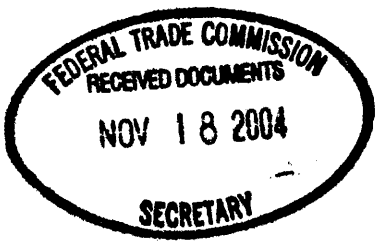
UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION



In the matter of	
Evanston Northwestern Healthcare Corporation, a corporation, and	Docket No. 9315
ENH Medical Group, Inc., a corporation.	**Public Record Version**

MEMORANDUM IN OPPOSITION TO COMPLAINT COUNSEL'S MOTION FOR PARTIAL SUMMARY DECISION ON COUNT III OF THE COMPLAINT

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Dated: November 18, 2004

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PRELIMINARY STATEMENT

Complaint Counsel's extraordinary attempt to obtain summary decision on Count III and deny Respondent Evanston Northwestern Healthcare Medical Group Inc. ("Medical Group") its day in court is based on little or no analysis and flawed inferences. Throughout this litigation, Complaint Counsel has continuously and mistakenly asserted that the Medical Group's negotiations of fee-for-service contracts with payors on behalf of all of its members was *per se* illegal[1] because not all of the physician-members were employees of the Medical Group's parent (i.e. "affiliated physicians").

Complaint Counsel's motion -- which dresses up its old *per* se theory in the garb of the Commission's decision in *Polygram,*[2] rests on two faulty premises: (1) the contracting practices of the Medical Group are "inherently suspect" and (2) these practices do not produce plausible and cognizable efficiency benefits. Respondents respectfully submit that the evidence

[1] *See* Complaint Counsel's Response to Interrogatory No. 19.

[2] *In the Matter of Polygram Holding, Inc.*, 2003 FTC LEXIS 120 (July 24, 2003). Under *Polygram,* conduct that is "inherently suspect" — typical *per se* conduct — cannot be summarily condemned in the face of "plausible" and "cognizable" efficiency justifications.

demonstrates that both of Complaint Counsel's premises are flawed, and that a litany of facts disputing these contentions preclude summary decision.

First, the Medical Group's conduct is not a horizontal agreement between competitors to fix prices, and thus "inherently suspect," because the record evidence demonstrates that (i) the affiliated physicians were free to, and did, negotiate with payors outside of the Medical Group (through other IPAs and/or individually), often at rates above those negotiated by the Medical Group and (ii) the physicians in the Medical Group did not all compete against each other, either by specialty practice or geographically.

Second, even if the conduct is deemed "inherently suspect," the evidence demonstrates that the contracting activities of the Medical Group produced plausible and cognizable efficiencies, including, among other things (i) significant transaction cost efficiencies that directly benefit payors, as well as physicians, (ii) the development of a larger network of geographically diverse physicians across a broad range of specialties that payors can access for their own network requirements, (iii) a more efficient patient-referral system, (iv) increased risk sharing that allowed the Medical Group members to more easily absorb the risk contained in the capitated contracts, and (v) increased clinical integration through the use of clinical pathways by a greater number of physicians.

MATERIAL FACTS

A. The ENH Medical Group Is Part Of An Integrated Healthcare Delivery System And Was Formed To Help Facilitate Managed Care Contracting

Evanston Northwestern Healthcare ("ENH") is an integrated healthcare delivery system based in the northern suburbs of Chicago, Illinois. ENH provides in- and out-patient hospital services, physician services, home health care, medical research and other healthcare related services.[3] As an integrated healthcare delivery system, ENH owns Faculty Practice Associates ("FPA"), which employs an array of physicians that practice at various ENH facilities.[4] The FPA also owns the Medical Group, an Independent Physician Association ("IPA") whose members include the ENH-employed physicians, as well as a number of non-employed (affiliated) physicians with staff privileges at the ENH hospitals.[5]

The Medical Group was formed in the early 1990s, when it appeared that health maintenance organizations ("HMOs") would be the future of managed care contracting, for the purpose of securing and providing medical care to patients under capitated contracts.[6] As both payors and doctors recognize, capitated contracts are viable primarily for larger physicians groups, such as IPAs, as such organizations are better able to absorb the risk inherent in such contracts.[7] **[REDACTED]**[8] The Medical Group has approximately 70,000 covered lives under capitated contracts, the third most in the Chicago area.[9] In 2000, the Medical Group received a

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[3] *See, e.g.*, ENH DL 004099 **(Tab 77)**. *See* Respondent's Separate and Concise Statement of Material Facts as to Which There Exists a Genuine Issue for Trial ("Respondent's SOF") at ¶ 81.

[4] First Amended Answer at 7 **(Tab 78)**. *See* Respondent's SOF at ¶ 81.

[5] First Amended answer at 8 **(Tab 78)**. *See* Respondent's SOF at ¶ 81.

[6] Miller Aff. ¶ 3 **(Tab 17)**. *See* Respondent's SOF at ¶ 81.

[7] Guttman Dep. Tr. at 176-77 **(Tab 9)**; Holt-Darcy Dep. Tr. at 134-35 **(Tab 2)**; Golbus Dep. Tr., (July 8, 2004) at 135-37, 164 **(Tab 10)**. *See* Respondent's SOF at ¶ 88.

[8] **[REDACTED]**

[9] ENH-FSM 30, at 7 **(Tab 7)**. *See* Respondent's SOF at ¶ 89.

meaningful part of its business from capitated contracts.[10]

B. The Medical Group, Like Other IPAs in the Chicagoland Area, Includes a Diverse Group of Employed and Affiliated Doctors

ENH merged with Highland Park Hospital effective January 1, 2000, and the Medical Group also became legally integrated with the Highland Park Independent Practice Associates, Inc. ("Highland Park IPA") that same day.[11] Prior to the merger, the Highland Park IPA was associated with Highland Park Hospital and was comprised solely of affiliated physicians. By the time of the merger, the Highland Park IPA consisted of 350 affiliated physicians.[12] Some Highland Park doctors chose not to join the Medical Group because they could negotiate better reimbursement rates with payors on their own.[13]

[REDACTED][14]

[15]

[16]

[10] Miller Aff. ¶ 3 **(Tab 17)**. *See also* Miller Dep. Tr. at 48 **(Tab 72)**. *See* Respondent's SOF at ¶ 89.

[11] Golbus Dep. Tr. (July 8, 2004) at 92-93 **(Tab 10)**. Dr. Golbus was not involved in the decision to merge the hospitals. *Id.* at 74-75. *See* Respondent's SOF at ¶ 82.

[12] CX 1332 at 4 **(Tab 79)**. *See* Respondent's SOF at ¶ 82.

[13] Golbus Dep. Tr. (July 9, 2004) at 25 **(Tab 73)**. *See* Respondent's SOF at ¶ 97.

[14] **[REDACTED]**

[15] **[REDACTED]**

[16] **[REDACTED]**

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[REDACTED]

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The Medical Group is one of several IPAs in the Chicagoland area, many of which are hospital-based and consist of both employed and affiliated physicians.[21] These IPAs have been negotiating fee-for-service contracts with payors on behalf of their affiliated physicians for several years, and most payor organizations have not objected to this practice.[22]

[REDACTED]

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[17] Miller Aff. ¶ 7 **(Tab 17)**. *See* Respondent's SOF at ¶ 87

[18] Golbus Dep. Tr. (July 8, 2004) at 82 **(Tab 10)**. *See* Respondent's SOF at ¶ 87

[19] For example, the United Healthcare rate of 125% of RBRVS had been in effect since 1995. ENH JL 000223-33 **(Tab 60)**. *See* Respondent's SOF at ¶ 87.

[20] **[REDACTED]**

[21] *See, e.g.*, ENH-FSM 29 **(Tab 6)**; ENH-FSM 30 **(Tab 7)**. *See* Respondent's SOF at ¶ 86.

[22] **[REDACTED]**

[23] **[REDACTED]**

[REDACTED] [24]

C. The Medical Group is Not Exclusive

1. Payors are Free to Contract with Medical Group Affiliated Doctors Individually and Through Other IPAs, and Have Done So

Payors have always been free to contract with Medical Group affiliated physicians individually and/or through other IPAs.[25]

[REDACTED] [26]

[27] Other physicians and payors have negotiated individual contracts directly with each other,[28] and no one from the Medical Group ever told a payor that it could not contract directly with affiliated physicians.[29] Additionally, almost half of the affiliated physicians in the Medical Group belong to more than one IPA.[30]

[REDACTED]

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[24] **[REDACTED]**

[25] **[REDACTED]**

[26] **[REDACTED]**

[27] **[REDACTED]**

[28] ***See, e..g.*, Rosenberg Dep. Tr. at 16 (Tab 16); Curry Dep. Tr. at 106 (Tab 23). [REDACTED]**

[29] Ballengee Dep. Tr. at 173 **(Tab 1)**; Golbus Dep. Tr. (July 8, 2004) at 141, 158 **(Tab 10)**. *See* Respondent's SOF at ¶ 98.

[30] *See* McChesney Rep. at Ex. 8 **(Tab 12)**. *See* Respondent's SOF at ¶ 96.

[REDACTED] [31] The Medical Group, however, does not monitor what other IPAs its physicians are affiliated with or the individual contracts they may have with payors, nor do they know the rates the physicians have obtained through these other contracts.[32]

2. Medical Group Affiliated Physicians Are Able To Obtain Better Rates Outside of the Medical Group

Most physicians in the 5 counties in which the Medical Group members are located are not themselves members of the Medical Group, even though the Medical Group has generally been open to any doctor on the professional staff who wants to join.[33]

[REDACTED]

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D. Although the Medical Group Allowed Its Affiliated Physicians To Have Contracts Through Other IPAs and/or Individual Contracts With Payors, Payors Were Not Always Equipped To Handle Multiple Affiliations

Although the Medical Group members are free to join other IPAs and/or contract individually with payors, these multiple affiliations/contracts often caused problems for the

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[31] **[REDACTED]**

[32] Mittleman Dep. Tr. at 28-29, 56-57, 100, 106 **(Tab 11)**; Levine Dep. Tr. at 22 **(Tab 18)**; Coyle Dep. Tr. at 38 **(Tab 36)**. *See* Respondent's SOF at ¶ 101.

[33] McCheseny Rep. at 53 (Table 1) **(Tab 12)**; Miller Aff. ¶ 4 **(Tab 17)**. *See* Respondent's SOF at ¶ 86.

[34] **[REDACTED]**

[35] **[REDACTED]**

payors.

[37] [38]

[39] [40]

[41] [42]

[43]

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[45] Indeed, the Medical Group staff did not even know what rates the affiliated physicians were getting through their individual and/or other IPA

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[36] **[REDACTED]**

[37] Coyle Dep. Tr. at 29-30, 50 **(Tab 36)**; Mittleman Dep. Tr. at 27-28, 30-31, 35-37, 187-89 **(Tab 11)**. *See* Respondent's SOF at ¶ 105-06.

[38] **[REDACTED]**

[39] **[REDACTED]**

[40] **[REDACTED]**

[41] **[REDACTED]**

[42] **[REDACTED]**

[43] **[REDACTED]**

[44] **[REDACTED]**

[45] **[REDACTED]**

contracts.[46]

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[REDACTED]

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[46] [REDACTED]
[47] [REDACTED]
[48] [REDACTED]

[49] [REDACTED]
[50] [REDACTED]

[51] [REDACTED]

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[REDACTED]

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[52] [REDACTED]

[53] [REDACTED]
[54] [REDACTED]
[55] [REDACTED]
[56] [REDACTED]

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[REDACTED]

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[57] [REDACTED]
[58] [REDACTED]
[59] [REDACTED]
[60] [REDACTED]

[61] [REDACTED]

[62] [REDACTED]

[63] [REDACTED]
[64] [REDACTED]

[65]

[REDACTED]

[66]

[67]

One year after the multiple affiliation problem came to light, the administrative difficulties resulting from multiple affiliations continued.

[REDACTED]

[68]

E. The Medical Group's Ability To Contract On Behalf Of Its Affiliated Physicians Generates Numerous Efficiencies For Payors, Its Member Physicians, And Patients

The Medical Group's ability to negotiate contracts on behalf of both its employed and affiliated physicians effects a substantial time and cost savings for both payors and physicians. These efficiencies induce many physicians to join the Medical Group, which in turn produces other benefits.

1. Single Signature Contracting Significantly Reduces The Cost Of Negotiations For Both Payors And Physicians And Induces Physicians To Join The Medical Group

Rather than payors having to negotiate reimbursement rates with over 800 doctors and/or hundreds of physician groups individually, and the physicians having to negotiate with individual payors, the Medical Group's contracting practices allowed payors to enter into a

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[65] **[REDACTED]**

[66] **[REDACTED]**

[67] **[REDACTED]**

[68] **[REDACTED]**

single contract and bring the Medical Group's entire physician membership into their provider network.[69]

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Doctors also recognized the benefits of single signature contracting. Several doctors

[69] Chan Dep. Tr. at 151 **(Tab 48)**. *See* Respondent's SOF at ¶ 123.

[70] **[REDACTED]**

[71] **[REDACTED]**

[72] **[REDACTED]**

[73] **[REDACTED]**

[74] **[REDACTED]**

joined the Medical Group because of single signature contracting.[75]

[REDACTED]

[76]

[77]

2. The Medical Group's Contracting Activities Produced Additional Transaction Costs Savings For Both Payors And Physicians

a. Credentialing

Affiliated physicians must be credentialed with each individual payor with whom they have contracted,[78] which involves a substantial amount of paperwork.[79] Accordingly, in 1999 and 2000, the Medical Group employed three full-time credentialing coordinators to handle credentialing for the payors and physicians.[80] Several payors have recognized that credentialing is a time-consuming administrative burden that they would rather delegate to the Medical Group.[81]

[REDACTED]

[75] **[REDACTED]**

[76] **[REDACTED]**

[77] **[REDACTED]**

[78] Coyle Dep Tr. at 17 **(Tab 36)**; Miller Dep. Tr. at 10-11 **(Tab 72)**. *See* Respondent's SOF at ¶ 131.

[79] Credentialing involves gathering the required licensure and documentation from the physicians (including the physician's license, DEA number, hospital privilege verification, education verification, and malpractice information), providing the documentation to the payors, and following up with the payors and physicians to provide any further information the payors required. Coyle Dep Tr. at 8, 15-16, 47 **(Tab 36)**; Mittleman Dep. Tr. at 111 **(Tab 11)**; *see also* Guttman Dep. Tr. at 172-73 **(Tab 9)**. *See* Respondent's SOF at ¶ 132.

[80] Coyle Dep. Tr. at 23 **(Tab 36)**; *see also* Guttman Dep. Tr. at 197 **(Tab 9)**. *See* Respondent's SOF at ¶ 132.

[81] **[REDACTED]**

[REDACTED]

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The doctors also agree that delegating credentialing to the Medical Group is a substantial time savings for them.[83]

b. Ease of Referrals

Patients who are in strict HMOs must see doctors within the HMO network, or their expenses will not be covered.[84] Patients who are in PPOs similarly desire to be referred to doctors within their payor's network to obtain maximum insurance coverage.[85] By negotiating single-signature contracts on behalf of all of its physicians, employed and affiliated, the Medical Group automatically produces a large network of doctors who are contracted with the same payors. As a result, physicians within the Medical Group have a greater array of specialists to whom they can refer patients, and they can refer patients freely to one another without having to contract individually with the same payors or check in each instance whether that doctor is contracted with the patient's insurance company.[86]

87 These physicians did not expect that the Medical Group could negotiate better reimbursement rates

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[82] **[REDACTED]**

[83] **[REDACTED]**

[84] Miller Aff. ¶ 3 **(Tab 17)**.

[85] Miller Aff. ¶ 8 **(Tab 17)**.

[86] Miller Aff. ¶ 8 **(Tab 17)**. *See* Respondent's SOF at ¶ 136.

with payors than they were already receiving from other IPAs or could obtain individually.[88]

To facilitate patient referrals within the ENH network, the Medical Group provided all of its participating physicians with a physician directory so they would know what doctors were in the network for referral purposes.[89] The Medical Group also facilitates physician referrals by acting as a referral clearinghouse and by obtaining the necessary pre-approvals from managed care plans.[90]

c. Assistance with Payor-Physician Relationships

The Medical Group has a dedicated staff of provider relations representatives that serve as liaisons between its physicians and the payors.[91] The provider relations specialists can intervene if, for example, a physician is not being reimbursed properly by a payor, if there are contractual issues that need to be clarified, if a physician is unsure of a health plan policy or procedure, or if a physician has any other issues with a payor.[92] Payors prefer to deal with a dedicated staff at the Medical Group rather than the individual doctors because of lower transaction costs.[93] Patients also benefit in that doctors can spend more time seeing patients and focusing on the practice of medicine.[94]

3. The Larger Size Of The Medical Group As A Result Of Single Signature Contracting On Behalf Of Both Employed And Affiliated Physicians

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[87] **[REDACTED]**

[88] Alexander Dep. Tr. at 52 **(Tab 19)**; Moller Dep. Tr. at 131 **(Tab 13)**. *See* Respondent's SOF at ¶¶ 103-04.

[89] Mittleman Dep. Tr. at 16 **(Tab 11)**. *See* Respondent's SOF at ¶ 136.

[90] Guttman Dep. Tr. at 178-79 **(Tab 9)**; Hochberg Dep. Tr. at 83 **(Tab 21)**; Katz Dep. Tr. at 65-66 **(Tab 22)**. *See* Respondent's SOF at ¶ 137.

[91] Mittleman Dep. Tr. at 7 **(Tab 11)**. *See* Respondent's SOF at 61 ¶ 138. These services are explicitly provided for in the Physicians' Participation Agreement. *See* CX 1503 at 9 (Provision 3.3) **(Tab 34)**. *See* Respondent's SOF at ¶ 35.

[92] Mittleman Dep. Tr. at 9 **(Tab 11)**; Coyle Dep. Tr. at 8 **(Tab 36)**.

[REDACTED]

See Respondent's SOF at ¶ 138.

[93] **[REDACTED]**

[94] *See* Katz Dep. Tr. at 93 **(Tab 22)**. *See* Respondent's SOF at ¶ 139.

Generates Additional Efficiencies That Benefit Payors, Physicians, And Patients

The increased size of the network that resulted from the Medical Group's ability to negotiate a single signature contract for both its employed and affiliated physicians generates additional efficiencies which further benefit payors, physicians, and their patients.

a. A Better Network of Physicians

The increased size of the Medical Group allows the Group to offer a network to payors with broader geographic coverage and more high end specialists.

[REDACTED]

[95]

b. Provision of Various Administrative Services

In addition to credentialing, many payors delegate a number of administrative responsibilities to the Medical Group.

[REDACTED]

[96] The Medical Group not only employs a full-time staff to collect the necessary data and information for the payors on the use of these protocols, but it also disseminates to the physicians information provided by the payors, such as data flow sheets; information and educational material about the protocols; and updated managed care policies.[97] Without the Medical Group, these services would otherwise be handled by the payors.

The fact that payors require Medical Group physicians to use clinical protocols benefits

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[95] **[REDACTED]**

[96] **[REDACTED]**

[97] Guttman Dep. Tr. at 84, 89, 166-72 **(Tab 9)**. *See also* ENHL JL 028685-028695 **(Tab 83)**. *See* Respondent's SOF at ¶ 141. Indeed, utilization management and peer review procedures are specifically detailed as services provided by the Medical Group in the physicians' participation agreement. *See* CX 1504 at 8 **(Tab 35)**. *See* Respondent's SOF at ¶ 34.

not only the Medical Group's capitated patients, but all patients, as most doctors do not know what type of coverage a patient has at the time they treat the patient.[98] Doctors generally treat all of their patients the same way,[99] and doctors who are required to follow protocols for their capitated patients inevitably end up following the same protocols for their non-capitated patients.[100]

c. Increased Integration

As discussed above, IPAs are inherently risk-sharing organizations. Payors prefer to deal with the Medical Group than contract with individual doctors for their capitated products because the Medical Group's size gave it a large enough mass to handle the risk.[101] Spreading the risk among a large group of doctors allows doctors who would not otherwise be able to participate in capitated contracts to do so.

[REDACTED]

[102]

F. The Medical Group Stopped Negotiating on Behalf of Affiliates Before This Litigation Began

[103]

[REDACTED]

[98] Solmor Dep. Tr. at 101 **(Tab 30)**; Hochberg Dep. Tr. at 124 **(Tab 21)**. *See* Respondent's SOF at ¶ 142.

[99] Katz Dep. Tr. at 89-90 **(Tab 22)**; Solmor Tr. at 101 **(Tab 30)**; Hochberg Tr. at 125 **(Tab 21)**. *See* Respondent's SOF at ¶ 142.

[100] Solmor Dep. Tr. at 101-02 **(Tab 30)**; Guttman Dep. Tr. at 86-87, 179-80 **(Tab 9)**. *See* Respondent's SOF at ¶ 142.

[101] Golbus Dep. Tr. (July 8, 2004) at 135-37, 164 **(Tab 10)**. **[REDACTED]**

[102] **[REDACTED]**

[103] **[REDACTED]**

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[REDACTED]

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[104] [REDACTED]
[105] [REDACTED]
[106] [REDACTED]
[107] [REDACTED]

[108] [REDACTED]
[109] [REDACTED]

[REDACTED]

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Regardless of which option the payors prefer, however, the Medical Group has ceased the conduct on which Count III is based.[112] Before the complaint was even filed in this case, Respondents proposed to settle Count III on substantially similar terms as those included in the more than 20 IPA-related consent decrees in recent years.[113] Respondents repeated this offer several times to Complaint Counsel after these proceedings were initiated. All of Respondents' offers were rejected.

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[110] **[REDACTED]**

[111] **[REDACTED]**

[112] Golbus Dep. Tr. at (July 8, 2004) at 169-70, 172-75 **(Tab 10)**; Golbus Dep. Tr. (July 9, 2004) at 174 **(Tab 73)**; Miller Dep. Tr. at 15, 18 **(Tab 72)**. *See* Respondent's SOF at ¶ 149.

[113] Letter from Sibarium to Cowie of 12/12/2003 **(Tab 89)**.

ARGUMENT

I. DISPUTED ISSUES OF MATERIAL FACTS PRECLUDE GRANTING COMPLAINT COUNSEL'S MOTION FOR SUMMARY DECISION

A litany of disputed issues of material fact compels denial of Complaint Counsel's motion. Pursuant to Commission Rule of Practice 3.24(a)(2), summary decision may only be "rendered . . . if the pleadings and any depositions, answers to interrogatories, admissions on file, and affidavits show that there is no genuine issue as to any material fact and that the moving party is entitled to such decision as a matter of law." 16 C.F.R. § 3.24(a)(2). "A genuine issue of material fact is one whose resolution could establish an element of a claim and, therefore, affects the outcome of the action." *In the Matter of Rambus Inc.*, Docket No. 9302, at 3 (Order Denying Respondent's Motion for Summary Decision) (J. McGuire) (Apr. 14, 2003). *(citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). All of the non-movant's evidence must be accepted as true, and all reasonable inferences must be drawn in its favor. *In the Matter of Telebrands, Corp.,* Docket No. 9313, at 2-3 (Order Denying Respondents' Motion For Summary Decision) (J. McGuire) (Apr. 13, 2004). In addition, a judge may not make credibility determinations or weigh the evidence. *In the Matter of Rambus Inc.*, Docket No. 9302, at 3 (*citing Anderson*, 477 U.S. at 255).

As the Medical Group more than amply demonstrates below, there are a number of "genuine issues of material fact" that are critical to the appropriate resolution of Complaint Counsel's allegations. In this case, the numerous disputed issues of material fact preclude summary decision and the Medical Group is entitled to their day in court on the allegations cited in Count III. Complaint Counsel should not be allowed simply to allege conduct in a complaint and summarily condemn it without proving those allegations on a full record at trial, particularly when so many of the material facts are hotly disputed. Indeed, as this Court has stated, "sound judicial policy and the proper exercise of judicial discretion permit denial of such a motion for

the case to be developed fully at trial." *In the Matter of Telebrands, Corp.*, Docket No. 9313, at 3 (citations omitted). Accordingly, the Medical Group respectfully requests that Your Honor deny Complaint Counsel's motion.

II. THE ACTIVITIES OF THE MEDICAL GROUP AND ITS MEMBERS ARE NOT "INHERENTLY SUSPECT"

Complaint Counsel repeatedly characterizes the conduct in which the Medical Group and its members engaged as a *"per se"* illegal "price-fixing" agreement. Complaint Counsel ultimately acknowledges, however, that true *per se* analysis is inappropriate, citing to the Commission's opinion in *In the Matter of Polygram Holding, Inc.*, 2003 FTC LEXIS 120 (July 24, 2003). Complaint Counsel Mem. at 17. In *Polygram*, the Commission identified a multi-step analysis to be employed when the restraint involved is "inherently suspect:" (i) the plaintiff must first satisfy its initial burden of establishing that the activity in question is "inherently suspect;" (ii) the defendant must then articulate a plausible and cognizable legitimate justification for the activity; (iii) plaintiff must then "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;" and (iv) defendant must show "countervailing procompetitive virtue." *Polygram*, 2003 FTC LEXIS 120 at *68. *See also Massachusetts Bd. of Registration in Optometry*, 110 F.T.C. 549, at *13 (1988) (articulating a similar, abbreviated standard of analysis). Throughout this analysis, Complaint Counsel retains the overall burden of persuasion. *Polygram*, 2003 FTC LEXIS 120 at *68.

The Medical Group's conduct does not appropriately fall into the "inherently suspect" class of activities and a full rule of reason analysis is therefore required. *Id.* at *61. The Commission recognized in *Polygram* that "[t]he 'rule of reason' is the touchstone for evaluating challenged conduct." *Id.* at *34. Departures from the "touchstone" should be made only with respect to the most egregious conduct with which the judiciary has much experience. *Broad.*

Music, Inc. v. Columbia Broad. Sys., Inc., 441 U.S. 1, 9-10 (1979) ("BMI") ("[I]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations.") (citation omitted); *Car Carriers, Inc. v. Ford Motor Co.*, 745 F.2d 1101, 1108 (7th Cir. 1984) ("the *per se* label must be applied with caution and we will expand that class of violations 'only after the courts have had considerable experience with the type of conduct challenged and application of the Rule of Reason has inevitably resulted in a finding of anticompetitive effects.'") (internal citations omitted). Such caution is particularly appropriate here given the paucity of *litigated* cases involving a claim of price-fixing among members of a valid IPA. As former-Chairman Morris has stated:

> [t]he 'managed care revolution' has fundamentally changed the manner in which health care services are both purchased and sold. As managed care has come to dominate, providers -- doctors and hospitals -- are combining in myriad ways, some of which appear anticompetitive, but others of which promise benefits to consumers, including some of the cost-reducing features of managed care itself. Given our uncertainty about these practices, the rapidly evolving market, and lack of both judicial and academic familiarity with them, full rule of reason analysis is warranted.

Timothy J. Muris, Symposium: Antitrust Scrutiny of Joint Ventures: The Federal Trade Commission and the Rule of Reason: In Defense of Massachusetts Board, 66 ANTITRUST L.J. 773 (1998).[114]

As demonstrated below, the activities of the Medical Group are not "inherently suspect" – i.e. it can not be said that the conduct "appears likely, absent an efficiency justification, to 'restrict competition and decrease output.'" *Mass. Board* at *13 (citations omitted).

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[114] While there may not be any categorical exemption from *per se* analysis for the "learned professions," the Supreme Court itself overwhelmingly employs rule of reason analysis to judge the effects of "restraints" undertaken by professionals in the management of their business affairs. The Supreme Court has "been slow to condemn rules adopted by professional associations as unreasonable *per se*, ... and, in general, to extend *per se* analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious." *Federal Trade Comm'n v. Indiana Federation of Dentists*, 476 U.S. 447, 458-59 (1986).

A. The Conduct In Which The Medical Group And Its Members Engaged Is Not The Type Of "Price-Fixing" To Which A *Per Se* Analysis Is Applied

Negotiation of reimbursement rates by the Medical Group on behalf of affiliated physicians simply cannot effect any of the anti-competitive consequences that constitute the *raison d'être* for *per se* characterization. As the Supreme Court stated, "[n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints." *Broad. Music, Inc. v. Columbia Broad. System, Inc.*, 441 U.S. 1, 23 (1979). The type of price-fixing that is typically subject to *per se* treatment depends upon cartel members being able to monitor and enforce adherence to the prices agreed upon.[115] Without any mechanism to deter cheating, especially in a market full of competitors selling heterogeneous products, the individual self interest of cartel members to cheat will leave the cartel with little chance of success. If the agreement in question has neither the effect nor the potential to prevent competition, the agreement is meaningless from an antitrust perspective.[116] *See Matsushita Elec. Indust. Co. v.* Zenith *Radio Corp.*, 475 U.S. 574, 592 (1986) (maintaining supra-competitive prices depends on the continued adhesion of the parties to the price set in the agreement).

The Court's opinion in *BMI* confirms this analysis. In *BMI,* copyright holders to musical works assigned to an intermediary (ASCAP or BMI) a non-exclusive right to license their work

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See Goldfarb v. Virginia State Bar, 421 U.S. 773, 788, n.17 (1975); *California Dental Ass'n v. Federal Trade Comm'n*, 526 U.S. 756, 771-73 (1999); *National Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 696 (1978).

[115] "[C]artels tend to be more stable as the number of participants is reduced. Individual members of a cartel always have an incentive to cheat and will do so when cheating seems profitable. As a result, the managers of the cartel must be vigilant about detecting cheating and disciplining the cheater. The more members in a cartel, the more difficult to detect cheating by a single member." Hovenkamp, XII Antitrust Law ¶ 2002f1 (page 25).

[116] The true evil of a price fixing agreement is the fact that the agreement fundamentally thwarts consumer choice, impairs the functioning of the market, and reduces consumer welfare. *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1927) ("The aim and result of every price-fixing agreement, if effective, is the elimination of one form of competition."). *See also National Soc'y of Professional Engineers v. United States* 435 U.S. 679, 694-95 (1978) (in applying a rule of reason analysis, the Court explained that it is the reduction in the "free opportunity to select among alternative offers" that is the heart of the legislative judgment behind the Sherman Act). Rather than "reducing alternative offers" available in the marketplace, the conduct of the Medical Group provides more options for payors.

according to a set fee schedule. ASCAP/BMI offered a "blanket license" where, for one set fee, the licensee was granted rights to every copyrighted composition in the organization's repertory. 441 U.S. at 5-6. In explaining its refusal to apply the *per se* standard, the Court explained that:

> [T]he blanket license cannot be wholly equated with a simple horizontal arrangement among competitors. ASCAP does set the price for its blanket license, but that license is quite different from anything any individual owner could issue. *The individual composers and authors have neither agreed not to sell individually in any other market nor use the blanket license to mask price fixing in such other markets.*

Id. at 23-24 (emphasis added).

The negotiation of fee-for-service contracts by the Medical Group on behalf of affiliated physicians likewise does not warrant *per se* or "inherently suspect" characterization for at least the following additional reasons. First, like the copyright holders in *BMI*, the affiliated physicians in the Medical Group were free to contract with payors individually and through other IPAs, and they did so to a substantial degree.[117] Second, the Medical Group has no means of enforcing that the rates negotiated by its members outside of the Medical Group are at least as high as its own rates when it did not know (and had no desire to know) what other contracts its members had with payors (either through other IPAs or directly with payors), let alone the rates they received through these other contracts.[118] Third, rather than eliminating competition from the market, the Medical Group provided payors with an additional choice, creating a new and improved product (a large, quality network of geographically diverse physicians in a broad range of specialties), that afforded numerous cost saving efficiencies to payors and physicians. Payors preferred contracting with the Medical Group precisely because of these efficiencies, just as

[117] *See* pp. 6-7, *supra*.

[118] *See* FN. 31 and accompanying text, *supra*.

"[m]any consumers clearly prefer[red] the characteristics and cost advantages" of blanket licenses from BMI and ASCAP. *Id.* at 22.

The present case differs from *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), cited by Complaint Counsel. The plurality opinion in *Maricopa* held that a federation of doctors that regularly set maximum reimbursement rates through a vote of the membership constituted *per se* price fixing because "[e]ven if a fee schedule is therefore desirable, it is not necessary that the doctors do the price fixing." *Id.* at 352.[119] This case is distinguishable from *Maricopa* because the Medical Group physicians have no direct involvement in negotiations with payors and are not precluded from negotiating with payors outside of the Medical Group for lower rates either directly or through affiliation with other IPAs.

B. The "To Whom It May Concern" Letters Do Not Provide The Necessary Evidence That Medical Group Members Agreed To Adhere To A Set Price

[REDACTED]

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[119] Significantly, the cases cited by Complaint Counsel to support their statement that "An agreement among competitors to appoint a third party - here ENH Medical Group - to set the prices for all the conspirators is illegal, just like an agreement among competitors to charge a particular price" (Complaint Counsel Mem. at 17) dictate the employment of the rule of reason standard. *See National Soc'y of Professional Engineers v. United States* 435 U.S. 679, 694-95 (1978); *California Dental Ass'n v. Federal Trade Comm'n* 526 U.S. 756, 777-81 (1999).

[120] **[REDACTED]**

[121] **[REDACTED]**

[122] **[REDACTED]**

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[REDACTED]

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A triable issue of fact exists and precludes summary decision.

C. The Medical Group Physicians Are Not Horizontal Competitors

The type of price-fixing that is typically subject to *per se* treatment takes place among horizontal competitors. *Denny's Marina v. Renfro Productions, Inc.*, 8 F.3d 1217, 1221-22 (7th Cir. 1993) ("horizontal price-fixing is illegal per se . . . because joint action by competitors to suppress price-cutting has the requisite 'substantial potential for impact on competition,' to

[123] **[REDACTED]**

warrant *per se* treatment.") (internal citations omitted); *Products Liability Insur. Agency, Inc. v. Crum & Forster Insur. Cos.*, 682 F.2d 660 (7th Cir. 1982) ("Agreements that are illegal per se are for the most part horizontal, that is, between competing sellers"). Because of this, Complaint Counsel repeatedly characterizes Medical Group members as "competitors" and their conduct as *per se* illegal. *See* Complaint Counsel Mem. at 1, 5, and 16. Complaint Counsel pursues a *per se* theory of liability in order to avoid undertaking any meaningful market analysis, which would highlight the absurdity of its allegations, as demonstrated below.

[REDACTED]

According to Complaint Counsel's theory, a primary care physician located in Lindenhurst competes against another primary care physician located in Olympia Fields (over 60 miles away), and a podiatrist competes against a cardiologist. Because Complaint Counsel makes no distinction among the Medical Group's affiliated physicians, doctors belonging to the same practice group are also deemed "competitors." The absurdity of these examples serves to underscore why *per se* treatment is wholly inappropriate. At most, physicians compete with other physicians within the same specialty in the same geographic area, though not every physician even agrees with that.[125]

Without evidence that the Medical Group physicians are "competitors," the Medical Group's conduct cannot fairly be characterized as "inherently suspect," and Complaint Counsel's motion for summary decision must be denied.

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[124] **[REDACTED]**

[125] **[REDACTED]**

III. THE ACTIVITIES OF THE MEDICAL GROUP AND ITS MEMBERS PRODUCE PLAUSIBLE AND COGNIZABLE EFFICIENCIES, PRECLUDING THE GRANT OF SUMMARY DECISION

Even if the contracting activities of the Medical Group are considered "inherently suspect," summary decision is still inappropriate because these activities produce "plausible" and "cognizable" efficiency justifications (i.e., pro-competitive benefits).[126] Complaint Counsel constructs a false legal paradigm by asserting that the only recognized justifications for the Medical Group's conduct are "financial" or "clinical" integration. *Id.* at 19-20. Complaint Counsel ignores myriad other justifications for the Medical Group's contracting activities and relies solely on its own internal guidelines to do so. ***There is absolutely no legal support for such a narrow approach.*** Complaint Counsel's own internal guidelines on enforcement policy do not have the force of law. *Cf. Federal Trade Comm'n v. PPG Indus., Inc.*, 798 F.2d 1500, 1503 n.4 (D.C. Cir. 1986) (merger guidelines are not law and are not binding on the Commission itself or on the courts); *Fruehauf Corp. v. Federal Trade Comm'n*, 603 F.2d 345, 353-54 (2d Cir. 1979); *Olin Corp. v. Federal Trade Comm'n*, 986 F.2d 1295, 1300 (9th Cir. 1993). Moreover, Complaint Counsel fails to cite its internal guidelines fully or accurately. In fact, the Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care ("Health Care Guidelines") explicitly state that while "more significant efficiencies are likely to result from a physician network joint venture's substantial financial risk sharing or substantial clinical integration," the Agencies will also *"consider a broad range of possible cost savings, including improved cost controls, case management and quality assurance, economies*

[126] Once the Medical Group articulates these justifications, the burden shifts back to Complaint Counsel to "address the justification, and provide the tribunal with sufficient evidence to show that anticompetitive effects are in fact likely . . ." *Polygram* at *68. Because Complaint Counsel does not attempt to present undisputed evidence that the Medical Group's conduct has produced anti-competitive effects, or that any such effects outweigh the conduct's "countervailing procompetitive virtue," which could not be done in a motion for summary decision, the challenged conduct cannot be summarily condemned and Complaint Counsel's motion must be denied.

of scale, and reduced administrative or transaction costs."[127] Complaint Counsel's expert economist herself has previously recognized the breadth of plausible and cognizable efficiencies.[128]

In *BMI*, the Supreme Court recognized the numerous "cognizable" efficiencies resulting from ASCAP's/BMI's "blanket license":

> This substantial lowering of costs, which is of course potentially beneficial to both sellers and buyers, differentiates the blanket license from individual use licenses. The blanket license is composed of the individual compositions plus the aggregating service. Here, the whole is truly greater than the sum of its parts; it is, to some extent, a different product. The blanket license has certain unique characteristics: It allows the licensee immediate use of covered compositions, without the delay of prior individual negotiations and great flexibility in the choice of musical material. Many consumers clearly prefer the characteristics and cost advantages of this marketable package, and even small-performing rights societies that have occasionally arisen to compete with ASCAP and BMI have offered blanket licenses. Thus, to the extent the blanket license is a different product, ASCAP is not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw material. ASCAP, in short,

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[127] *See* http://www.ftc.gov/reports/hlth3.pdf, "Eighth Statement" (emphasis added). *See also* Antitrust Guidelines for Collaborations Among Competitors Issued by the Federal Trade Commission and the U.S. Department of Justice (April 2000), http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf, at Section 2.1 (recognized efficiencies include providing "goods or services that are cheaper, more valuable to consumers, or brought to market faster," "better use of existing assets or may provide incentives for them to make output-enhancing investments that would not occur absent the collaboration," lowering cost production or improving quality of product, and economies of scale or scope), at Section 3.2 (rule of reason applied to conduct "that might otherwise be considered per se illegal" where efficiencies relating to "expanding output, reducing price, or enhancing quality, service, or innovation" are produced).

[128] *See* D. Haas-Wilson, Managed Care and Monopoly Power, p. 143 (2003)

> Specifically, horizontal consolidation in health care markets can be efficiency-enhancing in the following seven ways: (1) by lowering transaction costs--the costs of negotiating, writing, monitoring, and enforcing contracts among physicians, hospitals, insurers, and employers; (2) by allowing the realization of economies of scale in production or administration (administration costs include the capital costs of computer-based information systems to monitor utilization, costs, and quality, and the costs of marketing, financial accounting, and state and federal government reporting); (3) by eliminating excess capacity; (4) by facilitating specialization and its associated increases in experience, skill, and quality of care; (5) by facilitating group risk bearing; (6) by increasing incentives to monitor and improve quality; and (7) by increasing competition among all or some firms in the market.

> made a market in which individual composers are inherently unable to compete fully effectively.

BMI, 441 U.S. at 21-23. *See also United States v. Brown University*, 5 F.3d 658, 674-75 (3d Cir. 1993) (holding that the increase in quality of the educational product and the increased consumer choice were properly considered as pro-competitive benefits). These same efficiencies are present here.

1. Decreased Transaction Costs

The Medical Group produces numerous transaction cost savings to both payors and physicians by contracting on behalf of both its employed and affiliated physicians. It is undisputed that single signature contracting allows payors to quickly aggregate a broad-based network of doctors in a diverse range of medical practices and specialties at low transaction costs.[129] As a result of single signature contracting, payors can offer better products to their customers and bring those products to market faster.[130] Additionally, the efficiencies produced by single signature contracting induce more physicians to join the Medical Group, generating even greater efficiencies from the larger size of the network.[131]

Single signature contracting has an even greater benefit with respect to referrals. By contracting on behalf of a large, diversified group of primary care physicians and specialists, the Medical Group assures that its members have a broad referral base and can refer patients to each other without having to determine whether the services will be covered by the patient's insurance plan. While affiliated doctors may be able to accomplish this same result by negotiating with each payor individually, single signature contracting by the Medical Group does this at lower transaction costs.

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[129] Maxwell Dep. Tr. at 145 **(Tab 25)**; Neary Dep. Tr. at 150 **(Tab 5)**; Holt-Darcy Dep. Tr. at 134-35 **(Tab 2)**; Craven Dep. Tr. at 112-13 **(Tab 8)**. *See* Respondent's SOF at ¶¶ 123-30.

[130] *See* Holt-Darcy Dep. Tr. at 135 **(Tab 2)**; Golbus Dep. Tr. (July 8, 2004) at 137 **(Tab 10)**. *See* Respondent's SOF at ¶¶ 123-30.

The Medical Group also lowers the transaction costs involved in the referral process in an additional way — by providing a referral clearinghouse and by obtaining the necessary pre-approvals from managed care plans.[132] A full-time Medical Group staff member familiar with each payors' pre-approval process can handle pre-approvals more efficiently than each individual doctor. Serving as a clearinghouse also allows the Medical Group to inform doctors and patients in advance if the services provided will be covered by the patient's health plan.

The Medical Group's contracting on behalf of affiliated physicians also reduces the transaction costs involved with credentialing. Delegating credentialing to a dedicated, full-time staff at the Medical Group reduces the time and other costs required to get each doctor credentialed with a health plan.[133] This is particularly true as the full-time staff becomes familiar with the credentialing requirements of each payor.[134] The transaction cost savings resulting from the Medical Group's negotiating on behalf of its affiliated physicians is magnified when services such as credentialing are negotiated at the same time as reimbursement rates, rather than each item being negotiated separately. It is clearly more efficient for payors to negotiate all of the services that the Medical Group will provide at one time than to negotiate for each service separately.

The Medical Group also lowers transaction costs for both payors and physicians by providing a dedicated staff to both parties that can handle any number of administrative issues, including contract issues.[135] This facilitation is specifically provided in the Physician

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[131] *See* section E2, *supra*.

[132] Guttman Dep. Tr. at 178-79 **(Tab 9)**; Hochberg Dep. Tr. at 83 **(Tab 21)**; Katz Dep. Tr. at 65-66 **(Tab 22)**. *See* Respondent's SOF at ¶¶ 136-37.

[133] Craven Dep. Tr. at 112-13, 120, 144-45 **(Tab 8)**; Neary Dep. Tr. at 150 **(Tab 5)**; Katz Dep. Tr. at 92-93 **(Tab 22)**. *See* Respondent's SOF at ¶¶ 123-30.

[134] *See* Chan Dep. Tr. at 162-163 **(Tab 48)**. *See* Respondent's SOF at ¶¶ 123-30.

[135] Mittleman Dep. Tr. at 7, 9 **(Tab 11)**; Coyle Dep. Tr. at 8-9 **(Tab 36)**. *See* Respondent's SOF at ¶¶ 138-40.

Participation Agreement.[136] As with credentialing, the transaction cost savings increase as the staff becomes more familiar with the recurring issues and can handle them more quickly and efficiently.

[REDACTED]

Additionally, because of the Medical Group's ability to negotiate single signature contracts for all of its physician members, the Medical Group staff was more easily able to become familiar with the contracts and the types of contracting issues that arise, allowing them to resolve these issues in a more efficient manner.

Significantly, all of the services the Medical Group provides allow physicians to spend less time on administrative matters, and spend more time on the practice of medicine. This results in a greater output of medical services, which can only benefit patients.

2. The Medical Group's Activities Create Other Plausible and Cognizable Efficiencies

Because of the transaction cost efficiencies that the Medical Group provides by negotiating fee-for-service contracts on behalf of affiliated doctors, physicians have an incentive to join the Medical Group, thus increasing the overall membership in the Medical Group. This creates additional plausible and cognizable efficiencies. For example, the increased size of the Medical Group allows it to recruit more tertiary and high end specialists, thereby allowing the Medical Group to offer a better network to payors than it could have otherwise.[137] Moreover, access to all employed and affiliated physicians at once — like the "blanket license" in *BMI* — is a different product than what any individual physician can offer. *BMI*, 441 U.S. at 23-24 ("that

[136] CX 1503 at 9 (Provision 3.3) **(Tab 34)**.

[137] Golbus Dep. Tr. (July 8, 2004) at 307-08 **(Tab 10)**. *See* Respondent's SOF at ¶ 130.

[blanket] license is quite different from anything any individual owner could issue.").

The larger size of the Medical Group also increased clinical integration and financial integration, the two efficiencies that Complaint Counsel admit are plausible and cognizable. Complaint Counsel argues that the Medical Group did not engage in any clinical integration, and that it took only nominal steps to effect clinical integration after learning of the FTC's investigation. This simply is not true. Clinical integration was a new term used by the FTC in late 2002-early 2003 that did not have any meaning to the Medical Group members.[138]

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[REDACTED]

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Moreover, the affiliated physicians have always been involved in the efforts to improve clinical quality.[141] Indeed, the Physician Participation Agreement specifically states that "ENHMG shall provide for appropriate utilization management and peer review procedures as identified in the Rules & Regulations which are necessary to achieve and maintain cost effective

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[138] Guttman Dep. Tr at 188 **(Tab 9)**; Golbus Dep. Tr. (July 8, 2004) at 50 **(Tab 10)**; Golbus Dep. Tr. (July 9, 2004) at 170-71 **(Tab 73)**; Miller Dep. Tr. at 102 **(Tab 72)**. *See* Respondent's SOF at ¶ 143-44.

[139] **[REDACTED]**

[140] **[REDACTED]**

[141] Miller Dep. Tr. at 132, 135-37, 140 **(Tab 72)**. *See* Respondent's SOF at ¶¶ 141-44.

delivery of quality health care as provided by ENHMG Physicians and hospitals."[142] In late 2002-early 2003, the Medical Group took further steps to formalize and expand its "clinical integration" efforts.[143] Contrary to Complaint Counsel's representations, the Medical Group's clinical integration activities remain ongoing.[144]

Complaint Counsel has dismissed the Medical Group's care management activities — its dissemination of clinical protocols and data collection related to those protocols — as evidence of clinical integration because the care management activities relate only to capitated patients. This distinction falls flat because doctors typically adopt a single practice style for treating patients, and clinical integration on the capitated side "spills over" to patients covered under the Medical Group's fee-for-service plans.[145] To the extent capitated plans require the use of protocols that constitute good medical practice, physicians will apply these protocols to all of their patients.[146] Accordingly, the Medical Group did engage in clinical integration, and to the extent the Medical Group increases its membership as a result of its ability to negotiate on behalf of its affiliated doctors, it affects a corresponding increase in the Medical Group's "clinical" integration that benefits all of its patients.

Similarly, the increase in Medical Group membership as a result of its contracting activities on behalf of affiliated doctors also produces a corresponding increase in financial integration. This financial risk sharing allows doctors who would not otherwise be likely and/or

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[142] CX 1504 at 8 **(Tab 35)**. *See* Respondent's SOF at ¶¶ 34.

[143] Golbus Dep. Tr. (July 8, 2004) at 57-59, 61-62 **(Tab 10)**; Golbus Dep. Tr. (July 9, 2004) at 39-40 **(Tab 73)**; Miller Dep. Tr. at 100-01, 176-77 **(Tab 72)**. *See* Respondent's SOF at ¶¶ 141-44.

[144] **[REDACTED]**

Guttmann Dep. Tr. at 136 **(Tab 9)**. *See* Respondent's SOF at ¶¶ 141-44.

[145] Solmor Dep. Tr. at 101-02 **(Tab 30)**; Guttman Dep. Tr. at 86-87, 179-80 **(Tab 9)**. *See* Respondent's SOF at ¶ 142.

[146] Solmor Dep. Tr. at 101-02 **(Tab 30)**; Guttman Dep. Tr. at 84-85, 179-80 **(Tab 9)**. *See* Respondent's SOF at ¶ 142.

able to participate in capitated plans to do so.[147] Indeed, payors prefer dealing with the Medical Group rather than contracting with doctors individually precisely because the large size enabled them to effectively share the risk of capitated contracts.[148] Complaint Counsel ignores these important efficiencies by focusing solely on the Medical Group's fee-for-service contracts.

[REDACTED]

[149] Moreover, in 2000, the Medical Group's capitated contracts accounted for a meaningful share of its business.[150] Complaint Counsel's real argument on financial and clinical integration is that the Medical Group is not financially or clinically integrated enough to justify negotiating on behalf of affiliated physicians.

In sum, because the aforementioned efficiencies produced by the Medical Group's contracting activities are both plausible and cognizable, by Complaint Counsel's own terms, its motion for summary decision must be denied. To the extent that Complaint Counsel takes issue with the magnitude of these efficiencies or whether these efficiencies outweigh any purported anti-competitive effect, these are fact-questions that must be reserved for trial. As the Commission stated, "in antitrust cases, summary dismissal is inappropriate where there is a genuine dispute as to the material facts underlying the alleged efficiency defense." *In re Matter of Polygram Holding, Inc.,* Docket No. 9298, at 3 (Order Denying Motion For Summary Decision) (Feb. 26, 2002).[151]

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[147] *See* Guttman Dep. Tr. at 176-77 **(Tab 9)**. *See* Respondent's SOF at 62 ¶ 142.

[148] Golbus Dep. Tr. (July 8, 2004) at 135-37, 164 **(Tab 10)**. See Respondent's SOF at ¶ 88.

[149] **[REDACTED]**

[150] Miller Aff. ¶ 3 **(Tab 17)**. *See also* Miller Dep. Tr. at 48 **(Tab 72)**. *See* Respondent's SOF at ¶ 89.

[151] *See also Continental Airlines, Inc. v. United Airlines, Inc.*, 277 F.3d 499, 510-11 (4th Cir. 2002) ("Certainly courts have been wary of summary judgment in the context of quick-look analysis. In fact, the parties have not cited, and we have not found, a single case in which the Supreme Court has approved a quick-look analysis in which the parties received less then a full evidentiary hearing, either before an administrative agency or in court.").

IV. COMPLAINT COUNSEL'S PURPORTED PRICING EVIDENCE DOES NOT DEMONSTRATE AN ANTI-COMPETITIVE EFFECT

While arguing that summary decision is appropriate because there are no plausible and cognizable efficiency justifications for the Medical Group's conduct, (Complaint Counsel Mem. at 11-13, 21-22), Complaint Counsel also proffers evidence of alleged anti-competitive effects. Complaint Counsel Mem. at 9-10. Consideration of anti-competitive effects, however, is irrelevant (under *Polygram*) unless the challenged conduct produces plausible and cognizable efficiency justifications. By arguing that the Medical Group's activities produce anti-competitive effects, Complaint Counsel implicitly admits that an analysis of the challenged conduct's competitive effects (i.e. rule of reason analysis) is required.

Moreover, Complaint Counsel again mischaracterizes the evidence.

[REDACTED]

In detailing the allegedly anti-competitive price increases obtained by the Medical Group, Complaint Counsel merely compares the stated percentage of RBRVS in the pre-merger contracts with the percentage in the contracts negotiated after the merger (See Complaint Counsel Rule 3.24 Statement at ¶¶ 47-60). No adjustment is made, however, for the fact that the base RBRVS for the two contracts differ and that RBRVS does not keep up with medical cost inflation. As such, Complaint Counsel's price comparison is inherently faulty. Indeed, there is no evidence that there was a *real* (i.e. adjusted) increase in price. Complaint Counsel also fails to take into account the fact that IPA contracts are typically re-negotiated infrequently.

[REDACTED] As a result of these time lags in contracting, prices that appear high in the beginning years of a contract appear low at the end of the contract. Because of the time lag in these contract negotiations, simple "before" and "after" comparisons like the ones conducted by Complaint Counsel are

meaningless.

Additionally, Complaint Counsel implies that any price increase negotiated by the Medical Group must be the product of anti-competitive activity. Such an implication is unsupportable. Prices may rise for any number of reasons, not all of which are anti-competitive. For instance, the evidence shows that after the merger, the Medical Group was able to offer a more premium product to payors – one-stop shopping for a larger, more diverse group of physicians that included high end specialists. A price increase resulting from selling a higher quality, more desirable product cannot be anti-competitive or else a former Toyota dealer could not begin selling Cadillacs at higher prices without the increase in price being considered evidence of anti-competitive activity. *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1411-12 (7th Cir. 1995) ("[W]hen dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable finder of fact cannot infer monopoly power just from higher prices – the difference may reflect a higher quality more costly to provide . . . .").

Indeed, the evidence shows that any price increase obtained by the Medical Group after the merger was not the result of anti-competitive conduct. First, the rates obtained by the Medical Group were comparable to the rates obtained by comparable IPAs which negotiated contracts around the same time.[152] Second, when offered the opportunity to terminate the allegedly anti-competitive contracts, payors overwhelmingly refused to do so.[153] Third, most doctors in the geographic area do not belong to the Medical Group even through they generally have been free to join.[154] If the Medical Group is able to obtain supra-competitive prices because of its price-fixing, it stands to reason that every doctor in the area would be clamoring to

[152] McChesney Rep. at Ex. 3 **(Tab 12)**. *See* Respondent's SOF at ¶ 87.

[153] *See* Respondent's SOF at ¶¶ 147-48.

[154] McChesney Rep. at 53 (Table 1) **(Tab 12)**. Miller Aff. ¶ 4 **(Tab 17)**. *See* Respondent's SOF at ¶ 86.

become a member.

[REDACTED]

[155] Finally, the prices obtained by the Medical Group could not be anti-competitive unless the Medical Group possessed market power in some relevant market. *Chicago Prof'l. Sports Ltd. Pshp. v. National Basketball Ass'n.*, 95 F.3d 593, 600 (7th Cir. 1996) ("Substantial market power is an indispensable ingredient of every claim under the full Rule of Reason."). Complaint Counsel has neither alleged nor offered evidence of such market power.

V. EQUITABLE RELIEF IS NOT NECESSARY TO ADDRESS THE ALLEGATIONS IN COUNT III.

As demonstrated above, the myriad questions of material fact at issue in Count III render summary decision improper, and Respondents are prepared to defend Count III on the merits. Nevertheless, contrary to Complaint Counsel's assertions (Complaint Counsel's Mem. at 24-25), this Court may and should also deny the motion for partial summary decision (and dismiss *sua sponte* Count III) without reaching the merits of the underlying allegations given that: (1) the relief requested in Count III is exclusively equitable in nature;[156] and (2) equitable relief is *not* warranted because there is no "cognizable danger of recurrent violation."[157]

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[155] **[REDACTED]**

[156] Complaint Counsel's request for relief pertaining to Count III is limited to equitable relief and does not seek disgorgement, restitution, or any other financial payment from Respondents. Complaint Counsel's Answers & Objections to Resps.' First Set of Interrogs. at 48 (addressing Interrog. No. 23); Compl. at 12 (Notice of Contemplated Relief). Indeed, Complaint Counsel has no right in this proceeding to seek disgorgement or restitution from the Medical Group, especially considering that the complained of conduct has ceased. *Heater v. Federal Trade Comm'n*, 503 F.2d 321 (9th Cir. 1974) (holding that the Commission is not empowered under Section 5 of the FTC Act to order disgorgement or restitution; such remedial powers "are inconsistent and at variance with the over-all purpose and design of the Act"); *see also Federal Trade Comm'n v. Ruberoid*, 343 U.S. 470, 473 (1952).

[157] *United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953); *see also, e.g., In re Furr's Inc.*, 1965 WL 92980 (affirming dismissal of complaint because there was little danger of recurrent violation); *In re Sperry Rand Corp.*, Docket No. 7559, 64 FTC 842, 1964 WL 72881 (Feb. 17, 1964) (Comm'n Op.) (vacating initial decision and dismissing complaint because the probability of recurrent violation was remote and insubstantial); *cf. In re Revco*

A. Equitable Relief Is Warranted Only If Complaint Counsel Can Show A Cognizable Danger Of Recurrent Violation

Section 5 of the FTC Act confers limited authority on this Court to enter equitable relief when necessary "to prevent persons from using unfair methods of competition in or affecting commerce and unfair or deceptive acts or practices in or affecting commerce." 15 U.S.C. § 45(a)(2). "If the probability of such recurrence [of unlawful conduct] is remote and insubstantial, the [Court] may conclude that the public interest does not require entry of a formal order."[158]

In *United States v. W.T. Grant Co.*, the Supreme Court held that to obtain injunctive relief against a defendant that has discontinued the allegedly illegal conduct at issue, the moving party must show that "there exists some *cognizable danger of recurrent violation*, something more than the mere possibility which serves to keep the case alive."[159] This rule equally applies when Complaint Counsel is seeking equitable relief: "complaint counsel have the burden of showing that there exists a cognizable chance of recurrent violation necessitating injunctive relief."[160] Under this standard, the Court can and should decline to issue a cease and desist order even if the merits of Count III were not technically moot.[161]

D.S., Inc., Docket No. 8576, 67 FTC 1158, 1965 WL 92821 (June 28, 1965) (Initial Decision) (noting that, after considering an abandonment defense, the court may dismiss the complaint or issue a declaratory order).

[158] *In re Sperry Rand Corp.*, 64 FTC 842; *see also Stokely-Van Camp, Inc. v. Federal Trade Comm'n*, 246 F.2d 458, 465 (7th Cir. 1957) (explaining that a cease a desist order was unnecessary because defendants ceased the allegedly illegal practices prior to the issuance of the complaint, and had not resumed those practices thereafter); *In re Furr's Inc.*, Docket No. 8581, 68 FTC 584, 1965 WL 92980 (Oct. 20, 1965) (Comm'n Op.) ("Where the Commission is convinced that a particular practice has been fully stopped and will not be resumed in the future, it has the power to refrain from issuing an injunctive order and may instead terminate the proceeding by a declaration of its position.").

[159] 345 U.S. at 633 (emphasis added).

[160] *In re Massachusetts Bd. of Registration in Optometry*, Docket No. 9195, 110 F.T.C. 549 (June 20, 1986) (Initial Decision); *accord Borg-Warner Corp.v. Federal Trade Comm'n*, 746 F.2d 108, 110-111 (2d Cir. 1984) (reversing the Commission's cease and desist order because the Commission's contention that the defendant might again violate Section 8 of the FTC Act was based on speculation and conjecture); *TRW, Inc. v. FTC*, 647 F.2d 942, 954 (9th Cir. 1981).

[161] *United States v. Concentrated Phosphate Export Ass'n, Inc.*, 393 U.S. 199, 203 (1968) (finding case not moot, but holding that "it [was] still open to appellees to show, on remand, that the likelihood of further violations is sufficiently remote to make injunctive relief unnecessary"); *W.T. Grant Co.*, 345 U.S. at 635 (concluding that, "although the actions were not moot, no abuse of discretion has been demonstrated in the trial court's refusal to

B. No Relief Pertaining To Count III Is Warranted Because Complaint Counsel Cannot Show A Cognizable Danger Of Recurrent Violation

Complaint Counsel cannot show that there is any danger, much less a "cognizable" one, that the Medical Group will resume negotiating fee-for-service contracts on behalf of affiliated physicians. As discussed above, the Medical Group already has ceased such negotiations and has given managed care payors the opportunity to terminate their existing fee-for-service contracts.

Complaint Counsel places undue reliance on the fact that certain of the Medical Group's fee-for-service contracts are still in effect today. ENH gave serious consideration to dissolving the Medical Group in 2003. Recognizing that such action might materially disrupt the expectations of patients, physicians and payors, ENH instead notified payors of their right to cancel the fee-for-service contracts without penalty. It is unclear why Complaint Counsel criticizes this approach given that it mirrors the relief requested by Complaint Counsel – *i.e.*, "an order requiring Respondents to provide an opportunity for managed care payers to terminate their contracts."[162] Indeed, this is precisely the approach that the Commission has adopted when accepting consent decrees in *In re Washington University Physician Network*, File No. 021 0188 (Aug. 22, 2003) (Decision and Order), and numerous other IPA cases involving alleged price fixing of physician services.

Moreover, in a further effort to avoid extraordinarily costly and wholly unnecessary litigation -- without admitting any liability whatsoever -- the Medical Group offered to settle Count III by entering into a consent decree that would give Complaint Counsel all of the relief

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award injunctive relief"); *TRW, Inc.*, 647 F.2d at 954 (finding case not moot but that the Commission abused its discretion in issuing cease and desist order).

[162] Complaint Counsel's Answers & Objections to Resps.' First Set of Interrogs. at 48 **(Tab 87)**; Golbus Dep. (July 8, 2004) at 169-70, 172-75 **(Tab 10)**; Golbus Dep. (July 9, 2004) at 174 **(Tab 73)**; Mem. from Golbus, MD, to ENH Medical Group IPA Physicians of 12/23/2003, ENHL RG 003019 **(Tab 37)**; *See* FNs 105-106 and accompanying text, *supra*.

sought on that claim. The Medical Group even modeled the proposed consent decree after numerous Commission settlements with other IPAs accused of fixing prices for physician services, even though the evidence of strong efficiencies and an absence of anticompetitive effects in this case compares favorably to the facts underlying the Commission's IPA settlements in other matters. To date, Complaint Counsel has rejected such a consent decree. The end result, of course, is that substantial resources that otherwise would have been spent on providing medical care to patients have been diverted to defending the overreaching, unsupported and unwarranted charges in Count III.

CONCLUSION

With respect to the two premises on which Complaint Counsel's motion is based, Respondents have demonstrated the existence of numerous disputed issues of material fact. Accordingly, Respondents respectfully request that the Court deny the motion for Summary Decision.

Dated: November 18, 2004

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 18, 2004, a copy of the foregoing Memorandum in Opposition to Complaint Counsel's Motion for Partial Summary Decision on Count III of the Complaint was served by e-mail and hand delivery on:

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Chief Administrative Law Judge
Federal Trade Commission
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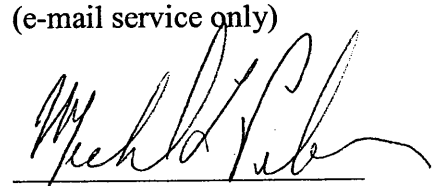

Michael L. Sibarium, Esq.

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

In the matter of	)	
Evanston Northwestern Healthcare Corporation, a corporation, and	)	Docket No. 9315
ENH Medical Group, Inc., a corporation.	)	**Public Record Version**

RESPONDENT'S ATTACHMENT TO THE MEMORANDUM IN OPPOSITION TO COMPLAINT COUNSEL'S MOTION FOR PARTIAL SUMMARY DECISION PURSUANT TO RULE 3.45(e)

Pursuant to Rule 3.45(e) of the Commission's Rules, Respondent ENH Medical Group, Inc., by counsel, identifies the following redacted materials in Respondent's Memorandum in Opposition to Complaint Counsel's Motion for Partial Summary Decision on Count III of the Complaint, dated November 15, 2004:

1. The redacted materials in footnotes 31, 35-36, 66, 75-77, 83, 87, 92, 123, and 144 and accompanying text relate to the testimony of Dr. Jay Alexander, Dr. Laurie Hochberg, Dr. Richard Katz, Dr. Neil Moller, Amy Rogers and Dr. Allan Solmor. The attorney for the doctors, and Ms. Rogers is George Lynch, Burke Warren MacKay & Serritella, 330 North Wabash Avenue, 22nd Floor, Chicago, Illinois 60611 who can be reached at (312) 840-7008.

2. The redacted materials in footnotes 22-23, 28, 51 and 60 and accompanying text relate to the testimony of Jane Ballengee and documents produced by Private HealthCare Systems. The attorney for Ms. Ballengee and PHCS is Jerome Hoffman, Holland & Knight, 315 South Calhoun Street, Tallahassee FL 32302, who can be reached at (850) 425-5654.

3. The redacted materials in footnotes 75-76 and accompanying text relate to the testimony of Dr. Harry Burstein. The attorney for Dr. Burstein is George Lynch, Burke Warren MacKay & Serritella, 330 North Wabash Avenue, 22nd Floor, Chicago, Illinois 60611 who can be reached at (312) 840-7008.

4. The redacted materials in footnotes 23, 70, 72, 81, 109, and 111 and accompanying text relate to the testimony of Ronald J. Craven and documents produced by HFN, Inc. The attorney for Mr. Craven and HFN is Laura C. Liu, Hogan Marren, LTD, 205 North Michigan Avenue, Suite 4300, Chicago, Illinois 60601 who can be reached at (312) 916-1800.

5. The redacted materials in footnote 28 and accompanying text relate to the testimony of Robert Curry and documents produced by the Chandler Group, Inc. The attorney for the Chandler Group, Inc. is Don Scherzer, 208 So. LaSalle Street, Suite 814, Chicago, IL 60604-1101 who can be reached at (216) 615-7418.

6. The redacted materials in footnotes 22 and 70 and accompanying text relate to the testimony of Lenore Holt-Darcy and documents produced by Unicare. The attorney for Ms. Holt-Darcy and Unicare is Elizabeth G. Doolin, Chittendent, Murday & Novotny, LLC, 303 West Madison Street, Suite 1400, Chicago, Illinois 60606 who can be reached at (312) 281-3604.

7. The redacted materials in footnotes 22-23 and 52 and accompanying text relate to the testimony of Sherry Husa and documents produced by Cigna. The attorney for Ms. Husa and Cigna is Karen M. Espaldon, Jones Day, 51 Louisiana Avenue, N.W. Washington, D.C. 20001-2113 who can be reached at (202) 879-3939.

8. The redacted materials in footnotes 39, 51, and 111 and accompanying text relate to the testimony of Brian Jans and documents produced by First Health. The attorney for Mr. Jans and First Health is Jennifer E. Schneid, 3200 Highland Avenue, Downers Grove, Illinois 60515 who can be reached at (630) 737-7426.

9. The redacted materials in footnotes 23, 38, 40, 70, 73, and 110 and accompanying text relate to the testimony of John Maxwell and documents produced by Humana. The attorney for Mr. Maxwell and Humana is William . Chittenden, III, Chittenden, Murday & Novotny LLC, 303 West Madison Street, Suite 1400, Chicago, Illinois 60606 who can be reached at (312) 281-3601.

10. The redacted materials in footnote 22 and accompanying text relate to the testimony of Robert K. Mendonsa and documents produced by Aetna. The attorney for Mr. Mendonsa and Aetna is Steven C. Tolliver, 980 Jolly Road, Blue Bell, Pennsylvania 19422 who can be reached at (215) 775-3674.

11. The redacted materials in footnotes 23, 51, 70, 81-82, 93, and 111 and accompanying text relate to the testimony of Patrick R. Neary and Kevin A. Dorsey and documents produced by GreatWest Healthcare. The attorney for Mr. Neary, Mr. Dorsey, and GreatWest Healthcare is Franklin S. Schwerin, Schwartz, Cooper, Greenberger & Krauss, 180 North LaSalle Street, Suite 2700, Chicago, Illinois 60601 who can be reached at (312) 845-5109.

12. The redacted materials in footnotes 28 and 125 and accompanying text relate to the testimony of Dr. Fred Rosenberg. The attorney for Dr. Rosenberg is Thomas B. Shapira, Much, Shelist, 191 North Wacker Drive, Suite 1800, Chicago, Illinois 60606 who can be reached at (312) 521-2599.

13. The remaining redacted materials in the Memorandum in Opposition to Complaint Counsel's Motion for Partial Summary Decision on Count III of the Complaint include the testimony of Dr. Michael Ankin and Dr. Leon Dragon, and employees and former employees of, or documents produced by Respondents, Evanston Northwestern Healthcare Corp. and ENH Medial Group, Inc, and its expert, Fred S. McChesney. The attorney for Respondents is Michael

MATERIAL FACTS

A. The ENH Medical Group Is Part Of An Integrated Healthcare Delivery System And Was Formed To Help Facilitate Managed Care Contracting

Evanston Northwestern Healthcare ("ENH") is an integrated healthcare delivery system based in the northern suburbs of Chicago, Illinois. ENH provides in- and out-patient hospital services, physician services, home health care, medical research and other healthcare related services.[3] As an integrated healthcare delivery system, ENH owns Faculty Practice Associates ("FPA"), which employs an array of physicians that practice at various ENH facilities.[4] The FPA also owns the Medical Group, an Independent Physician Association ("IPA") whose members include the ENH-employed physicians, as well as a number of non-employed (affiliated) physicians with staff privileges at the ENH hospitals.[5]

The Medical Group was formed in the early 1990s, when it appeared that health maintenance organizations ("HMOs") would be the future of managed care contracting, for the purpose of securing and providing medical care to patients under capitated contracts.[6] As both payors and doctors recognize, capitated contracts are viable primarily for larger physicians groups, such as IPAs, as such organizations are better able to absorb the risk inherent in such contracts.[7] **[REDACTED]**[8] The Medical Group has approximately 70,000 covered lives under capitated contracts, the third most in the Chicago area.[9] In 2000, the Medical Group received a

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[3] *See, e.g.*, ENH DL 004099 **(Tab 77)**. *See* Respondent's Separate and Concise Statement of Material Facts as to Which There Exists a Genuine Issue for Trial ("Respondent's SOF") at ¶ 81.

[4] First Amended Answer at 7 **(Tab 78)**. *See* Respondent's SOF at ¶ 81.

[5] First Amended answer at 8 **(Tab 78)**. *See* Respondent's SOF at ¶ 81.

[6] Miller Aff. ¶ 3 **(Tab 17)**. *See* Respondent's SOF at ¶ 81.

[7] Guttman Dep. Tr. at 176-77 **(Tab 9)**; Holt-Darcy Dep. Tr. at 134-35 **(Tab 2)**; Golbus Dep. Tr., (July 8, 2004) at 135-37, 164 **(Tab 10)**. *See* Respondent's SOF at ¶ 88.

[8] **[REDACTED]**

[9] ENH-FSM 30, at 7 **(Tab 7)**. *See* Respondent's SOF at ¶ 89.

meaningful part of its business from capitated contracts.[10]

B. The Medical Group, Like Other IPAs in the Chicagoland Area, Includes a Diverse Group of Employed and Affiliated Doctors

ENH merged with Highland Park Hospital effective January 1, 2000, and the Medical Group also became legally integrated with the Highland Park Independent Practice Associates, Inc. ("Highland Park IPA") that same day.[11] Prior to the merger, the Highland Park IPA was associated with Highland Park Hospital and was comprised solely of affiliated physicians. By the time of the merger, the Highland Park IPA consisted of 350 affiliated physicians.[12] Some Highland Park doctors chose not to join the Medical Group because they could negotiate better reimbursement rates with payors on their own.[13]

[REDACTED]

[14]

[15]

[16]

[10] Miller Aff. ¶ 3 **(Tab 17)**. *See also* Miller Dep. Tr. at 48 **(Tab 72)**. *See* Respondent's SOF at ¶ 89.

[11] Golbus Dep. Tr. (July 8, 2004) at 92-93 **(Tab 10)**. Dr. Golbus was not involved in the decision to merge the hospitals. *Id.* at 74-75. *See* Respondent's SOF at ¶ 82.

[12] CX 1332 at 4 **(Tab 79)**. *See* Respondent's SOF at ¶ 82.

[13] Golbus Dep. Tr. (July 9, 2004) at 25 **(Tab 73)**. *See* Respondent's SOF at ¶ 97.

[14] **[REDACTED]**

[15] **[REDACTED]**

[16] **[REDACTED]**

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[REDACTED]

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The Medical Group is one of several IPAs in the Chicagoland area, many of which are hospital-based and consist of both employed and affiliated physicians.[21] These IPAs have been negotiating fee-for-service contracts with payors on behalf of their affiliated physicians for several years, and most payor organizations have not objected to this practice.[22]

[REDACTED]

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[17] Miller Aff. ¶ 7 **(Tab 17)**. *See* Respondent's SOF at ¶ 87

[18] Golbus Dep. Tr. (July 8, 2004) at 82 **(Tab 10)**. *See* Respondent's SOF at ¶ 87

[19] For example, the United Healthcare rate of 125% of RBRVS had been in effect since 1995. ENH JL 000223-33 **(Tab 60)**. *See* Respondent's SOF at ¶ 87.

[20] **[REDACTED]**

[21] *See, e.g.*, ENH-FSM 29 **(Tab 6)**; ENH-FSM 30 **(Tab 7)**. *See* Respondent's SOF at ¶ 86.

[22] **[REDACTED]**

[23] **[REDACTED]**

[REDACTED] [24]

C. The Medical Group is Not Exclusive

1. Payors are Free to Contract with Medical Group Affiliated Doctors Individually and Through Other IPAs, and Have Done So

Payors have always been free to contract with Medical Group affiliated physicians individually and/or through other IPAs.[25]

[REDACTED] [26]

[27] Other physicians and payors have negotiated individual contracts directly with each other,[28] and no one from the Medical Group ever told a payor that it could not contract directly with affiliated physicians.[29] Additionally, almost half of the affiliated physicians in the Medical Group belong to more than one IPA.[30]

[REDACTED]

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[24] **[REDACTED]**

[25] **[REDACTED]**

[26] **[REDACTED]**

[27] **[REDACTED]**

[28] ***See, e..g.*, Rosenberg Dep. Tr. at 16 (Tab 16); Curry Dep. Tr. at 106 (Tab 23). [REDACTED]**

[29] Ballengee Dep. Tr. at 173 **(Tab 1)**; Golbus Dep. Tr. (July 8, 2004) at 141, 158 **(Tab 10)**. *See* Respondent's SOF at ¶ 98.

[30] *See* McChesney Rep. at Ex. 8 **(Tab 12)**. *See* Respondent's SOF at ¶ 96.

[REDACTED] [31] The Medical Group, however, does not monitor what other IPAs its physicians are affiliated with or the individual contracts they may have with payors, nor do they know the rates the physicians have obtained through these other contracts.[32]

2. Medical Group Affiliated Physicians Are Able To Obtain Better Rates Outside of the Medical Group

Most physicians in the 5 counties in which the Medical Group members are located are not themselves members of the Medical Group, even though the Medical Group has generally been open to any doctor on the professional staff who wants to join.[33]

[REDACTED]

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D. Although the Medical Group Allowed Its Affiliated Physicians To Have Contracts Through Other IPAs and/or Individual Contracts With Payors, Payors Were Not Always Equipped To Handle Multiple Affiliations

Although the Medical Group members are free to join other IPAs and/or contract individually with payors, these multiple affiliations/contracts often caused problems for the

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[31] **[REDACTED]**

[32] Mittleman Dep. Tr. at 28-29, 56-57, 100, 106 **(Tab 11)**; Levine Dep. Tr. at 22 **(Tab 18)**; Coyle Dep. Tr. at 38 **(Tab 36)**. *See* Respondent's SOF at ¶ 101.

[33] McCheseny Rep. at 53 (Table 1) **(Tab 12)**; Miller Aff. ¶ 4 **(Tab 17)**. *See* Respondent's SOF at ¶ 86.

[34] **[REDACTED]**

[35] **[REDACTED]**

payors.

[37] [38]

[39] [40]

[41] [42]

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[45] Indeed, the Medical Group staff did not even know what rates the affiliated physicians were getting through their individual and/or other IPA

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[36] **[REDACTED]**

[37] Coyle Dep. Tr. at 29-30, 50 **(Tab 36)**; Mittleman Dep. Tr. at 27-28, 30-31, 35-37, 187-89 **(Tab 11)**. *See* Respondent's SOF at ¶ 105-06.

[38] **[REDACTED]**

[39] **[REDACTED]**

[40] **[REDACTED]**

[41] **[REDACTED]**

[42] **[REDACTED]**

[43] **[REDACTED]**

[44] **[REDACTED]**

[45] **[REDACTED]**

contracts.[46]

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[REDACTED]

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[46] **[REDACTED]**
[47] **[REDACTED]**
[48] **[REDACTED]**

[49] **[REDACTED]**
[50] **[REDACTED]**

[51] **[REDACTED]**

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[REDACTED]

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[52] [REDACTED]

[53] [REDACTED]
[54] [REDACTED]
[55] [REDACTED]
[56] [REDACTED]

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[REDACTED]

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[57] [REDACTED]
[58] [REDACTED]
[59] [REDACTED]
[60] [REDACTED]

[61] [REDACTED]

[62] [REDACTED]

[63] [REDACTED]
[64] [REDACTED]

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[REDACTED]

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One year after the multiple affiliation problem came to light, the administrative difficulties resulting from multiple affiliations continued.

[REDACTED]

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E. The Medical Group's Ability To Contract On Behalf Of Its Affiliated Physicians Generates Numerous Efficiencies For Payors, Its Member Physicians, And Patients

The Medical Group's ability to negotiate contracts on behalf of both its employed and affiliated physicians effects a substantial time and cost savings for both payors and physicians. These efficiencies induce many physicians to join the Medical Group, which in turn produces other benefits.

1. Single Signature Contracting Significantly Reduces The Cost Of Negotiations For Both Payors And Physicians And Induces Physicians To Join The Medical Group

Rather than payors having to negotiate reimbursement rates with over 800 doctors and/or hundreds of physician groups individually, and the physicians having to negotiate with individual payors, the Medical Group's contracting practices allowed payors to enter into a

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[65] **[REDACTED]**

[66] **[REDACTED]**

[67] **[REDACTED]**

[68] **[REDACTED]**

single contract and bring the Medical Group's entire physician membership into their provider network.[69]

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Doctors also recognized the benefits of single signature contracting. Several doctors

[69] Chan Dep. Tr. at 151 **(Tab 48).** *See* Respondent's SOF at ¶ 123.

[70] **[REDACTED]**

[71] **[REDACTED]**

[72] **[REDACTED]**

[73] **[REDACTED]**

[74] **[REDACTED]**

joined the Medical Group because of single signature contracting.[75]

[REDACTED]

[76]

[77]

2. The Medical Group's Contracting Activities Produced Additional Transaction Costs Savings For Both Payors And Physicians

a. Credentialing

Affiliated physicians must be credentialed with each individual payor with whom they have contracted,[78] which involves a substantial amount of paperwork.[79] Accordingly, in 1999 and 2000, the Medical Group employed three full-time credentialing coordinators to handle credentialing for the payors and physicians.[80] Several payors have recognized that credentialing is a time-consuming administrative burden that they would rather delegate to the Medical Group.[81]

[REDACTED]

[75] **[REDACTED]**

[76] **[REDACTED]**

[77] **[REDACTED]**

[78] Coyle Dep Tr. at 17 **(Tab 36)**; Miller Dep. Tr. at 10-11 **(Tab 72)**. *See* Respondent's SOF at ¶ 131.

[79] Credentialing involves gathering the required licensure and documentation from the physicians (including the physician's license, DEA number, hospital privilege verification, education verification, and malpractice information), providing the documentation to the payors, and following up with the payors and physicians to provide any further information the payors required. Coyle Dep Tr. at 8, 15-16, 47 **(Tab 36)**; Mittleman Dep. Tr. at 111 **(Tab 11)**; *see also* Guttman Dep. Tr. at 172-73 **(Tab 9)**. *See* Respondent's SOF at ¶ 132.

[80] Coyle Dep. Tr. at 23 **(Tab 36)**; *see also* Guttman Dep. Tr. at 197 **(Tab 9)**. *See* Respondent's SOF at ¶ 132.

[81] **[REDACTED]**

[REDACTED]

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The doctors also agree that delegating credentialing to the Medical Group is a substantial time savings for them.[83]

b. Ease of Referrals

Patients who are in strict HMOs must see doctors within the HMO network, or their expenses will not be covered.[84] Patients who are in PPOs similarly desire to be referred to doctors within their payor's network to obtain maximum insurance coverage.[85] By negotiating single-signature contracts on behalf of all of its physicians, employed and affiliated, the Medical Group automatically produces a large network of doctors who are contracted with the same payors. As a result, physicians within the Medical Group have a greater array of specialists to whom they can refer patients, and they can refer patients freely to one another without having to contract individually with the same payors or check in each instance whether that doctor is contracted with the patient's insurance company.[86]

87 These physicians did not expect that the Medical Group could negotiate better reimbursement rates

[82] **[REDACTED]**
[83] **[REDACTED]**

[84] Miller Aff. ¶ 3 **(Tab 17)**.
[85] Miller Aff. ¶ 8 **(Tab 17)**.
[86] Miller Aff. ¶ 8 **(Tab 17)**. *See* Respondent's SOF at ¶ 136.

with payors than they were already receiving from other IPAs or could obtain individually.[88]

To facilitate patient referrals within the ENH network, the Medical Group provided all of its participating physicians with a physician directory so they would know what doctors were in the network for referral purposes.[89] The Medical Group also facilitates physician referrals by acting as a referral clearinghouse and by obtaining the necessary pre-approvals from managed care plans.[90]

c. Assistance with Payor-Physician Relationships

The Medical Group has a dedicated staff of provider relations representatives that serve as liaisons between its physicians and the payors.[91] The provider relations specialists can intervene if, for example, a physician is not being reimbursed properly by a payor, if there are contractual issues that need to be clarified, if a physician is unsure of a health plan policy or procedure, or if a physician has any other issues with a payor.[92] Payors prefer to deal with a dedicated staff at the Medical Group rather than the individual doctors because of lower transaction costs.[93] Patients also benefit in that doctors can spend more time seeing patients and focusing on the practice of medicine.[94]

3. The Larger Size Of The Medical Group As A Result Of Single Signature Contracting On Behalf Of Both Employed And Affiliated Physicians

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[87] **[REDACTED]**

[88] Alexander Dep. Tr. at 52 **(Tab 19)**; Moller Dep. Tr. at 131 **(Tab 13)**. *See* Respondent's SOF at ¶¶ 103-04.

[89] Mittleman Dep. Tr. at 16 **(Tab 11)**. *See* Respondent's SOF at ¶ 136.

[90] Guttman Dep. Tr. at 178-79 **(Tab 9)**; Hochberg Dep. Tr. at 83 **(Tab 21)**; Katz Dep. Tr. at 65-66 **(Tab 22)**. *See* Respondent's SOF at ¶ 137.

[91] Mittleman Dep. Tr. at 7 **(Tab 11)**. *See* Respondent's SOF at 61 ¶ 138. These services are explicitly provided for in the Physicians' Participation Agreement. *See* CX 1503 at 9 (Provision 3.3) **(Tab 34)**. *See* Respondent's SOF at ¶ 35.

[92] Mittleman Dep. Tr. at 9 **(Tab 11)**; Coyle Dep. Tr. at 8 **(Tab 36)**.

[REDACTED]

See Respondent's SOF at ¶ 138.

[93] **[REDACTED]**

[94] *See* Katz Dep. Tr. at 93 **(Tab 22)**. *See* Respondent's SOF at ¶ 139.

Generates Additional Efficiencies That Benefit Payors, Physicians, And Patients

The increased size of the network that resulted from the Medical Group's ability to negotiate a single signature contract for both its employed and affiliated physicians generates additional efficiencies which further benefit payors, physicians, and their patients.

a. A Better Network of Physicians

The increased size of the Medical Group allows the Group to offer a network to payors with broader geographic coverage and more high end specialists.

[REDACTED]

[95]

b. Provision of Various Administrative Services

In addition to credentialing, many payors delegate a number of administrative responsibilities to the Medical Group.

[REDACTED]

[96] The Medical Group not only employs a full-time staff to collect the necessary data and information for the payors on the use of these protocols, but it also disseminates to the physicians information provided by the payors, such as data flow sheets; information and educational material about the protocols; and updated managed care policies.[97] Without the Medical Group, these services would otherwise be handled by the payors.

The fact that payors require Medical Group physicians to use clinical protocols benefits

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[95] **[REDACTED]**

[96] **[REDACTED]**

[97] Guttman Dep. Tr. at 84, 89, 166-72 **(Tab 9)**. *See also* ENHL JL 028685-028695 **(Tab 83)**. *See* Respondent's SOF at ¶ 141. Indeed, utilization management and peer review procedures are specifically detailed as services provided by the Medical Group in the physicians' participation agreement. *See* CX 1504 at 8 **(Tab 35)**. *See* Respondent's SOF at ¶ 34.

not only the Medical Group's capitated patients, but all patients, as most doctors do not know what type of coverage a patient has at the time they treat the patient.[98] Doctors generally treat all of their patients the same way,[99] and doctors who are required to follow protocols for their capitated patients inevitably end up following the same protocols for their non-capitated patients.[100]

c. Increased Integration

As discussed above, IPAs are inherently risk-sharing organizations. Payors prefer to deal with the Medical Group than contract with individual doctors for their capitated products because the Medical Group's size gave it a large enough mass to handle the risk.[101] Spreading the risk among a large group of doctors allows doctors who would not otherwise be able to participate in capitated contracts to do so.

[REDACTED]

[102]

F. The Medical Group Stopped Negotiating on Behalf of Affiliates Before This Litigation Began

[103]

[REDACTED]

[98] Solmor Dep. Tr. at 101 **(Tab 30)**; Hochberg Dep. Tr. at 124 **(Tab 21)**. *See* Respondent's SOF at ¶ 142.

[99] Katz Dep. Tr. at 89-90 **(Tab 22)**; Solmor Tr. at 101 **(Tab 30)**; Hochberg Tr. at 125 **(Tab 21)**. *See* Respondent's SOF at ¶ 142.

[100] Solmor Dep. Tr. at 101-02 **(Tab 30)**; Guttman Dep. Tr. at 86-87, 179-80 **(Tab 9)**. *See* Respondent's SOF at ¶ 142.

[101] Golbus Dep. Tr. (July 8, 2004) at 135-37, 164 **(Tab 10)**. **[REDACTED]**

[102] **[REDACTED]**

[103] **[REDACTED]**

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[REDACTED]

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[104] [REDACTED]
[105] [REDACTED]
[106] [REDACTED]
[107] [REDACTED]

[108] [REDACTED]
[109] [REDACTED]

[REDACTED]

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Regardless of which option the payors prefer, however, the Medical Group has ceased the conduct on which Count III is based.[112] Before the complaint was even filed in this case, Respondents proposed to settle Count III on substantially similar terms as those included in the more than 20 IPA-related consent decrees in recent years.[113] Respondents repeated this offer several times to Complaint Counsel after these proceedings were initiated. All of Respondents' offers were rejected.

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[110] **[REDACTED]**

[111] **[REDACTED]**

[112] Golbus Dep. Tr. at (July 8, 2004) at 169-70, 172-75 **(Tab 10)**; Golbus Dep. Tr. (July 9, 2004) at 174 **(Tab 73)**; Miller Dep. Tr. at 15, 18 **(Tab 72)**. *See* Respondent's SOF at ¶ 149.

[113] Letter from Sibarium to Cowie of 12/12/2003 **(Tab 89)**.

"[m]any consumers clearly prefer[red] the characteristics and cost advantages" of blanket licenses from BMI and ASCAP. *Id.* at 22.

The present case differs from *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), cited by Complaint Counsel. The plurality opinion in *Maricopa* held that a federation of doctors that regularly set maximum reimbursement rates through a vote of the membership constituted *per se* price fixing because "[e]ven if a fee schedule is therefore desirable, it is not necessary that the doctors do the price fixing." *Id.* at 352.[119] This case is distinguishable from *Maricopa* because the Medical Group physicians have no direct involvement in negotiations with payors and are not precluded from negotiating with payors outside of the Medical Group for lower rates either directly or through affiliation with other IPAs.

B. The "To Whom It May Concern" Letters Do Not Provide The Necessary Evidence That Medical Group Members Agreed To Adhere To A Set Price

[REDACTED]

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[119] Significantly, the cases cited by Complaint Counsel to support their statement that "An agreement among competitors to appoint a third party - here ENH Medical Group - to set the prices for all the conspirators is illegal, just like an agreement among competitors to charge a particular price" (Complaint Counsel Mem. at 17) dictate the employment of the rule of reason standard. *See National Soc'y of Professional Engineers v. United States* 435 U.S. 679, 694-95 (1978); *California Dental Ass'n v. Federal Trade Comm'n* 526 U.S. 756, 777-81 (1999).

[120] **[REDACTED]**

[121] **[REDACTED]**

[122] **[REDACTED]**

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[REDACTED]

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A triable issue of fact exists and precludes summary decision.

C. The Medical Group Physicians Are Not Horizontal Competitors

The type of price-fixing that is typically subject to *per se* treatment takes place among horizontal competitors. *Denny's Marina v. Renfro Productions, Inc.*, 8 F.3d 1217, 1221-22 (7th Cir. 1993) ("horizontal price-fixing is illegal per se . . . because joint action by competitors to suppress price-cutting has the requisite 'substantial potential for impact on competition,' to

[123] **[REDACTED]**

warrant *per se* treatment.") (internal citations omitted); *Products Liability Insur. Agency, Inc. v. Crum & Forster Insur. Cos.*, 682 F.2d 660 (7th Cir. 1982) ("Agreements that are illegal per se are for the most part horizontal, that is, between competing sellers"). Because of this, Complaint Counsel repeatedly characterizes Medical Group members as "competitors" and their conduct as *per se* illegal. *See* Complaint Counsel Mem. at 1, 5, and 16. Complaint Counsel pursues a *per se* theory of liability in order to avoid undertaking any meaningful market analysis, which would highlight the absurdity of its allegations, as demonstrated below.

[REDACTED]

According to Complaint Counsel's theory, a primary care physician located in Lindenhurst competes against another primary care physician located in Olympia Fields (over 60 miles away), and a podiatrist competes against a cardiologist. Because Complaint Counsel makes no distinction among the Medical Group's affiliated physicians, doctors belonging to the same practice group are also deemed "competitors." The absurdity of these examples serves to underscore why *per se* treatment is wholly inappropriate. At most, physicians compete with other physicians within the same specialty in the same geographic area, though not every physician even agrees with that.[125]

Without evidence that the Medical Group physicians are "competitors," the Medical Group's conduct cannot fairly be characterized as "inherently suspect," and Complaint Counsel's motion for summary decision must be denied.

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[124] **[REDACTED]**
[125] **[REDACTED]**

III. THE ACTIVITIES OF THE MEDICAL GROUP AND ITS MEMBERS PRODUCE PLAUSIBLE AND COGNIZABLE EFFICIENCIES, PRECLUDING THE GRANT OF SUMMARY DECISION

Even if the contracting activities of the Medical Group are considered "inherently suspect," summary decision is still inappropriate because these activities produce "plausible" and "cognizable" efficiency justifications (i.e., pro-competitive benefits).[126] Complaint Counsel constructs a false legal paradigm by asserting that the only recognized justifications for the Medical Group's conduct are "financial" or "clinical" integration. *Id.* at 19-20. Complaint Counsel ignores myriad other justifications for the Medical Group's contracting activities and relies solely on its own internal guidelines to do so. ***There is absolutely no legal support for such a narrow approach.*** Complaint Counsel's own internal guidelines on enforcement policy do not have the force of law. *Cf. Federal Trade Comm'n v. PPG Indus., Inc.*, 798 F.2d 1500, 1503 n.4 (D.C. Cir. 1986) (merger guidelines are not law and are not binding on the Commission itself or on the courts); *Fruehauf Corp. v. Federal Trade Comm'n*, 603 F.2d 345, 353-54 (2d Cir. 1979); *Olin Corp. v. Federal Trade Comm'n*, 986 F.2d 1295, 1300 (9th Cir. 1993). Moreover, Complaint Counsel fails to cite its internal guidelines fully or accurately. In fact, the Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care ("Health Care Guidelines") explicitly state that while "more significant efficiencies are likely to result from a physician network joint venture's substantial financial risk sharing or substantial clinical integration," the Agencies will also *"consider a broad range of possible cost savings, including improved cost controls, case management and quality assurance, economies*

[126] Once the Medical Group articulates these justifications, the burden shifts back to Complaint Counsel to "address the justification, and provide the tribunal with sufficient evidence to show that anticompetitive effects are in fact likely . . ." *Polygram* at *68. Because Complaint Counsel does not attempt to present undisputed evidence that the Medical Group's conduct has produced anti-competitive effects, or that any such effects outweigh the conduct's "countervailing procompetitive virtue," which could not be done in a motion for summary decision, the challenged conduct cannot be summarily condemned and Complaint Counsel's motion must be denied.

Participation Agreement.[136] As with credentialing, the transaction cost savings increase as the staff becomes more familiar with the recurring issues and can handle them more quickly and efficiently.

[REDACTED]

Additionally, because of the Medical Group's ability to negotiate single signature contracts for all of its physician members, the Medical Group staff was more easily able to become familiar with the contracts and the types of contracting issues that arise, allowing them to resolve these issues in a more efficient manner.

Significantly, all of the services the Medical Group provides allow physicians to spend less time on administrative matters, and spend more time on the practice of medicine. This results in a greater output of medical services, which can only benefit patients.

2. The Medical Group's Activities Create Other Plausible and Cognizable Efficiencies

Because of the transaction cost efficiencies that the Medical Group provides by negotiating fee-for-service contracts on behalf of affiliated doctors, physicians have an incentive to join the Medical Group, thus increasing the overall membership in the Medical Group. This creates additional plausible and cognizable efficiencies. For example, the increased size of the Medical Group allows it to recruit more tertiary and high end specialists, thereby allowing the Medical Group to offer a better network to payors than it could have otherwise.[137] Moreover, access to all employed and affiliated physicians at once — like the "blanket license" in *BMI* — is a different product than what any individual physician can offer. *BMI*, 441 U.S. at 23-24 ("that

[136] CX 1503 at 9 (Provision 3.3) **(Tab 34)**.

[137] Golbus Dep. Tr. (July 8, 2004) at 307-08 **(Tab 10)**. *See* Respondent's SOF at ¶ 130.

[blanket] license is quite different from anything any individual owner could issue.").

The larger size of the Medical Group also increased clinical integration and financial integration, the two efficiencies that Complaint Counsel admit are plausible and cognizable. Complaint Counsel argues that the Medical Group did not engage in any clinical integration, and that it took only nominal steps to effect clinical integration after learning of the FTC's investigation. This simply is not true. Clinical integration was a new term used by the FTC in late 2002-early 2003 that did not have any meaning to the Medical Group members.[138]

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[REDACTED]

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Moreover, the affiliated physicians have always been involved in the efforts to improve clinical quality.[141] Indeed, the Physician Participation Agreement specifically states that "ENHMG shall provide for appropriate utilization management and peer review procedures as identified in the Rules & Regulations which are necessary to achieve and maintain cost effective

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[138] Guttman Dep. Tr at 188 **(Tab 9)**; Golbus Dep. Tr. (July 8, 2004) at 50 **(Tab 10)**; Golbus Dep. Tr. (July 9, 2004) at 170-71 **(Tab 73)**; Miller Dep. Tr. at 102 **(Tab 72)**. *See* Respondent's SOF at ¶ 143-44.

[139] **[REDACTED]**

[140] **[REDACTED]**

[141] Miller Dep. Tr. at 132, 135-37, 140 **(Tab 72)**. *See* Respondent's SOF at ¶¶ 141-44.

delivery of quality health care as provided by ENHMG Physicians and hospitals."[142] In late 2002-early 2003, the Medical Group took further steps to formalize and expand its "clinical integration" efforts.[143] Contrary to Complaint Counsel's representations, the Medical Group's clinical integration activities remain ongoing.[144]

Complaint Counsel has dismissed the Medical Group's care management activities — its dissemination of clinical protocols and data collection related to those protocols — as evidence of clinical integration because the care management activities relate only to capitated patients. This distinction falls flat because doctors typically adopt a single practice style for treating patients, and clinical integration on the capitated side "spills over" to patients covered under the Medical Group's fee-for-service plans.[145] To the extent capitated plans require the use of protocols that constitute good medical practice, physicians will apply these protocols to all of their patients.[146] Accordingly, the Medical Group did engage in clinical integration, and to the extent the Medical Group increases its membership as a result of its ability to negotiate on behalf of its affiliated doctors, it affects a corresponding increase in the Medical Group's "clinical" integration that benefits all of its patients.

Similarly, the increase in Medical Group membership as a result of its contracting activities on behalf of affiliated doctors also produces a corresponding increase in financial integration. This financial risk sharing allows doctors who would not otherwise be likely and/or

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[142] CX 1504 at 8 **(Tab 35)**. *See* Respondent's SOF at ¶¶ 34.

[143] Golbus Dep. Tr. (July 8, 2004) at 57-59, 61-62 **(Tab 10)**; Golbus Dep. Tr. (July 9, 2004) at 39-40 **(Tab 73)**; Miller Dep. Tr. at 100-01, 176-77 **(Tab 72)**. *See* Respondent's SOF at ¶¶ 141-44.

[144] **[REDACTED]**

Guttmann Dep. Tr. at 136 **(Tab 9)**. *See* Respondent's SOF at ¶¶ 141-44.

[145] Solmor Dep. Tr. at 101-02 **(Tab 30)**; Guttman Dep. Tr. at 86-87, 179-80 **(Tab 9)**. *See* Respondent's SOF at ¶ 142.

[146] Solmor Dep. Tr. at 101-02 **(Tab 30)**; Guttman Dep. Tr. at 84-85, 179-80 **(Tab 9)**. *See* Respondent's SOF at ¶ 142.

able to participate in capitated plans to do so.[147] Indeed, payors prefer dealing with the Medical Group rather than contracting with doctors individually precisely because the large size enabled them to effectively share the risk of capitated contracts.[148] Complaint Counsel ignores these important efficiencies by focusing solely on the Medical Group's fee-for-service contracts.

[REDACTED]

[149] Moreover, in 2000, the Medical Group's capitated contracts accounted for a meaningful share of its business.[150] Complaint Counsel's real argument on financial and clinical integration is that the Medical Group is not financially or clinically integrated enough to justify negotiating on behalf of affiliated physicians.

In sum, because the aforementioned efficiencies produced by the Medical Group's contracting activities are both plausible and cognizable, by Complaint Counsel's own terms, its motion for summary decision must be denied. To the extent that Complaint Counsel takes issue with the magnitude of these efficiencies or whether these efficiencies outweigh any purported anti-competitive effect, these are fact-questions that must be reserved for trial. As the Commission stated, "in antitrust cases, summary dismissal is inappropriate where there is a genuine dispute as to the material facts underlying the alleged efficiency defense." *In re Matter of Polygram Holding, Inc.*, Docket No. 9298, at 3 (Order Denying Motion For Summary Decision) (Feb. 26, 2002).[151]

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[147] *See* Guttman Dep. Tr. at 176-77 **(Tab 9)**. *See* Respondent's SOF at 62 ¶ 142.

[148] Golbus Dep. Tr. (July 8, 2004) at 135-37, 164 **(Tab 10)**. See Respondent's SOF at ¶ 88.

[149] **[REDACTED]**

[150] Miller Aff. ¶ 3 **(Tab 17)**. *See also* Miller Dep. Tr. at 48 **(Tab 72)**. *See* Respondent's SOF at ¶ 89.

[151] *See also Continental Airlines, Inc. v. United Airlines, Inc.*, 277 F.3d 499, 510-11 (4th Cir. 2002) ("Certainly courts have been wary of summary judgment in the context of quick-look analysis. In fact, the parties have not cited, and we have not found, a single case in which the Supreme Court has approved a quick-look analysis in which the parties received less then a full evidentiary hearing, either before an administrative agency or in court.").

IV. COMPLAINT COUNSEL'S PURPORTED PRICING EVIDENCE DOES NOT DEMONSTRATE AN ANTI-COMPETITIVE EFFECT

While arguing that summary decision is appropriate because there are no plausible and cognizable efficiency justifications for the Medical Group's conduct, (Complaint Counsel Mem. at 11-13, 21-22), Complaint Counsel also proffers evidence of alleged anti-competitive effects. Complaint Counsel Mem. at 9-10. Consideration of anti-competitive effects, however, is irrelevant (under *Polygram*) unless the challenged conduct produces plausible and cognizable efficiency justifications. By arguing that the Medical Group's activities produce anti-competitive effects, Complaint Counsel implicitly admits that an analysis of the challenged conduct's competitive effects (i.e. rule of reason analysis) is required.

Moreover, Complaint Counsel again mischaracterizes the evidence.

[REDACTED]

In detailing the allegedly anti-competitive price increases obtained by the Medical Group, Complaint Counsel merely compares the stated percentage of RBRVS in the pre-merger contracts with the percentage in the contracts negotiated after the merger (See Complaint Counsel Rule 3.24 Statement at ¶¶ 47-60). No adjustment is made, however, for the fact that the base RBRVS for the two contracts differ and that RBRVS does not keep up with medical cost inflation. As such, Complaint Counsel's price comparison is inherently faulty. Indeed, there is no evidence that there was a *real* (i.e. adjusted) increase in price. Complaint Counsel also fails to take into account the fact that IPA contracts are typically re-negotiated infrequently.

[REDACTED] As a result of these time lags in contracting, prices that appear high in the beginning years of a contract appear low at the end of the contract. Because of the time lag in these contract negotiations, simple "before" and "after" comparisons like the ones conducted by Complaint Counsel are

become a member.

[REDACTED]

[155] Finally, the prices obtained by the Medical Group could not be anti-competitive unless the Medical Group possessed market power in some relevant market. *Chicago Prof'l. Sports Ltd. Pshp. v. National Basketball Ass'n.*, 95 F.3d 593, 600 (7th Cir. 1996) ("Substantial market power is an indispensable ingredient of every claim under the full Rule of Reason."). Complaint Counsel has neither alleged nor offered evidence of such market power.

V. EQUITABLE RELIEF IS NOT NECESSARY TO ADDRESS THE ALLEGATIONS IN COUNT III.

As demonstrated above, the myriad questions of material fact at issue in Count III render summary decision improper, and Respondents are prepared to defend Count III on the merits. Nevertheless, contrary to Complaint Counsel's assertions (Complaint Counsel's Mem. at 24-25), this Court may and should also deny the motion for partial summary decision (and dismiss *sua sponte* Count III) without reaching the merits of the underlying allegations given that: (1) the relief requested in Count III is exclusively equitable in nature;[156] and (2) equitable relief is *not* warranted because there is no "cognizable danger of recurrent violation."[157]

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[155] **[REDACTED]**

[156] Complaint Counsel's request for relief pertaining to Count III is limited to equitable relief and does not seek disgorgement, restitution, or any other financial payment from Respondents. Complaint Counsel's Answers & Objections to Resps.' First Set of Interrogs. at 48 (addressing Interrog. No. 23); Compl. at 12 (Notice of Contemplated Relief). Indeed, Complaint Counsel has no right in this proceeding to seek disgorgement or restitution from the Medical Group, especially considering that the complained of conduct has ceased. *Heater v. Federal Trade Comm'n*, 503 F.2d 321 (9th Cir. 1974) (holding that the Commission is not empowered under Section 5 of the FTC Act to order disgorgement or restitution; such remedial powers "are inconsistent and at variance with the over-all purpose and design of the Act"); *see also Federal Trade Comm'n v. Ruberoid*, 343 U.S. 470, 473 (1952).

[157] *United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953); *see also, e.g., In re Furr's Inc.*, 1965 WL 92980 (affirming dismissal of complaint because there was little danger of recurrent violation); *In re Sperry Rand Corp.*, Docket No. 7559, 64 FTC 842, 1964 WL 72881 (Feb. 17, 1964) (Comm'n Op.) (vacating initial decision and dismissing complaint because the probability of recurrent violation was remote and insubstantial); *cf. In re Revco*

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Dated: November 18, 2004

CERTIFICATE OF SERVICE

I hereby certify that on November 18, 2004, a copy of the foregoing ***Attachment to the Memorandum in Opposition to Complaint Counsel's Motion for Partial Summary Decision Pursuant to Rule 3.45(e)*** was served by email and hand delivery on:

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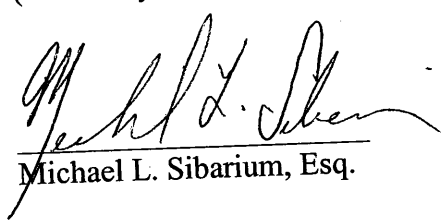

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