd v. Exxon Corp.*, 275 F.3d 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 Int'l, Inc. v. Realty One, Inc.*, 173 F.3d 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").

14 *See also Indiana Fed'n of Dentists*, where 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." 476 U.S. at 460.

member physicians' fees. In fact, NTSP itself admits that its contracted fee schedules–the products of collective negotiations–are at higher levels than its physicians received under direct contracts or contracts through other IPAs. (*See, e.g.*, CX0256 at 2; CPF 383). Additionally, several health plans estimated that the price increases they incurred as a result of NTSP's price-fixing, which were not attributable to any efficiencies, were substantial.[15]

Moreover, though the evidence of higher fees received by NTSP's Fort Worth physicians is, standing alone, sufficient to establish an anticompetitive restraint in that market, Complaint Counsel has introduced substantial evidence that demonstrates that the relevant market here is the services of physicians, or certain categories of physicians, in Fort Worth. Health plans and the City of Fort Worth testified that a health plan would not be marketable to Fort Worth-based employers and consumers unless it had a substantial network of physicians in Fort Worth, including specialists, and including doctors who admit at certain critical hospitals in Fort Worth.[16] The evidence also demonstrates that NTSP physicians account for a significant percentage of certain types of specialists, and of specialists who practice at these key Fort Worth hospitals. (CPF 91-96). Health plans testified that it was the ability of NTSP to threaten

[15] For example, 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% higher than Aetna's standard fee schedule at the time. (*See also* CPF 266, 254).

[16] CPF 81, 82, 87-89. There is testimony that even if physician prices were 5% or 10% lower outside of Fort Worth, such as in Dallas or the Mid-Cities, a network that did not have a large number of physicians in Fort Worth and required patients to travel to those locations would not be marketable to Fort Worth employers. (CPF 89-90).

disruption of their Fort Worth physician networks that forced them to accede to the demands of NTSP and its physicians for higher prices.[17]

4. NTSP has not met its burden of proving that its anticompetitive conduct was ancillary to and necessary to achieve real and legally cognizable efficiencies that outweigh anticompetitive effects

In an effort to justify its collective pricing activity, Respondent makes repeated claims of efficiencies and procompetitive benefits flowing from its conduct. However, Respondent has submitted no evidence that its price-related activity was reasonably ancillary to and necessary to achieve any of its proposed efficiencies. No matter how large any claimed efficiencies may be, they are legally irrelevant as a justification for otherwise anticompetitive conduct unless the defendant has demonstrated that its conduct was ancillary to the efficiencies.[18] On the contrary, NTSP's "business model" and claimed efficiencies were not even mentioned until well after its price-fixing activities were underway, and NTSP's Executive Director admitted that NTSP used its claims of achieved efficiencies as a justification for the higher prices it was demanding in its collective fee negotiations with health plans. (CX1196 (Van Wagner, Dep. at 145-146)).

Moreover, Respondent's claimed efficiencies are not supported by concrete evidence and data, but consist of speculation and unsupported assertions. Respondent has made no attempt to quantify its claimed efficiencies and show that they offset the millions of dollars that admittedly

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[17] *See* CPF 185-190, 194-200, 203-204, 206, 209-210, 213, 217, 244, 250, 254, 257 (United); 320-344, 347-351, 357-381, 383-385 (Aetna); 260-262, 276-281, 286 (Cigna).

[18] Complaint Counsel in its Post-Trial Brief (at 33-37) fully discussed the standards for assessing an efficiency claim, and the burden on Respondent to show that its conduct was ancillary to the claimed efficiency. Respondent has not addressed this issue at all.

resulted from the increased fees negotiated by NTSP on behalf of its members.[19] Respondent relies heavily on testimony by Karen Van Wagner–a lay witness who lacks the required qualifications and expertise to testify on the issues of efficiencies and clinical integration–who has substantial personal and financial interest in the outcome of these proceedings. (Van Wagner, Tr. 1455-1457). Respondent's own experts conceded that their purported analyses of NTSP's cost and quality performance were based almost entirely on information given to them by NTSP and Van Wagner, with little independent research and review of materials.[20] Such unsupported efficiency claims cannot outweigh the clear anticompetitive effects of NTSP's conduct.

a. Instead of evidence that its past conduct was ancillary to contemporaneous efficiencies, NTSP relies on "post-hoc" rationalizations and claims of future efficiencies

Many of the "efficiencies" and improved physician performance cited by Respondent are at best recently-adopted programs that NTSP claims may achieve certain benefits today or in the future. However, NTSP cannot fix prices first and "integrate" clinical operations later. Such "post hoc" rationalizations by NTSP itself cannot be used to explain or justify anticompetitive conduct during the 1999-2001 period, in the face of the clear contemporaneous evidence that its conduct was intended to increase physician revenue, rather than achieve any of the subsequently-

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[19] NTSP's Executive Director testified that a 5% increase in the percentage of RBRVS received by NTSP's physicians can mean millions of dollars in additional physician reimbursement. (CPF 476).

[20] For example, Respondent refers to studies performed by its expert, Dr. Maness, which were based on three practice groups within NTSP and which supposedly support NTSP's efficiencies claim. However, Dr. Maness admitted that he did not know how the practice groups were selected nor did he consider selection-bias. In truth, Respondent's experts' analyses of NTSP's efficiencies were abjectly deficient. (*See* CPF 431-434, 440-441, 443-474).

articulated efficiencies.[21] *See United States v. United States Gypsum*, 333 U.S. 364, 396 (1947); see also *Flynn v. Secretary of the Dep't of Health and Human Servs.*, 1990 U.S. Cl. Ct. Lexis 211 (Ct. Cl. 1990) ("written records contemporaneously created by 'disinterested' persons should ordinarily be considered more reliable evidence than testimony of persons with a financial or other strong interest in the outcome of litigation"). For example, Respondent's claims that beginning in January 2004 it required all member physicians to take risk is irrelevant to any assessment of the competitive effects of its conduct in 2000 or 2001. Likewise, NTSP now claims that it communicates and provides guidelines and protocols to its member physicians via its website; however, NTSP's website was not even developed until August 2003. (CX0154).

b. NTSP has not proven the existence of legally cognizable efficiencies applicable to its non-risk contracts

Most of NTSP's purported clinical integrations or efficiencies have little or nothing to do with the non-risk contracts that are at issue here–and non-risk contracts represent the vast majority of the business engaged in by NTSP and its physicians. (CPF 55). There is no evidence that NTSP's non-risk physician panel is in any way clinically or financially integrated. (CPF 422). The data cited by Respondent to support its efficiency claims is largely limited to data covering risk contracts, which involve fewer than half of NTSP's physicians.[22] NTSP has admitted that its information systems do not include data for patients covered under its non-risk

[21] *See* CPF 147-416.

[22] NTSP's only risk contract is with PacifiCare. (CPF 6). Out of the approximately 600 NTSP physicians, only 239 participate in this PacifiCare risk contract. (RX 17 at 16; Wilensky, Tr. 2202).

contracts. (CPF 419). NTSP's cited examples of "teamwork" among its member physicians are mostly concentrated on its risk business, with little application to NTSP's non-risk contracts.

Respondent asserts that it is capable of identifying outlier physicians who do not adhere to guidelines and protocols or who do not perform as well as the average member physician in utilization and quality. Regardless of the theoretical possibilities of such effects, NTSP's ability to identify such outliers is strictly limited to its risk panel. (CPF 419; Van Wagner, Tr. 1506-1507). Respondent also claims that NTSP provides feedback to its physicians regarding patient care, but it does not do so for NTSP's non-risk contracts. (CPF 419; Lonergan, Tr. 2722-2723). NTSP also refers to the role of its medical directors, but they are not responsible for controlling costs for patients under NTSP's non-risk contracts. (CPF 420; Deas, Tr. 2553). In fact, NTSP's Medical Management Committee does not even evaluate the care of patients under NTSP's fee-for-service contracts, and its hospital utilization management program does not apply to patients under its non-risk contracts. (CPF 420; Van Wagner, Tr. 1837-1838; Deas, Tr. 2250-2251).

c. NTSP has not proven that its price-related actions are necessary to achieve any claimed efficiency

Despite Respondent's repeated invocation of claimed "efficiencies," the record is devoid of any evidence that it could not have achieved any of these efficiencies without setting collective prices or coercively imposing those collective prices on customers. Thus, Respondent has failed to prove that its conduct was "ancillary" to any efficiency. When a defendant has engaged in "inherently suspect" conduct, such as price-fixing, it must advance a "legitimate justification" for the challenged practice. *Polygram Holding*, F.T.C. Docket No. 9298 at 29. To be cognizable, the justification must "create or improve competition" and establish a "specific link between the

challenged restraint and the purported justification." *Id.* at 31-32. *See also NCAA v. Bd. of Regents of Univ. of Oklahoma*, 468 U.S. 85, 113-15 (1984) (holding no efficiency justification where the alleged benefit could be achieved "just as effectively" without the restraint in question); *Dagher v. Saudi Refining, Inc.*, 369 F.3d 1108 (9th Cir. 2004).

Respondent asserts that it needs to obtain higher physician fees from health plans to assure that all doctors will participate in each network, and that its "efficiencies" require it to assure that the same physicians participate in all its risk and non-risk health plan networks. However, Respondent has failed to provide any evidence whatsoever establishing that this is necessary, or that the higher prices it has imposed on customers contribute in any way to the claimed efficiencies. Both of Respondent's experts failed to demonstrate the need for the alleged continuity of physician panels among networks; on the contrary, the evidence shows that no such continuity even exists. (CPF 442, 456). Respondent admits (RPF 115) that any physician participating in the same health plan contract offer can be part of the NTSP "team," regardless of whether that physician is participating through NTSP's group contract or through another entity. Furthermore, there is no evidence that the fee levels demanded by NTSP were in fact the levels that would be required to assure the participation of all or most physicians. On the contrary, NTSP set its initial "minimum acceptable" fee levels before it conducted its first general poll of the membership, and often insisted that a health plan agree to a higher fee level through NTSP, even when most NTSP physicians were already participating in the plan at lower fees. (CPF 106). Thus, the "team" or "network" was assembled before NTSP started fixing prices. NTSP's expressed concerns about preserving network "continuity" are no more than another rationalization for its naked price-fixing conduct.

d. The evidence and data cited by NTSP does not substantiate any claimed efficiencies

Respondent mentions a number of NTSP programs that it claims create efficiencies, and cites to data that purportedly substantiate these efficiency claims. There is no merit to any of these assertions. Respondent claims that the interaction between its member primary care physicians and specialists is important to NTSP's development of clinical protocols and guidelines (RPF 59); however, NTSP provides little opportunity for such interaction. For example, NTSP's Primary Care Council, which serves as the only forum for primary care physicians within NTSP to discuss quality and cost efficiencies, meets only 2-4 times a year (with average attendance of 6-10 physicians), provides little information to other physicians, and is ineffective in its efforts to improve quality. (CPF 428; CX1183 (Lonergan, Dep. at 31-32)).

Respondent has also failed to submit evidence supporting the claimed effectiveness of its own clinical protocols and guidelines. Respondent concedes that NTSP only "sometimes" develops its own protocols and guidelines, but for the most part merely directs members to non-NTSP developed guidelines and protocols, which are already easily accessible via these other organizations' websites. (CPF 425; RPF 61; Van Wagner, Tr. 1539). Moreover, NTSP does not require use of these protocols and guidelines, or even consistently assist member physicians in learning about and employing them. (CPF 425).

Respondent seeks to support its claimed efficiencies by citing highly flawed outcomes studies. For example, much of NTSP's data on which NTSP's expert relied are actually irrelevant since it does not include appropriate population and case mix adjustments. (CPF 462) (*See also* CPF 474 (Aetna did not find NTSP's data "credible" in actuarial terms")).

Additionally, Respondent cites to patient surveys, conducted by NTSP itself, as evidence of NTSP's efficiencies. However, these surveys do not provide any quantitative analysis of NTSP's efficiency claims, and are irrelevant to an assessment of whether or not NTSP succeeded in offsetting its higher fees with more efficient utilization of physician services or other benefits. (Van Wagner, Tr. 1541-1543 (description of survey questions)).

Furthermore, the data cited by Respondent does not show efficiencies from NTSP's collective actions, but at best may demonstrate that certain individual physicians within NTSP are efficient in their own practices. There is no evidence that attributes the efficiency of these individual physicians to the actions of NTSP itself, such as its negotiation of higher fees from health plans. Similarly, there is no evidence that the accomplishment of these physicians' efficiencies directly resulted from their membership within NTSP, rather than from the activities of their own clinically integrated practice groups. (Casalino Tr. 2844-2845, 2847-2848, 2911-2912). Respondent also discusses a favorable clinical cost/outcome comparison for one NTSP primary care physician group. However, this is only one group chosen from within NTSP and does not prove NTSP's collective performance. Respondent provides little or no data from divisions with multiple practice groups for proper comparison, nor does it provide meaningful data relating to NTSP's level of efficiency as a collective. Even Respondent's own expert admitted that certain positive results in NTSP's outcomes data might show merely that NTSP selected good physicians initially and that the practice of these physicians as individuals resulted in these apparent efficiencies. (CPF 451).

e. **Health plans have testified that NTSP has not demonstrated the existence of any significant efficiencies**

Contrary to Respondent's claims of efficiencies, two large health plans testified that upon careful examination of NTSP's data, they concluded that these claimed efficiencies, particularly in cost savings, did not exist. [redacted] **(CPF 288),** ***in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)***}. Interestingly, NTSP has an arrangement with CIGNA which rewards NTSP with financial bonuses upon demonstrating quality and cost efficiencies. [redacted] **(CPF 287, 290-292),** ***in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)***}. Aetna also analyzed NTSP's data to determine the validity of NTSP's efficiency claims, and believed it to be "critical" to determining how to control Aetna's own costs and compete with other health plans. (CPF 396, 474). Aetna concluded that NTSP's data was not "credible" in actuarial terms. (CPF 474). Even upon further analysis using data from its own database, Aetna concluded that NTSP's assertions could not be supported by Aetna's or NTSP's own data.

f. **NTSP has not proven the existence of "spillover" efficiencies from its risk business to its non-risk contracts**

Perhaps recognizing its lack of evidence to demonstrate any efficiencies in its non-risk business, Respondent instead suggests that there are certain efficiencies derived from its risk panel of physicians that somehow "spill over" to the conduct of its non-risk panel. Regardless of the theoretical possibility of such effects, there is no evidence that any such "spillover" actually

occurred. Even NTSP's experts relied only on speculation and unsupported assertions of spillover. For example, Dr. Maness testified that significant spillover resulted from the alleged fact that the non-risk pool of physicians was an incubator for the risk pool. But Dr. Maness was forced on cross-examination to admit that he had not performed any studies of movement between NTSP's risk and non-risk member physician panels to confirm this. (CPF 472). Indeed, despite his claims of spillover efficiencies, Maness had not even analyzed the statistical significance of data on which he relied that had been provided by NTSP's sole risk contractor, PacifiCare. (CPF 450). Similarly, Dr. Wilensky, when asked about how she came to her conclusions about spillover, admitted that she had not assessed any empirical evidence regarding the alleged spillover effects from NTSP's risk panel to its non-risk panel, and, furthermore, was uncertain as to what NTSP actually did in its non-risk care. (CPF 433; Wilensky Tr. 2206-2209).

Significant spillover and the consequent production of significant efficiencies requires application of organized processes from risk contracts to non-risk patients.[23] (CPF 423; Casalino, Tr. 2864-2865). Some of these organized processes are low cost and practicable for NTSP's organization. However, as previously discussed, with the possible exception of distributing clinical guidelines and protocols, NTSP does not employ any organized processes to patients under its non-risk contracts. (CPF 423; Casalino, Tr. 2864-2865, 2870-2872; Frech, Tr. 1354-1355). Although NTSP physicians who practice under risk contracts may potentially realize some spillover by individual effort, "community" spillover from risk practicing physicians to

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[23] These organized processes include developing clinical guidelines and protocols, providing nurse-care managers to perform disease management, implementing a comprehensive patient education program, chart reviews for quality measures and site visits of physicians' offices. (Casalino, Tr. 2870-2871).

those NTSP physicians who only participate in non-risk contracts is minimal, insignificant and not measurable in this case. (Casalino, Tr. 1860, 2859-2860; Frech, Tr. 1348, 1353-1354).

Even PacifiCare, the health plan with which NTSP has its sole risk contract, did not concur with NTSP's contention that efficient techniques and practices developed by its risk physician panel are passed to and adopted by its non-risk physician panel through communication and interaction between the two. At best, PacifiCare acknowledged that efficiencies may spill over from physicians applying techniques and practices learned from risk contracts to their own non-risk practice. (Lovelady, Tr. 2678, 2660-2661). Thus, the majority of NTSP's members, who benefit from the price-fixing activities of NTSP, are not realizing any significant spillover benefits because they participate only in NTSP's non-risk contracts. (*See* Casalino, Tr. 2860-2861; Frech, Tr. 1353-1354).

B. There is Ample Evidence in the Record Showing Price-Related Agreements Among NTSP and its Participating Physicians

Respondent asserts that Complaint Counsel cannot prove an antitrust violation because it has failed to prove certain forms of "collusion" or "concerted action." In support, Respondent asserts only that Complaint Counsel's expert economist did not cite certain kinds of evidence of direct agreement between doctors on specific contracts at specific prices. Contrary to Respondent's suggestion, it is not the function of an expert economist to restate the entire factual record in a case, but rather to reach conclusions based upon an economic analysis, supported by the record. Furthermore, Respondent misstates the actual testimony of Dr. Frech, who concluded, on the basis of the total evidentiary record, that NTSP and its physicians indeed entered into agreements that had the effect of raising prices. (Frech Tr. 1280-1281, 1316-1327, 1332-1333).

Respondent then seeks to dismiss the abundant evidence of price agreements throughout the record as mere "circumstantial" evidence that is "consistent with independent action." (RPB at 16-17). Respondent misunderstands and misstates the applicable law relating to establishing a "contract, combination, or conspiracy" under § 1 of the Sherman Act or § 5 of the FTC Act. NTSP incorrectly suggests that only an explicit agreement among specifically-identified NTSP physicians to fix prices or reject specific offers can establish an illegal agreement involving NTSP. To the contrary, it is well-settled law that the existence of an agreement among any two persons or entities may be shown by either direct or circumstantial evidence. *See Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 764 (1984) (holding that it is sufficient to provide evidence that the parties "had a conscious commitment to a common scheme designed to achieve an unlawful objective"). In *Vitamins Antitrust Litig.*, No. 99-197, MDL. 1285, 2004 WL 1106436, at *9-10 (D.D.C. Apr. 8, 2004) ("*Vitamins*"), the court (in the context of a summary decision motion) held that each defendant must know of a conspiracy's "general purpose and scope," but that it is not necessary to prove a formal agreement or knowledge of every detail of the agreement, or to provide direct evidence of an agreement.[24] Furthermore, an agreement may be tacit or implicit, or an indirect agreement through an intermediary.[25] In *United States v.*

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[24] The court in *Vitamins* also noted the Supreme Court's holding in *Direct Sales Co. v. United States*, 319 U.S. 703, 713 (1943), that a party progresses from mere knowledge of an endeavor to an intent to join it when there is "informed and interested cooperation, stimulation, instigation." In finding concerted action the court further noted that "there is also a 'stake in the venture' which, even if it may not be essential, is not irrelevant to the question of conspiracy." *See also High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d 651 (7th Cir. 2002) ("*HFCS*").

[25] *See, e.g., Isaksen v. Vermont Castings, Inc.*, 825 F.2d 1158, 1162-63 (7th Cir. 1987) (jury could find a vertical price agreement from evidence that a dealer raised its prices a year after the manufacturer threatened to "mix up" its orders); *Maricopa*, 457 U.S. at 349-50 (medical society fixed prices). *See also Bender v. Southland Corp.*, 749 F.2d 1205, 1212-13 (6th

Masonite Corp., 316 U.S. 265, 275 (1942), the Supreme Court held that: "[t]he fixing of prices by one member of a group, pursuant to express delegation, acquiescence, or understanding, is just as illegal as the fixing of prices by direct, joint action."[26]

There is abundant direct evidence in the record that NTSP and its participating physicians entered into a "contract, combination or conspiracy." For example:

-- NTSP solicited and collected express agency agreements and powers of attorney from a large number of individual physicians, which gave NTSP the power to set and negotiate fees on their behalf.[27]

-- NTSP then used those powers of attorney to strengthen its bargaining position in price negotiations, by telling certain health plans that it had exclusive rights to act as a contracting agent for these physicians, thus increasing the likelihood that the health plan would conclude that it had no practical alternative to dealing with NTSP as the collective bargaining agent of its member physicians.[28]

Cir. 1984); *Helicopter Support Sys. v. Hughes Helicopter*, 818 F.2d 1530, 1535 (11th Cir. 1987).

[26] The law does not require any particular kind of agreement. It is sufficient that the conduct that is being challenged as anticompetitive be the result of an express or tacit agreement among two or more independent entities that are legally capable of conspiring with one another. *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 769 (1984). Though, as we discuss, there is substantial evidence of horizontal price-related agreements among NTSP and its competing physicians, agreements between NTSP and its individual doctors would still be subject to analysis under § 1 and § 5 even if they were not viewed as entirely horizontal in nature.

[27] CPF 135, 146, 214-215, 218, 222-224, 342-345. Only after United had threatened to reveal NTSP's anticompetitive conduct to federal and state agencies did NTSP for the first time assert that these powers of attorney were only for negotiation of non-price terms, and United continued to believe that NTSP had the exclusive right to negotiate fees under these powers of attorney. (CPF 245).

[28] CPF 137. In 2001, during price negotiations with United, NTSP told the members who had executed powers of attorney that they "should inform all United representatives who contact you that NTSP is your contracting agent for United Healthcare and instruct them to contact NTSP directly." (CPF 223).

-- NTSP also claimed that the participation agreement signed by its physicians, an explicit "contract," gave it exclusive rights to bargain on their behalf.[29]

-- NTSP was acting as an association of physicians in collecting these powers of attorney and exclusive rights, and the individual physicians agreed to confer these exclusive rights on NTSP with the knowledge that other physicians were being asked to take the same action.[30] These exclusive rights thus constitute horizontal agreements among the competing physicians.

-- NTSP caused the simultaneous departicipation of 108 physicians from the United network, as a result of the decision of the NTSP Board of Directors to terminate an existing contract. NTSP, on the very day of the termination, held a "General Membership Meeting" at which the termination was discussed and members were urged to continue to complain about the price terms of United's offer.[31] By accepting NTSP's suggestion to engage in concerted action by refusing to contract with United individually, the physicians ratified the decision of NTSP and expressed their agreement to participate in the collective conduct. It is not necessary to identify each physician who engaged in this conduct, as most of the 108 physicians in fact refrained from contracting with United on an individual basis, even though it would have been in their economic interest to do so. *See*

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[29] CPF 68 (Van Wagner, contradicting her trial testimony, testified in 2002 that a member physician may not act on an offer received directly from a health plan if NTSP is at the same time engaged in collective price negotiations with that plan).

[30] *See, e.g.*, CPF 146, 214, 318. During the 2001 collective price negotiations with United, NTSP sent a Fax Alert to its members telling them that it already had 107 powers of attorney giving NTSP the power to act for them in all contracting activity with United, and sought the submission of powers of attorney from other member physicians. (CPF 222). Though the powers of attorney themselves contain the names of the physicians involved, it is not necessary (contrary to NTSP's assertions) to provide the actual names of the specific physicians in order to establish a horizontal agreement among physicians within the context of their membership in NTSP.

[31] CPF 205-211. The implicit horizontal agreement underlying this collective termination is underscored by subsequent communications from NTSP to its members, reiterating that the termination had been the result of fees that were below Board minimums, but assuring members that NTSP would continue collective price negotiations and "pursue a direct contract with United Healthcare that meets or exceeds the fee schedule minimums set by the NTSP membership." (CPF 221). This was a signal and invitation to the membership to in effect ratify the termination by declining to contract individually while collective negotiations proceeded, and most members in fact declined to sign individual contracts. (CPF 220).

Trial Lawyers, 493 U.S. at 422-23 (finding that a concerted refusal to deal with a customer except on collectively agreed-to prices is an agreement).

-- NTSP admits that its Board of Directors–made up entirely of physicians–set minimum acceptable fee levels for collective contracts, often rejected contract offers below those minimums, and disseminated the minimum acceptable prices that it had set to the entire membership of NTSP. NTSP also used "polls" to collect information from members about their future prices; which it then aggregated and disseminated to the members.[32] The physician-members of the Board thus agreed directly on acceptable prices, while the other participating physicians were, in effect, invited to adhere to these price levels in their own dealings with health plans (and many did so).

-- NTSP at times, during acrimonious fee negotiations with certain health plans, urged its participating physicians to refrain from contracting individually with NTSP and to refer health plan offers to NTSP.[33] When many of the participating physicians acted in the way that NTSP urged, and adhered to the suggested collective course of conduct, their actions constituted an acceptance of the invitation to agree. *See Isaksen*, 825 F.2d at 1163.

NTSP suggests that this vast body of evidence is somehow deficient, and cannot support a finding of an agreement, because the "alleged conduct is consistent with independent action." To the contrary, however, the actions of NTSP's physicians reflect, not independent action, but rather interdependent conduct among competing entities. A court may infer an agreement on the basis of consciously parallel conduct by competitors who simultaneously take an action that would be economically risky for any one competitor, but which is mutually beneficial if each

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[32] RPB at 6-7, 18-19; RPF 124, 133, 140. Because it can lead to precisely the kind of concerted pricing behavior that occurred here, such dissemination of current or future pricing data among competitors is highly suspect under the antitrust laws. *See, e.g., United States v. Container Corp. of America,* 393 U.S. 333 (1969); *United States v. United States Gypsum Co.,* 438 U.S. 422 (1978). While not necessarily illegal in and of itself, evidence that competitors have shared current or future pricing data may be one "plus factor" that may lead to an inference of an agreement among those competitors. *See, e.g., Petroleum Prods. Antitrust Litig.,* 906 F.2d. 432, 445-50 (9th Cir. 1990). *See also HFCS*, 295 F.3d at 655-56 (on a summary judgment motion, evidence cannot be evaluated in isolation).

[33] *See, e.g.*, CPF 130-131, 223, 362.

competitor knows that others will act the same way. *See Matsushita Elec. Indus. Co. Ltd. v. Zenith Radio Corp.,* 475 U.S. 574, 588 (1986). Contrary to NTSP's suggestions, such "interdependence" can clearly be seen in the actions of NTSP and its participating physicians.[34]

No single physician, acting alone, would be likely to succeed in a demand for higher fees from a health plan. Individual physicians were well aware of this. *See, e.g.*, CX0256 at 2 ("As I have argued for a number of years, physicians divided will be cannon fodder in this business"). It would be risky for any one doctor to demand a higher fee and refuse to participate in a plan's network at lower fees: dropping out of the network would cost the doctor access to patients covered by that health plan, while other physicians might accept lower fees to remain in the health plan's network (and thus have access to the first physician's patients). NTSP provided a risk-free way for the doctors to engage in collective price negotiations and maximize their bargaining power. The participating physicians knew that NTSP was demanding certain high prices (through its Board minimums and collective negotiations with health plans), and were regularly briefed by NTSP's Board and staff on the status of the negotiations.[35] If, as NTSP suggested, individual physicians went along with NTSP's collective strategy, the result might be (and often was) a contract offer at higher fee levels than a health plan was offering to individual

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[34] Instead of directly addressing the legal and economic analysis required to support its conclusory claim at p. 18 (heading), NTSP's brief at 18-20 merely quibbles with a few facts: the interpretation of terms of its Physician Participation Agreement, the polling process, the response rate, and the nature of the price information that is disseminated to members. These quibbles are irrelevant to an analysis of interdependence. The question is whether the information given to physicians constituted an invitation to common action, and allowed the doctors to conclude that by acting similarly, and permitting NTSP to engage in collective price negotiations, they could achieve a benefit that no single doctor could achieve acting alone.

[35] CPF 63, 133, 159, 166–168, 192-195, 213, 221, 234, 252-256, 311, 357, 379.

doctors.[36] On the other hand, if the collective negotiations failed, or a significant number of physicians "broke ranks" and signed individual contracts, the physicians would always have the opportunity later to sign a contract (individually or through NTSP) at the best-available price. Thus, based on the actions of NTSP's Board and staff and the information and statements made to individual physicians, the participating physicians of NTSP had every incentive to act "interdependently" by following NTSP's lead in fee negotiations for as long as there was a reasonable prospect of success. By doing so, individual physicians entered into at least tacit price agreements.

Respondent makes much of the fact that its physicians at times signed contracts with certain health plans individually or through other physician groups, sometimes at rates lower than the minimums set by NTSP. (RPB at 19). This is simply irrelevant. The antitrust laws prohibit price agreements among competitors, whether or not the agreement has succeeded or failed in any given instance. Moreover, a price agreement that results in higher prices for certain contracts has unquestionably had an anticompetitive effect. A price-fixing conspiracy need not be perfect or complete in order to be unlawful. *HFCS*, 295 F.3d at 656 (the fact that many sales were made at prices lower than the list prices set by the defendants was not grounds for summary judgment). The evidence here shows that NTSP successfully negotiated higher fees from some health plans, although it was unsuccessful in other instances.

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[36] For example, by working together through NTSP during the United collective fee negotiations of 2001, NTSP physicians received the opportunity to contract with United at rates that were 10% higher than United had initially offered for its HMO and 15% higher for its PPO. (CPF 254).

Respondent's repeated citation of its claimed (though illusory) efficiencies and procompetitive effects does not negate this evidence of agreement. The test of agreement is not whether the conduct of individual doctors is "inconsistent with lawful competition" or whether it "can potentially benefit competition." (RPB at 20-21). What is relevant to the issue of "agreement" is the extensive evidence that NTSP physicians engaged in collective price-related activity, both through direct or tacit agreements and through interdependent parallel action (based upon physicians' expectation that competitors would act the same way and all would benefit from higher prices). *See, e.g., Monsanto*, 465 U.S. at 752; *Vitamins*, 2004 WL 1106436 at *9-10; *Matsushita*, 475 U.S. at 588, discussed earlier in this section. Even if NTSP had proven that the actions of NTSP and its physicians also had benefitted competition–not just "potentially" but in actual effect–this would not disprove an agreement, though it might be relevant to the analysis of competitive effects.

Moreover, the asserted link between the purported conduct and the claimed justifications for that conduct are entirely speculative, and thus do not prevent the Court from finding interdependence based on the actual economic motivations of the participating physicians. To take just one example, Respondent's Post-Trial Brief (at 24) spends considerable time discussing thirteen reasons for which it "may" refuse to send a health plan offer to its members. This may or may not be true, but what is relevant to this case is that on numerous instances NTSP refused to send the offer to its members for the purpose of implementing and enforcing a collective price agreement. Moreover, while NTSP claims that it "might" legitimately have refused to contract with the health plans who testified at trial because of their alleged "bad acts," the fact of the matter is that NTSP had no compunction about doing business with those health plans–as soon as

the health plans had caved in to the fee demands made by NTSP on behalf of its 600 participating physicians.

NTSP also suggests that Complaint Counsel's case is entirely based on allegations that NTSP did not "messenger every payor offer to its participating physicians." This is incorrect. This case is not about a mere refusal to "messenger" offers, but rather involves a broad pattern of collective price-fixing. NTSP's blatant misuse of the "messenger model" system, which it falsely claims to have followed, is merely one of the many means by which NTSP implemented its price agreements and coerced health plans to acquiesce to NTSP's collectively-set minimum prices.

NTSP improperly suggests that the Court should disregard the evidence that NTSP's physicians entered into price-related agreements because of the Fifth Circuit's decision in *Viazis v. American Ass'n of Orthodontists*, 314 F.3d 758 (5th Cir. 2002).[37] However, *Viazis* had absolutely nothing to do with joint price negotiations, but related only to the internal workings of the association's administrative procedures for addressing alleged ethical violations. The plaintiff presented no evidence that the proceedings were in any way designed to limit competition. *Id.* at 764. There was certainly no suggestion in *Viazis* that the association had encouraged collective pricing activity as a result of communications with its members. In contrast, the evidence here demonstrates that NTSP and its participating physicians engaged in

[37] NTSP asserts that *Viazis* and other Fifth Circuit cases "control" this case because most of NTSP's conduct took place in Texas. The FTC, however, has a statutory mandate to promote competition nationally, and as such, cases from any federal court can have persuasive value in cases brought to the Commission. While we do not believe that *Viazis*, correctly read, is in any way inconsistent with the Supreme Court, appellate court and Commission authority discussed in the text, we believe that the Court here should follow the broad weight of authority rather than NTSP's idiosyncratic reading of a single Fifth Circuit decision.

various forms of conduct that had the purpose and effect of limiting price competition among NTSP members and raising actual prices. The Court should not accept NTSP's extreme interpretation of *Viazis*, which would permit competitors to engage in naked price-fixing merely by forming an "association." Such a result obviously is contrary to the longstanding (and correct) view that "associations" negotiating prices for their members are, in that capacity, nothing more than devices for collective action, fully subject to the antitrust laws. *See, e.g., Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022, 1031 (9th Cir. 1988).

Finally, NTSP attempts to explain away evidence of direct or indirect price agreements by citing two totally irrelevant cases, *United States v. Colgate & Co.*, 250 U.S. 300 (1919), and *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 124 S. Ct. 872 (2004) ("*Trinko*"). *Colgate* was a vertical price-fixing case involving the unilateral decision by a single corporation, Colgate, not to sell its products to dealers who would resell it at prices below the suggested prices set by Colgate. As a single corporation, in fact and in form–unlike NTSP–Colgate could not conspire with itself, and the Court found insufficient evidence to infer vertical price agreements between Colgate and its dealers.[38] By contrast, NTSP is not a single entity with a "complete unity of purpose," thus incapable of conspiring with itself. *Copperweld*, 467 U.S. at 769. It is an association of individual competing physicians who have not integrated their practices and thus have separate and distinct economic interests. The relevant question is whether NTSP's conduct led to price-related agreements among its participating physicians. *See*

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[38] However, in subsequent vertical price-fixing cases, the Court has found that a price agreement may be inferred on the basis of conduct that constituted an invitation by dealers to agree on prices, and dealer concurrence in this invitation. *See Monsanto*, 465 U.S. at 1471 n.10; *see also Isaksen*, 825 F.2d at 1162-63.

Masonite, 316 U.S. at 275 (fixing of prices by one member of a group pursuant to delegation is unlawful). As discussed above, there is abundant evidence that NTSP did precisely that.

Trinko is likewise inapplicable to the facts of this case. In *Trinko*, the Court dealt with conduct by a single firm (Verizon) challenged as "monopolization" under § 2 of the Sherman Act, not with a § 1 "contract, combination or conspiracy." There was no allegation that the defendant had agreed with any other person on prices or on a refusal to deal.[39] The Court in *Trinko* merely held that the defendant was not required to make its communication network available to competitors. The Court's holding reflects the reluctance of courts to use the antitrust laws to force competitors to cooperate with one another, recognizing that such cooperation may instead lead to collusion or reduce incentives to innovate. *Trinko*, 124 S.Ct. at 879. Thus *Trinko* is completely inapposite to a case such as this, involving an agreement among independent competitors on prices, followed by concerted action (including terminations of existing contracts and coordinated refusals to deal) by the competitors to impose those prices on customers.

C. Contrary to Respondent's Assertions, There Is No Public Policy in Favor of Price-Fixing by Competing Physicians

Respondent claims that certain vague and undefined "public policy rationales" mean that NTSP's conduct should be encouraged, not condemned. Respondent again cites to its so-called "business model," and to the testimony of Dr. Gail Wilensky, a health care policy expert who admitted on the stand that she had little knowledge about the workings of physician organizations

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[39] The plaintiff alleged that the incumbent local exchange carrier (LEC) filled rivals' orders on a discriminatory basis as part of an anticompetitive scheme to discourage customers from becoming or remaining customers of competitive LECs in violation of § 2 of the Sherman Act, and impeded rival LECs' ability to enter and compete in the market for local telephone services. *Trinko*, 124 S. Ct. at 878.

in general or NTSP in particular.[40] Respondent repeats its assertions that its activities reduce utilization of physicians and total medical expense, largely through claimed "spillover" effects from its risk contracts.

Though there is a clear public policy in favor of medical cost containment, there most certainly is no such public policy in favor of price-fixing by health care providers, which can–and in this case did–lead to higher physician fees. The policy of the antitrust laws is to assure consumers the benefits of lower prices resulting from competition among competitors.

We have already explained the deficiencies in Respondent's claims of efficiencies, which have not been shown to be real or cognizable, and the achievement of which would not require NTSP to engage in collective price negotiations or price-related coercive conduct on its non-risk contracts. Instead of hard evidence about benefits that might be consistent with a "policy" in favor of medical cost containment, Respondent makes only abstract predictions based exclusively on the testimony of an expert who admittedly has little knowledge of how NTSP's non-risk business operated or the extent to which doctors reimbursed on a fee-for-service basis participated in efficiency-creating programs. (CPF 434). For example, NTSP claims that its business model and risk contracts "motivate participating physicians to become concerned about utilization and to control total medical expense" (RPB at 30-31), and NTSP "hopes" that efficiencies on risk contracts will be carried over to non-risk business if the same physicians participate in all contracts. (RPB at 5). NTSP's hopes and aspirations surely provide no basis for Your Honor to ignore the public policy behind the antitrust laws, that unfettered competition

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[40] CPF 431-434. The reasons why Dr. Wilensky's testimony should be given little weight were fully discussed in Complaint Counsel's Post Trial Brief at 45-47.

among providers of a service will ultimately lead to better service, lower costs, and the most efficient allocation of economic resources.

D. Complaint Counsel Has Demonstrated That the Conduct of NTSP is Within the Jurisdiction of the Federal Trade Commission Act

Complaint Counsel in its Post-Trial Brief cited extensively to the factual record and controlling legal precedent establishing that NTSP is, in operation and effect, an association acting in the pecuniary interests of its "members," the participating physicians, and thus is a "corporation" within the jurisdiction of the FTC Act. (CPB at 22-33). Largely ignoring the factual record, Respondent essentially makes two meritless arguments. First, Respondent argues that under the formal language of the Texas statute under which NTSP operates, it is a "memberless corporation." Second, Respondent makes the extraordinary claim that it does not provide any "tangible, pecuniary benefits" to its physicians.[41]

As Complaint Counsel explained in its Post-Trial Brief, the courts have held that the jurisdictional requirements of the FTC Act are to be analyzed not on the basis of legal technicalities, but rather on the basis of the practical operation of the organization. Complaint Counsel cited abundant evidence that NTSP in practice operates like any other professional association and treats its participating physicians as members. (CPB at 22-24). We also cited evidence that many of NTSP's activities are intended for the pecuniary benefit of its members. (CPB at 24-27). Most important, of course, is the role of NTSP as a collective negotiator of

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[41] Respondent also suggests (RPB at 35) that the Court should find a lack of jurisdiction because NTSP did not engage in "collusion" and because its refusals to deal with health plans were "unilateral" action. We regard this as an argument addressed to the merits of the case, rather than to the jurisdiction of the Commission, and we have addressed this argument at length earlier in this reply Brief, *see supra* at 25-35.

contract terms and fees with health plans. Not only have the actions of NTSP often resulted in higher fees–an obvious "pecuniary benefit" to its physicians–NTSP's Board and staff have boasted in contemporaneous communications to its physician "members" about their success in getting them higher fees. (CPF 7, 132, 379, 383). Respondent's assertions to the contrary in the context of this litigation are disingenuous at best.

Respondent also asserts that Complaint Counsel has not demonstrated that the alleged unlawful conduct had an effect on interstate commerce.[42] Respondent suggests four deficiencies in the evidence, of which the first three are merely a repetition of its contentions that NTSP has not colluded with its participating physicians. Respondent also asserts that "NTSP deals only with insurers located in Texas," and claims there is no evidence that its conduct with respect to such insurers had an interstate effect. On the contrary, there was abundant testimony at trial from three national health plans, United, Aetna and CIGNA, who testified that the collective price negotiations conducted by NTSP on behalf of its participating physicians resulted in higher fees for the physicians in their networks, which were paid in part by their employer clients, some of whom were large national corporations with employees in Texas and many other states. (CPF 9-10, 477-478). The interstate effect of NTSP's success in imposing higher fees on these health plans and employers could hardly be clearer.

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[42] As we explained in our Post-Trial Brief, the "affecting commerce" standard is only one of the tests under which a court may find jurisdiction, and some of Complaint Counsel's evidence that Respondent attacks as irrelevant applies to alternative standards (such as the operation of the parties to an agreement in interstate commerce). Nevertheless, as explained herein, Complaint Counsel has clearly met the "affecting commerce" test.

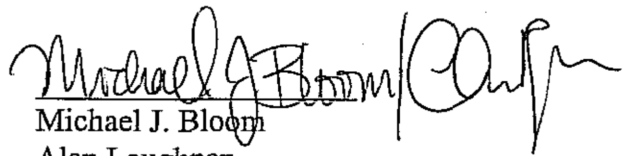
E. The Remedy Sought by Complaint Counsel Properly Goes Beyond Prohibition of Illegal Conduct

Respondent argues that any Order entered by the Court to remedy NTSP's past unlawful conduct should not require affirmative conduct by NTSP that is not required by law, and in particular, that it should not be required to "messenger" all contracts to its members for individual decision on whether or not to participate. (RPB at 38-43). As we explained in our Post-Trial Brief, the law and Commission precedent clearly recognize that in crafting an Order it is often necessary to go beyond the narrow conduct that is by itself unlawful, in order to remove the effects of the prior unlawful conduct. Thus it may be necessary to prohibit conduct that would be lawful standing alone, in order to cure the taint caused by its use in conjunction with past unlawful conduct. Likewise, a Respondent may be required to engage in affirmative conduct not required by law, but that is necessary to assure that its future conduct will not lead to the same harmful results.

The Proposed Order submitted by Complaint Counsel prohibits NTSP from: entering into or facilitating any agreement among physicians to collectively negotiate price or non-price terms of contracts, or to deal or refuse to deal with any health plan; exchanging certain competitively-sensitive information; or encouraging or pressuring any person to take any prohibited action. However, it is made clear that conduct that is reasonably necessary to further the purposes of any significant clinical or financial integration is permitted. This will permit NTSP to achieve any of its claimed efficiencies, to the extent that they are provable and require collective action. The Proposed Order does not explicitly require NTSP to deal with any health plan, or messenger any offer to any health plan. It provides only that if NTSP in the future wishes to operate as a "messenger model," it notify the Commission in advance of the

arrangement, any claimed efficiencies, and any procedures implemented by NTSP to limit anticompetitive effects. Given NTSP's history of using the term "messenger model" to cloak direct collective price negotiation, setting of minimum acceptable prices, termination of contracts, solicitation of exclusive bargaining powers, urging of physicians not to sign individual contracts with health plans, and threats of network disruption to employers, there is a compelling reason for the Court to require NTSP to provide certain competitive safeguards before it again holds itself out as a legitimate messenger model IPA.

Respectfully submitted,



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July 8, 2004

CERTIFICATE OF SERVICE

I, Christine Rose, hereby certify that on July 8, 2004, I caused a copy ofCorrected Complaint Counsel's Response to Respondent's Post-trial Proposed Findings of Fact (public version) to be served upon the following persons:

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

Hon. D. Michael Chappell
Administrative Law Judge
Federal Trade Commission
Room H-104
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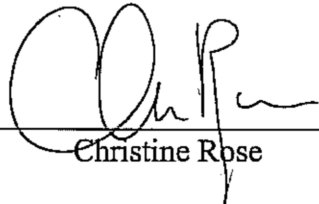
and by email upon the following: Gregory S. C. Huffman (gregory.huffman@tklaw.com). William Katz (William.Katz@tklaw.com), and Gregory Binns (gregory.binns@tklaw.com).



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