[PUBLIC RECORD]

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

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

NORTH TEXAS SPECIALTY PHYSICIANS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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PROPOSED FINDINGS OF FACT
AND CONCLUSIONS OF LAW

Pursuant to the Scheduling Order, Respondent North Texas Specialist Physicians ("NTSP") proposes the following findings of fact and conclusions of law. These proposals are based on a prediction of what the evidence at trial will be and what Complaint Counsel will contend factually and legally. NTSP reserves the right to amend, withdraw, or supplement these proposals as the proof and issues become clearer. These proposals are predictions, not assertions of fact, and hence do not constitute any admission or declaration against interest.[1]

I. Findings of Fact

A. Respondent

1. NTSP is non-profit corporation organized, existing, and doing business under and by virtue of the laws of Texas, with its office and principal place of business at 1701 River Run Road, Suite 210, Fort Worth, Texas 76107.[2]

2. NTSP is formed under section 5.01(a) of the Texas Medical Practice Act which allows nonprofit entities to engage in the practice of medicine for the purposes of research, medical education, or the delivery of health care to the public[3]

3. NTSP is a memberless organization and is not a "corporation" as defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44.

B. Respondent's Business Model

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[1] These proposed findings do not purport to respond specifically to Complaint Counsel's proposals. That will be done at a later date when the evidence has been heard.

[2] Complaint ¶ 1; Answer ¶ 1.

[3] TEX. OCC. CODE ANN. § 162.001 (Vernon 2004).

1. Risk Contracting and Spillover

4. NTSP is involved in both risk contracts and non-risk contracts.[4]

5. [redacted][5]

6. In 2003, NTSP had approximately 300 physicians in its risk panel and approximately 275 additional physicians who participate in one or more non-risk contracts.[6]

7. [redacted][9]

8. Dr. Frech admits that an IPA can improve quality by performing utilization review and medical management.[10]

9. [redacted]

[4] Complaint ¶ 14; Answer ¶ 14.

[5] Expert Report of Gail R. Wilensky, Ph.D. ("Wilensky Report") at 10.

[6] Deposition of Karen Van Wagner, Ph.D., August 30, 2002, at 225, 227-28.

[7] Expert Report of Robert S. Maness, Ph.D. ("Maness Report") ¶ 19.

[8] Maness Report ¶ 4.

[9] Maness Report ¶ 4.

[10] Deposition of H.E. Frech, Ph.D. at 99.

[redacted][11]

10. NTSP's business model is designed to achieve efficiencies and quality improvements through clinical integration techniques used on its risk contracts and then enabling the Risk Panel and other participating physicians to carry over those same techniques to their non-risk medical care.[12]

11. Doctors normally do not change their practice patterns patient-to-patient based on whether the payor is a HMO or PPO, or whether their treatment falls under a risk or non-risk contract.[13]

12. Carry over or "spillover" serves to increase the quality and efficiency of the physicians' non-risk medical care.[14]

13. Dr. Frech admits that NTSP generates efficiencies and improves quality of care through spillover from its risk contracts to the non-risk contracts that are the subject of this adjudicative proceeding.[15]

14. NTSP's maintaining continuity of personnel — in this case, the participating physicians — is important to achieving these efficiencies.[16]

15. Dr. Frech admits that it is more likely that NTSP would be able to carry over the efficiencies gained on its risk contracts to its non-risk contracts if

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[11] Wilensky Report at 11.

[12] Deposition of William Vance, M.D. at 117-18; Deposition of William Vance, M.D. at 287-88.

[13] Deposition of Harry Rosenthal, Jr., M.D. at 45-46; [redacted].

[14] Hughes Report at 14-15; Wilensky Report at 5-6, 11-15.

[15] Frech Deposition at 104-05, 110-17, 240-41.

[16] Frech Deposition at 104-05; [redacted].

it uses the same doctors on both types of contracts.[17]

16. Dr. Frech would expect the spillover effects to be greater the more continuous the physicians are who practice under NTSP's risk contracts and its non-risk contracts.[18]

17. Dr. Frech admits that spillover occurs from HMO contracts to non-HMO contracts, regardless of whether the non-HMO contracts are being performed by the same physicians or organization performing under the HMO contracts.[19]

18. Dr. Frech admits that, based on the literature, he expects there to be some spillover from the NTSP risk panel physicians to the NTSP physicians who are not on the risk panel. In fact, this spillover extends to physicians outside of NTSP who practice in the geographic area in and around Tarrant County.[20]

19. [redacted][21]

20. For each NTSP physician on the risk panel, Dr. Frech expects there to be significant spillover effects from that physician's risk practice to the

[17] Frech Deposition at 104-05.

[18] Frech Deposition at 105.

[19] Frech Deposition at 240.

[20] Frech Deposition at 240-41.

[21] Wilensky Report at 13.

physician's non-risk practice.[22]

21. [redacted][23]

22. [redacted][24]

23. This organizational capital benefits patients, for when it is developed, physicians know each other and know the patients. This relationship between physicians and patients leads to medical care rapport and better patient care in terms of cost and quality.

24. [redacted]

[22] Frech Deposition at 241.

[23] *See* Wilensky Report at 12-16; Hughes Report at 15-18; Maness Report ¶¶ 83-100.

[24] Maness Report ¶ 84.

[redacted][25]

25. [redacted][26]

26. [redacted][27]

[25] Maness Report ¶ 85; FTC/DOJ *Healthcare Guidelines*, § 8.A.4.

[26] Maness Report ¶ 87; Deposition of Karen Van Wagner, Ph.D., taken on August 29, 2002 at 19.

[27] Deposition of Edward F.X. Hughes, MD, M.P.H., at p. 88.

27. [redacted][28]

28. [redacted][29]

29. A large portion of NTSP's budget is dedicated to medical management programs. In fact, medical management expenditures by NTSP are approximately $2.5 million per year.

30. [redacted][30]

31. [redacted][31]

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[28] Hughes Report at 13.

[29] Wilensky Report at 11.

[30] Hughes Deposition at 17-18, 90-91.

[31] Wilensky Deposition at 72-75.

32. [redacted][32]

33. [redacted][33]

34. [redacted][34]

35. [redacted][35]

[32] Hughes Deposition at 55-56.

[33] Hughes Deposition at 99-102.

[34] Hughes Report at 13-14.

[35] Maness Report ¶ 88 and Exhibit 11.

36. [redacted][36]

37. [redacted][37]

38. [redacted][38]

39. [redacted]

[36] Maness Report ¶ 89; *see also Pacificare Southwest Region Provider Profile*, Reporting Period Ended 3/31/2003, Published Quarter 3, 2003, North Texas Specialty Physicians (PCP) Dec #15275, pp. 1, 38-43.

[37] Maness Report ¶ 90; *see also Pacificare Southwest Region Provider Profile*, pp. 33, 36, 58-59.

[38] Maness Report ¶ 92; Deposition of Mark Presley, M.D., at 136.

[redacted][40]

40. [redacted][41]

41. [redacted][42]

[39] Hughes Report at 17.

[40] Maness Report ¶ 93.

[41] Maness Report ¶ 94.

[42] Maness Report ¶ 95.

42. [redacted][43]

43. NTSP physicians generally perform equally as well in the capitation environment as they do in the fee-for-service environment. [redacted][44]

44. Additionally, NTSP's customer satisfaction rating for specialists exceeds those of the plans as a whole operating in the Dallas-Fort Worth area, indicating that NTSP's patients on the whole are happier with the quality of care NTSP provides relative to other physicians in DFW payors' networks.[45]

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[43] Maness Report ¶ 96.

[44] Maness Report ¶ 97.

[45] Maness Report ¶ 98.

45. The ability to increase quality and decrease costs has implications to the rates that NTSP might receive in its contracts. As with contracting costs, payors may be willing to pay more to receive the efficiencies that NTSP generates. In an otherwise competitive market, the fact that payors might be willing to pay more to obtain these efficiencies is not evidence that prices are above competitive levels. [redacted][46]

46. [redacted][47]

[46] Maness Report ¶ 99.

[47] Maness Report ¶ 100.

2. Respondent's Poll

47. The Complaint alleges that "NTSP periodically polls its participating physicians" to estimate at what rate levels a majority of the physicians, including those on its risk-capitation panel (the "Risk Panel"), will likely be interested in non-risk contracts.[48]

48. NTSP periodically calculates the mean, median, and mode of the Risk Panel physicians' poll responses separately for HMO and for PPO types of offers.[49]

49. NTSP's participating physicians do not rely on the mean/median/mode of NTSP's aggregated poll results and make their own independent decisions whether to accept an offer individually,[50] and, in numerous cases, accept offers below the rates established by NTSP's board.[51]

50. Dr. Frech testified that the response rate for the poll was very poor; only a small percentage (in some cases less than 10%) of the participating physicians respond at the specific rate that is actually used as a threshold by NTSP's board.[52]

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[48] *See* Complaint ¶ 17 ("NTSP periodically polls its participating physicians, asking each to disclose the minimum fee, typically stated in terms of a percentage of RBRVS, that he or she would accept in return for the provision of medical services pursuant to an NTSP-payor agreement.").

[49] *See* Complaint ¶ 17; Van Wagner Deposition taken on November 19, 2003 at 16-19.

[50] Rosenthal Deposition at 24; Deposition of John Johnson, M.D. at 25-26, 30; Deposition of Mark Collins, M.D., at 36-37 (free to contract directly or through another IPA).

[51] Rosenthal Deposition at 22-23; Johnson Deposition at 25, 27.

[52] Frech Deposition at 215-16.

51. Not all participating physicians respond to the poll,[53] and many physicians do not follow their own poll responses in individual contract decisions.[54]

52. In the 2001 poll for PPO and HMO products, 34% of the full panel of NTSP participating physicians responded, and 57% of the risk panel responded.[55] In the 2002 poll, 34% of the full panel responded, and 55% of the risk panel responded.[56]

53. The physicians are not informed as to which physicians responded or did not respond.

54. The responses of the approximately 190 physicians who respond to a poll are aggregated into the single statistics of mean, median and mode.

55. The FTC's Statements of Principles provide that five or more data points should be aggregated for reported statistics.[57] NTSP's reported statistics are 4000% more aggregated than the Statements' guideline.

56. Providing only the mean, median, and mode of the poll responses does not tell a participating physician what any other physician will do with respect to a payor offer.[58]

57. Because NTSP has limited resources and because NTSP does not want to expend its resources or efforts on offers which will not involve a

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[53] Frech Deposition at 149, 215-18

[54] Frech Deposition at 82, 215-18.

[55] RX 14 and RX 15.

[56] RX 16 and RX 17.

[57] *See* DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, *available at* http://www.ftc.gov/reports/hlth3s.htm.

[58] Frech Deposition at 149, 155.

significant percentage of its Risk Panel physicians, the board of directors has instructed NTSP's staff not to expend their time and resources on payor offers below these two mean/median/mode threshold levels.[59]

58. The their recent Bay Area Physicians advisory opinion, the FTC staff took a neutral position on a third-party messenger's concern about becoming involved in contracts in which less than a majority of its members participate.[60]

59. [redacted][61]

60. [redacted][62]

61. [redacted]

[59] Deposition of Tom Deas, M.D., October 10, 2002, at 21-22 & 25; Deposition of Tom Deas, M.D., January 26, 2004, at 37-38; Deposition of Jack McCallum, M.D., at 121-22 & 124; Deposition of Ira Hollander, M.D., at 27-28; Rosenthal Deposition at 25.

[60] Letter from Jeffrey W. Brennan to Martin J. Thompson, September 23, 2003, which can be found at http://ftc.gov/bc/adops/bapp030923.htm.

[61] Maness Report ¶ 55.

[62] Maness Report ¶ 56.

[redacted][63]

62. NTSP participating physicians are not even aware of the overall response rate, much less within a given specialty. A large percentage of physicians do not respond to the poll. The poll provides no information on the prices that are acceptable to specific physicians or specific specialties of physicians. [redacted][64]

63. In a recent Advisory Opinion to a physician group in Dayton, the FTC acknowledged that, "Increasing the amount of information available to patients, employers, physicians, and other interested parties can improve the functioning of markets and foster, rather than hinder, competition and consumer welfare."[65]

64. Dr. Frech admits that the collection and dissemination of market information, including market prices, can potentially benefit competition.[66]

65. Dr. Frech believes that payors conduct surveys and know what other payors are offering in a given market.[67]

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[63] Maness Report ¶ 56; Van Wagner Deposition taken on August 29, 2002 at 94.

[64] Maness Report ¶ 56; Van Wagner Deposition taken on November 19, 2003 at 89; RX 14, 15, 16, and 17.

[65] Letter from Jeffrey W. Brennan to Gregory G. Binford, February 6, 2003, which can be found at http://ftc.gov/bc/adops/030206dayton.htm.

[66] Frech Deposition at 155-58.

[67] Frech Deposition at 156.

66. Dr. Frech admits that payors usually have to offer a higher price to get a majority or more of physicians to participate in a contract.[68]

67. Higher prices are especially important to attract physicians that are more sought after and perceived to be of higher quality.[69]

68. Dr. Frech admits that, even where unit costs may be higher in a payor contract, consumers may benefit because of lower utilization rates by physicians that decrease the total cost of care.[70]

69. Dr. Frech admits that physicians commonly look to IPAs to handle discussions with a payor as to the legal terms of a contract,[71] and that IPAs save costs by eliminating multiplicative legal contractual reviews by individual physicians.[72]

70. [redacted]

[68] Frech Deposition at 182-83.

[69] Frech Deposition at 202.

[70] *See* Frech Deposition at 109.

[71] Frech Deposition at 80.

[72] *See* Frech Deposition at 167-68 (discussing diseconomies from having each practice group conduct its own contract review).

[redacted]

71. Payors are willing to pay more to get larger, more qualified, and more cost-efficient panels and to avoid multiplicative contracting costs.

3. Respondent Does Not Negotiate Rates

72. NTSP has no power to bind and does not bind any participating physician or physician group to a non-risk contract.[74]

73. NTSP is unable to conduct any binding negotiation on behalf of any physicians on a non-risk offer.

74. NTSP informs payors, on occasion, of its threshold rate levels for its involvement and gives them an opportunity to make an offer that will activate the NTSP network and fall within NTSP's authorization to act.[75]

75. NTSP does not "negotiate" to raise rates on non-risk contracts above the threshold levels for its involvement and has refused to do so in response to invitations from payors.[76]

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[73] Maness Report ¶ 75; Letter from Jeffrey W. Brennan to Martin J. Thompson, September 23, 2003, which can be found at http://ftc.gov/bc/adops/bapp030923.htm.

[74] Frech Deposition at 209.

[75] Van Wagner Deposition taken on August 29, 2002 at 62-63; Deposition of Dave Palmisano at 19.

[76] Van Wagner Deposition taken on August 29, 2002 at 24-25; Deposition of Dr. Tom Deas taken on October 10, 2002 at 73; Deposition of Leslie Carter at 20-21, 39-40, 44-45, 138, 141.

76. All non-risk offers presented by a payor to NTSP and in which NTSP has chosen to become involved as a contracting party has always then been messengered to NTSP's participating physicians.[77] Each physician or physician group then makes an independent decision whether to accept or reject the offer.[78]

77. For those offers that a payor chooses to present through another independent physician association ("IPA") or directly to physicians, the physicians also have the right to accept those offers on their own.

78. The physicians eligible to participate in NTSP contracts vary greatly in how many contracts they accept. Some are involved in none and some are involved in as many as 21 of the 24 contracts. The average number of contracts is 7.47.[79]

79. The physicians eligible to participate in NTSP contracts vary greatly in how many contracts they accept. Some are involved in none and some are involved in as many as 21 of the 24 contracts. The average number of contracts is 7.47.[80]

80. [redacted]

[77] Frech Deposition at 209.

[78] Frech Deposition at 209; Deposition of Tom Quirk at 54.

[79] RX 359 (NTSP physician participation chart).

[80] RX 359 (NTSP physician participation chart).

[redacted][81]

81. [redacted][82] [redacted] [redacted][83] All of the physicians who participate in one or more NTSP contracts also have individual contracts with the payors with whom NTSP has a contract.[84] The physicians participate, on average, in only 7.47 of NTSP's 25 contracts.[85] Of course, the physicians also have numerous other contracts with payors with whom NTSP has no contract.

C. Respondent Has a Right to Refuse to Deal with Payors

82. Operating the messenger model entails costs for NTSP. There are a number of costs that are incurred each time the messenger is approached with a new contract offer. [redacted]

[81] Maness Report at Exhibit 10; *see also* RX 316 [redacted].

[82] RX 26.20

[83] RX 26.7 - 26.8

[84] *See, e.g.,* Deposition of Dr. Jack McCallum, p. 136-137.

[85] RX 359 (NTSP physician participation chart).

[redacted][86]

83. NTSP has limited funds and managerial resources with which to carry out these functions. What funds NTSP does have are generated from two sources—a one-time $1000 fee when a physician's application to NTSP is accepted and NTSP's share of the profits from its risk contracts. Thus, the costs of managing the messenger model are borne directly by NTSP, and ultimately in an indirect sense by all participating physicians, from activities unrelated to its non-risk business.[87]

84. Dr. Frech admits that there are many reasons an entity might refuse to deal with another entity, including legal concerns or even not liking the other entity.[88]

85. Legal reasons why NTSP might refuse to deal with a payor include the following:

a. Avoiding illegal or potentially illegal or legally risky contracts;[89]

b. Avoiding the use of its resources in reviewing and servicing contracts where only a minority of the doctors on its panel are going to be involved;[90]

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[86] Maness Report ¶ 76; Van Wagner Deposition taken on August 29, 2002 at 56-57.

[87] [redacted]; Van Wagner Deposition taken on August 29, 2002 at 13, 56-57; Van Wagner Deposition taken on January 20, 2004 at 9-10; Deas Deposition taken on October 10, 2002 at 30.

[88] Frech Deposition at 92.

[89] *See, e.g.*, Deposition of Dr. Paul Grant at 69; Johnson Deposition at 28.

[90] *See, e.g.*, Deas Deposition taken on October 10, 2002 at 21-22, 25; Hollander Deposition at 27-28; McCallum Deposition at 121-22.

c. Avoiding credentialing and other activities in those situations where NTSP does not want to undergo the burden of those activities;

d. Avoiding situations which will be a drain on the time and resources of itself and the doctors on its panel through the use of incomprehensible compensation methodologies;[91]

e. Avoiding involvement in situations in which the payor is discriminating against the doctors on NTSP's panel;[92]

f. Avoiding involvement with payors who are not financially sound;[93]

g. Avoiding medical plans which appear risky from a medical treatment standpoint;

h. Avoiding other situations which appear legally risky to NTSP from a financial, administrative, or standard-of-care standpoint;[94]

i. Avoiding situations where the payor is undermining a NTSP risk contract;[95]

j. Avoiding situations where a payor has been breaching the existing contract;

k. Avoiding situations where the payor has engaged in deceit or other

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[91] *See, e.g.* Johnson Deposition at 28.

[92] *See, e.g.*, RX 1536; CX 775; [redacted]).

[93] *See, e.g.*, MSM Petition (proposed RX exhibit); RX 1555 and RX 1556 (articles regarding MSM bankruptcy).

[94] *See, e.g.*, Jagmin Deposition at 75.

[95] *See, e.g.*, Deposition of Jim C. Mosley at 19-20, 24-25, 36-37, 53-54.

conduct condemned by state officials;[96]

l. Avoiding situations which will be criticized by the physicians it hopes to continue to work with;[97]

m. Avoiding involvement in situations in which the payor refuses to share with NTSP medical data so that NTSP can further its own medical management goals;[98]

n. Avoiding those situations in which NTSP is not given time to make a knowledgeable decision about being involved in an offer; and

o. NTSP is seeking to obtain a risk contract with the payor.[99]

86. If NTSP declines to deal with a payor, the payor can contract with NTSP's participating physicians individually or through other IPAs.[100]

87. [redacted][101]

88. Payors can easily messenger contracts themselves.[102]

89. Dr. Frech admits that messengering is essentially a ministerial task that

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[96] *See, e.g.*, RX 339; RX 1805; RX 3101; RX 3103; [redacted]; CX 586.

[97] *See, e.g.*, Presley Deposition at 31.

[98] *See, e.g.*, [redacted].

[99] *See, e.g.*, [redacted].

[100] [redacted]; *see also* specific payor findings of fact, *infra*.

[101] RX 280[redacted]; *see* Quirk Deposition at 87-88 [redacted].

[102] Frech Deposition at 89-91.

anyone, including payors, can easily accomplish.[103]

D. Respondent Has a Right to Speak

90. NTSP has legitimate reasons to speak out and communicate about payors.

91. Legal reasons why NTSP might speak out about payors include:

a. Preventing payor deception or violation of a law;

b. Advising patients and their employers about changes in service and healthcare issues;

c. Advising physicians about the meaning of contractual terms or background on the contracting process; and

d. Advising physicians whether NTSP will be involved with a payor's offer and whether the physicians need to anything concerning an offer.

E. Relevant Geographic and Product Markets

1. Complaint Counsel has not defined any relevant market

92. Dr. Frech admits that he has not defined any relevant market.[104]

93. Dr. Frech admits that he has not calculated any concentration ratios.[105]

94. Dr. Frech admits that, although he has done zip code analysis on physician practices in other cases, he has not done that type of analysis in this case.[106]

95. Dr. Frech admits that he has not performed any type of entry analysis in

[103] Frech Deposition at 89-91.

[104] Frech Deposition at 120.

[105] Frech Deposition at 136.

[106] Frech Deposition at 134.

this case.[107]

2. Any relevant geographic market including Tarrant County would also include Dallas and other counties.

96. [redacted][108]

97. [redacted][109]

98. [redacted][110]

99. [redacted][111]

100. [redacted]

[107] Frech Deposition at 142.

[108] Maness Report ¶ 30.

[109] Maness Report ¶ 22.

[110] Maness Report ¶ 23.

[111] Maness Report ¶ 23.

[redacted][112]

101. [redacted][113]

102. Federal regulations are similar—requiring a PCP within 30 miles or a 30 minute drive, and a specialist within 50 miles.

103. [redacted][114]

104. Similarly, there are numerous examples, including the testimony of payors, that the payors consider the Dallas-Fort Worth Metroplex to be the relevant area to consider for determining adequate network coverage. Additionally, there is evidence that Dallas prices are often used to establish prices for Fort Worth physicians. Payors also note that the service area for their plans includes the Dallas-Fort WorthMetroplex, or at least Dallas and Tarrant Counties.[115]

105. [redacted]

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[112] Maness Report ¶ 24.

[113] Maness Report ¶ 25.

[114] Maness Report ¶ 25.

[115] [redacted]; *see, e.g.,* [redacted]; *see also* Quirk Deposition at 29, 46; Roberts Deposition at 60; [redacted].

[redacted][116]

106. Dr. Frech admits that geographic markets tend to become larger the more specialized the specialty.[117]

107. Dallas is a large city located only about 30 miles from Fort Worth with a large and well-recognized medical community.[118]

108. According to U.S. News and World Report, two Dallas-based hospitals made the list of Best Hospitals—Baylor University Medical Center and Parkland Memorial Hospital. In fact, these two hospitals are specifically recognized in specialties where NTSP has a high proportion of Tarrant County-based physicians, such as oncology, orthopedics, otolaryngology, cardiovascular surgery, kidney disease (nephrology) and respiratory disorders (pulmonology). In addition, there are a number of "top doctors" recognized in the DFW area, with many being located in Dallas.[119]

109. Another reference point as to the relevant geographic market boundary is defined by the Dartmouth Atlas of Health Care. The Dartmouth Atlas specifically defines hospital referral regions (HRR) for every state. HRRs are defined as "regional health care markets for tertiary medical care." Each HRR contained at least one hospital that performed major

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[116] Maness Report ¶ 27.

[117] Frech Deposition at 132-33.

[118] [redacted]

[119] [redacted].

cardiovascular procedures and neurosurgery. In a similar fashion, HRRs were defined by assigning HSAs (Hospital Service Areas) to the region where the greatest proportion of major cardiovascular procedures were performed, with minor modifications to achieve geographic contiguity, a minimum population size of 120,000, and a high localization index. [redacted][120]

110. The Dartmouth Atlas defines the Fort Worth HRR as being comprised of the following counties: Bosque, Dallas, Erath, Hamilton, Hill, Hood, Jack, Johnson, Palo Pinto, Parker, Somervell, Tarrant, Wise and Young.[121]

111. The Dallas HRR comprises the following counties: Collin, Cooke, Dallas, Denton, Ellis, Fannin, Freestone, Grayson, Henderson, Hopkins, Hunt, Johnson, Kaufman, Lamar, Montague, Navarro, Rains, Red River, Rockwall, Tarrant, Van Zandt and Wise.[122]

112. Dallas, Tarrant, Johnson and Wise Counties are considered to belong in both the Dallas and Fort Worth HRRs, indicating that patients from each HSA specifically receive care from providers in either Dallas and/or Tarrant counties.[123]

113. The "Mid-Cities" area contains a large population located between Fort Worth and Dallas. The Mid-Cities consists of a group of cities that lay in

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[120] Maness Report ¶ 28.

[121] [redacted].

[122] [redacted].

[123] [redacted].

the western third of Dallas County and the eastern third of Tarrant County. These cities include Arlington, Bedford, Cedar Hill, Colleyville, Coppell, Dalworth Gardens, Duncanville, Euless, Grand Prairie, Grapevine, Hurst, Irving, Kennedale, Mansfield, Pantego, and Southlake.[124]

114. [redacted][125]

115. Census Bureau data show that the collective population of the Mid-Cities is about 1,007,172. This represents about 27.5 percent of the total population of Dallas and Tarrant Counties.[126]

116. In addition, the Mid-Cities population of Tarrant County (excluding those Mid-Cities located in Dallas County) represents over 40 percent of the population of Tarrant County. [redacted][127]

117. [redacted][128]

118. [redacted]

[124] [redacted].

[125] Maness Report ¶ 29.

[126] [redacted]

[127] Maness Report ¶ 29 and Exhibit 5.

[128] Maness Report ¶ 29 and Exhibit 6.

[redacted][129]

119. Dr. Frech admits that the existence of a significant population in eastern Tarrant County (*i.e.*, the Mid-Cities area) on the border of Dallas County would act to tie Dallas and Tarrant Counties together.[130]

120. In their depositions, NTSP physicians report that they draw patients from a wide area, including the Mid-Cities and Dallas.[131]

121. The Department of Justice, in its review of the Aetna-Prudential merger concluded that the merger created anticompetitive monopsony power in the purchase of physician services in a relevant geographic market for physician services that it defined as the Dallas-Fort Worth Metropolitan Statistical Area. [redacted][132]

3. Relevant Product Market

122. [redacted][133]

[129] Maness Report ¶ 29.

[130] Frech Deposition at 130-31.

[131] [redacted]; Deposition of Dr. Susan Blue at 14-15; Collins Deposition at 12.

[132] Maness Report ¶ 30.

[133] Maness Report ¶ 20.

123. This definition is consistent with the way in which the FTC and the DOJ have defined product markets in prior cases.[134]

124. Many of NTSP's approximately 575 participating physicians practicing in 26 different specialties are not in competition with one another [redacted][135]

125. [redacted][136]

126. When assembling networks, payors look to include physicians across a broad range of specialties because they acknowledge that one specialty is not necessarily a good substitute for another.[137]

127. There are some areas where physicians from multiple specialties may be part of the same relevant product market. For instance, it is common for managed care plans to allow members to choose family practice or internal medicine doctors as primary care physicians. Many plans also allow female members to specify an OB/GYN as a primary care physician and allow members to use pediatricians as primary care physicians for children. In such circumstances, it is likely that there exists a primary care physician product market that includes family practice, internal medicine,

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[134] [redacted]; *see also* Letter from Joel I. Klein of the Department of Justice to Donald H. Lipson regarding Gastroenterologists, July 7, 1997; Complaint, In the Matter of R.T. Welter and Associates, Inc., et al., ¶ 11 and Amended Complaint, In the Matter of Mesa County Physicians Independent Practice Association, Inc., Docket No. 9284, ¶ 3.

[135] Maness Report ¶ 19.

[136] Maness Report ¶ 19.

[137] [redacted]; Complaint, ¶ 9; *see also* Letter from Joel I. Klein of the Department of Justice to Donald H. Lipson regarding Gastroenterologists, July 7, 1997.

and perhaps gynecologists and pediatricians. Similarly, medical care performed by ear, nose and throat doctors can often be provided by family practice physicians or pediatricians, among others. In such circumstances, the relevant product market may be broader than a single specialty.[138]

128. Dr. Frech admits that there can be significant crossovers of services between specialties.[139]

F. NTSP Does Not Have Market Power in Any Relevant Market

129. [redacted][140]

130. [redacted]

With such a small share of the number of physicians, NTSP does not possess the power to anticompetitively raise prices.[141]

131. Payors note that NTSP does not possess much market power, and they did not consider NTSP to be particularly important in establishing an effective network in the Dallas-Fort Worth area.[142]

132. [redacted]

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[138] [redacted]; *see* Amended Complaint, In the Matter of Mesa County Physicians Independent Practice Association, Inc., Docket No. 9284, ¶ 3.

[139] Frech Deposition at 121-25.

[140] Maness Report ¶ 33.

[141] Maness Report ¶ 33; *see Horizontal Merger Guidelines*, § 2.0.

[142] [redacted]; *see* Quirk Deposition at 15, 44-45 and Roberts Deposition at 24, 28-29.

[redacted][143]

133. [redacted][144]

134. [redacted][145]

135. [redacted][146]

136. [redacted]

[143] Maness Report ¶ 34 and Exhibit 8.

[144] Maness Report ¶ 35.

[145] Maness Report ¶ 35 and Exhibit 9.

[146] Maness Report ¶ 36.

[redacted][147]

137. [redacted] For instance, many types of colon and rectal surgery are also performed by general surgeons; a point recognized by antitrust authorities.[148]

138. [redacted][149]

139. [redacted]

[147] Maness Report ¶ 36.

[148] Maness Report ¶ 37; *see also* Health Care Business Review Letters Issued, Current as of 3/4/1999, Department of Justice, p. 18.

[149] Maness Report ¶¶ 37-38.

[redacted][150]

140. [redacted][151]

141. When assessing any market power that NTSP might face, it is important to note the network availability requirements that the companies have.

[redacted]

[150] Maness Report ¶ 39; *see also* Health Care Business Review Letters Issued, Current as of 3/4/1999, Department of Justice, pp. 7, 11, 18.

[151] Maness Report ¶ 40.

[redacted][152]

142. [redacted][153]

143. For example, one physician group with NTSP members has a direct non-risk contract with Cigna and does not participate in NTSP's contract with Cigna.[154] [redacted].[155]

144. [redacted][156]

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[152] Maness Report ¶ 41; *see also* RX 2887.012.

[153] Maness Report ¶ 42.

[154] Deas Deposition taken on October 10, 2002 at 37-39.

[155] *See* RX 9 [redacted]; CX 517 [redacted].

[156] Maness Report ¶ 42 and Exhibit 10; *see also* RX 2745.001-.004 and RX 295.

145. [redacted][157]

146. [redacted][158]

147. [redacted][159]

148. [redacted]

[157] Maness Report ¶ 45; Report of Dr. H.E. Frech, Exhibit 3.

[158] Maness Report ¶ 47.

[159] Maness Report ¶ 48

[redacted][160]

149. NTSP has never had a contract directly with Blue Cross.

150. NTSP had a direct contract with Aetna for only one year.

151. All NTSP participating physicians participate in a varying number of health plans outside of NTSP.[161]

152. Payors admit that they give NTSP the same rates given to other IPAs.

[redacted][162] Cigna gave NTSP the same rate it gave to HTPN, another IPA in Tarrant County.[163] Aetna gave NTSP the same rate it gave to MSM, another IPA in Tarrant County.[164]

153. Dr. Frech admits that it takes a higher price to activate a majority of physicians on a panel that what is required to activate just a few individual physicians.[165]

154. Not all payors will find what NTSP is offering as a network is worth the price NTSP charges. NTSP has demonstrated it provides low cost, good quality care, but for payors who wish to buy a different service, they can continue to do so. These payors can and do contract with other physicians

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[160] Maness Report ¶ 43.

[161] [redacted]

[162] *See* RX 282 [redacted].

[163] *See* CX 768 (NTSP offered 2000 rate same as for HTPN).

[164] *Compare* RX 968 (fax alert showing MSM Aetna rates at 140%/125%) to RX 24.021 (NTSP/Aetna IPA agreement showing rates at 140%/125%).

[165] Frech Deposition at 182-83.

or individually with physicians who are part of the NTSP network. [redacted][166]

155. Dr. Frech admits that knowing what a payor is paying a few physicians through direct contracts does not indicate what the payor would have to pay to activate more physicians in the market.[167]

156. Dr. Frech admits that more sought-after physicians often seek and obtain higher reimbursement rates.[168]

157. Dr. Frech admits that, under basic economic theory, higher quality can lead to higher price.[169]

158. [redacted][170]

159. [redacted][171]

160. Structurally, NTSP's business model benefits healthcare by reducing overall medical costs through development and implementation of a

[166] Wilensky Report at 16.

[167] Frech Deposition at 183.

[168] Frech Deposition at 202.

[169] Frech Deposition at 202.

[170] *See* RX 1708, 1710, 2178, 3177, 3178 and proposed exhibits RX 3285 and 3288.

[171] Hughes Report at 4.

comprehensive medical management process involving all segments of the continuum of care, including:

a. A medical management committee to supervise implementation of quality improvement strategies[172];

b. The monitoring of clinical indicators to identify practice pattern outliers and provide appropriate intervention[173];

c. The organizing of the physicians into specialty divisions to develop clinical protocols, monitor this implementation, and intervene when deviations from evidence-based medicine based practice patterns are detected[174];

d. [redacted][175];

e. The implementation of a care management system to monitor care of high-risk patients with complex medical conditions and endeavor to have these patients treated at the appropriate level of care, and under appropriate specialty guidance to reduce overall costs and improve quality[176];

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[172] Vance Deposition taken on January 7, 2004, at 48.

[173] Blue Deposition at 16-17; Grant Deposition at 111-12; Rosenthal Deposition at 16, 42-43.

[174] *See* RX 1590; Van Wagner Deposition taken on August 29, 2002, at 16-17; Hollander Deposition at 164-65.

[175] Hughes Deposition at 75-77.

[176] Blue Deposition at 16-17; Deas Deposition taken on January 26, 2004 at 104.

f. Participating in disease management programs developed internally or by payors[177];

g. Enhancing patient education and professional communication through the development of a sophisticated website replete with information on clinical and referral options and physician education for clinical and professional information on care options.[178]

161. The tangible benefits to healthcare from NTSP's business model are shown by recent patient surveys. In these surveys, the quality of care of NTSP's doctors and specialists was rated higher than United, Aetna, Cigna and PacifiCare's non-NTSP networks.[179]

G. There is No Evidence of Any Physician Collusion

1. Complaint Counsel cannot identify any collusion by physicians

162. Dr. Frech admits that he knows of no evidence that any physician has ever colluded with anyone else or has ever refused to entertain any payor offer which was tendered to him or her directly by a payor or through another IPA.[180]

163. Complaint Counsel, after having been ordered to respond to contention interrogatories, admits that there is no direct evidence of any agreement

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[177] Van Wagner Deposition taken on January 20, 2004 at 124-25.

[178] Blue Deposition at 16-17; Rosenthal Deposition at 46.

[179] *See* Proposed exhibits RX 3182 and RX 3183; *see also* RX 1801 and proposed exhibit RX 2384 (data for chart).

[180] Frech Deposition at 75-76, 80, 97, 155, 209.

between NTSP and a participating physician to reject a payor offer based on price or any other competitively significant term.[181]

164. Dr. Frech admits that he cannot identify any specific evidence showing that any of the following things occurred: (1) one or more participating physicians agreed with each other to reject a non-risk payor offer;[182] (2) any participating physician and any other entity agreed to reject a non-risk payor offer;[183] (3) any participating physician rejected a non-risk payor offer based on a power of attorney granted to NTSP;[184] (4) any participating physician refused to negotiate with a payor prior to a non-risk offer being messengered by NTSP;[185] (5) any participating physician knew what another physician was going to do in response to a non-risk payor offer;[186] (6) any participating physician gave NTSP the right to bind him or her to any non-risk payor offer;[187] or (7) any participating physician gave up his or her right to independently accept or reject a non-risk payor offer.[188]

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[181] Complaint Counsel's Second Supplemental Responses to Respondent's First Set of Interrogatories at 1-2 ("Complaint Counsel is not aware of communications between NTSP and any other person or entity taking the form of an express request by NTSP that a physician reject a specific payor offer, to which any physician expressly replied, "I agree to reject this offer.").

[182] Frech Deposition at 75-76.

[183] Frech Deposition at 75-76.

[184] Frech Deposition at 80.

[185] Frech Deposition at 75-76.

[186] Frech Deposition at 155.

[187] Frech Deposition at 209.

[188] Frech Deposition at 209.

165. Dr. Frech has proven that there is no collusion or agreement among NTSP's participating physicians; [redacted][189]

H. PacifiCare

166. NTSP has current risk contracts with PacifiCare.[190]

167. [redacted][191]

168. [redacted][192]

I. Aetna / MSM

169. In 1994, many physicians signed a HMO risk contract and a PPO fee-for-service contract with another IPA, Harris Methodist Select (HMS), to treat Aetna patients. The contracts were exclusive and were not terminable until June 30, 1999.

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[189] Report of Dr. H.E. Frech at Exhibits 8A-8C.

[190] [redacted]

[191] Lovelady Deposition at 54, 64-65, 97

[192] Lovelady Deposition at 59-60, 66-67, 96.

170. NTSP was formed in 1995 as an entity to engage in risk contracts. Many of the physicians who had contracts with HMS signed participating physician agreements with NTSP.

171. NTSP negotiated on two risk contracts with HMS, whereby NTSP was to accept downloaded risk from HMS and Aetna, in 1996 and 1997.[193]

172. In 1997, HMS breached its contractual obligations with physicians by attempting to amend the 1994 contracts without consent, by agreeing to non-exclusivity with Aetna, and by failing to make full payments under the 1994 contract.[194] The 1997 proffered HMS HMO contracts were the equivalent of a risk contract due to rate adjustment clause.[195]

173. In 1999, during the time the contract was being breached, HMS became Medical Select Management ("MSM"), and the contracts between the physicians and Harris were assigned to MSM.[196]

174. As a result of the continuing breach by HMS, the physicians approached NTSP in 1997 and asked that NTSP attempt to enter into a risk contract to replace HMS. NTSP did so but could not reach agreement with HMS or MSM.

175. NTSP also was appointed by the physicians to represent them in their breach of contract dispute with HMS. A lawsuit was initiated by NTSP in

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[193] *See* RX 308 (1996 offer); RX 312 (1997 term sheet); [redacted]; *see also* [redacted].

[194] *See* RX 832 (fax alert detailing situation).

[195] Van Wagner Deposition taken on November 19, 2003 at 180;

[196] *See* RX 382 (fax alert detailing situation).

June 1999 based on HMS's and MSM's refusal to honor the 1994 contracts with physicians.[197]

176. NTSP sued HMS and MSM as the class representative for the physicians.[198] As the class representative, NTSP had a right to be involved in the resolution of the class members' claims.

177. HMS / MSM continued to breach the contract after the lawsuit was filed by continuing not to pay claims.[199] Despite HMS's and MSM's continuing breaches, the physicians until late 2000 continued to perform under the 1994 contract so as not to affect patient care. The parties attempted to conclude the litigation, but HMS wanted the implementation of a new contract to be tied to NTSP's settlement of the lawsuit.[200]

178. During this time, NTSP was informing Aetna that MSM had ongoing difficulties in paying claims.[201] Aetna repeatedly claimed that MSM was solvent and able to fulfill its obligations.

179. In July 2001, the Texas Department of Insurance placed MSM under supervision, and a week later MSM filed for bankruptcy.[202] An Aetna audit uncovered embezzlement by one of MSM's officers.[203] MSM chief

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[197] RX 849 (fax alert detailing situation); Deposition of Mark Collins, pp. 6-9; proposed exhibit RX 3277 (MSM petition).

[198] *See* proposed exhibit RX 3277 (MSM petition).

[199] Van Wagner Deposition taken on August 29, 2002 at 90.

[200] RX 1300 (correspondence with MSM).

[201] RX 1039.

[202] Roberts Deposition at 47-48. *See also* RX 3102 (TDI press release on supervision); RX 1555 and 1556 (TDI press releases on bankruptcy).

[203] Roberts Deposition at 44-46.

operating officer Frederick C. Miller was convicted of fraud, money laundering, and tax evasion.[204]

180. Aetna assumed the MSM contracts, but ignored the prior breaches by MSM.[205]

181. [redacted][206]

182. NTSP had a right to comment on and be involved in the contractual issues with HMS, MSM, and Aetna in light of these disputes.

183. NTSP and Aetna discussed a direct risk contract, without MSM, in 2000. The parties ultimately entered into a non-risk contract in late December 2000.[207] NTSP contracted at the existing MSM rates. NTSP did not participate in non-risk contract rate discussions with Aetna above Board minimums.[208]

184. Jose Montemayor, the Texas Commissioner of Insurance, had sent a letter in December 2000 questioning certain misrepresentations Aetna was making in contract discussions with physicians.[209] Aetna decided to contract with NTSP following this letter and other communication with the Commissioner about Aetna's conduct.[210]

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[204] *See* RX 1805 (indictment); RX 3101 (article regarding conviction).

[205] RX 1700 (letter from Aetna assuming financial responsibility for MSM's covered services).

[206] *See* CX 656 [redacted]; RX 1632 [redacted].

[207] RX 24 (contract).

[208] *See* RX 38; Van Wagner Deposition taken on August 29, 2002 at 99-100.

[209] CX 586.002-.003.

[210] *See* RX 38; [redacted]; Van Wagner Deposition taken on August 29, 2002 at 99-100.

185. Aetna terminated its contract with NTSP in 2001.[211]

186. NTSP and Aetna's contract had a requirement that there be mutual agreement for any contractual changes. Aetna attempted to change the rate under the 2000 contract. NTSP did not consent to the unilateral change and the contract terminated.[212]

187. The new rate proposed by Aetna fell below the threshold level required to activate NTSP's network. As a result, NTSP did not have the authority to accept such an offer (although Aetna was free to contract with physicians directly).

188. After the termination of the contract, Aetna contracted directly with the NTSP physicians it had formerly contracted with under the 2000 agreement.[213]

189. Doctors were not prevented from dealing directly with Aetna.[214] [redacted] [215]

190. Aetna did not need NTSP in 2001 and does not need NTSP now. Aetna does not currently have a contract with NTSP and does not have any network inadequacy problems.[216]

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[211] Roberts Deposition at 52.

[212] CX 504 (letter from Aetna explaining no mutual agreement); Roberts Deposition at 43-44, 49.

[213] Roberts Deposition at 18, 58-59.

[214] *See* RX 1076 (fax alert attaching Aetna letter).

[215] RX 13 [redacted].

[216] Roberts Deposition at 28-29; *see also* RX 305 and 306 (Texas Board of Medical Examiners' data on physicians by county); RX 1 (Aetna physician panel list); RX 9 [redacted]; RX 350 [redacted]; CX 517 [redacted].

191. During the time NTSP was in contract discussions with Aetna, Aetna was engaging in conduct which were challenged by governmental authorities as legal violations.

192. Chris Jagmin, a medical director for Aetna, was disciplined in August 2001 by the Texas Attorney General for violating an Assurance of Voluntary Compliance by making false representations.[217]

193. [redacted][218]

194. The Department of Justice sued Aetna over its acquisition of Prudential Insurance Company of America as an attempt to gain improper market power over doctors.[219]

195. [redacted][220]

196. The Texas Office of the Attorney General sued Aetna in May 2000 over its contracting practices and also fined Aetna $1.5 million for prompt-pay violations.[221]

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[217] RX 339 (notice of breach from Texas Office of the Attorney General).

[218] CX 186.032 [redacted].

[219] RX 451.002 (Board minutes reporting telephone conversation with DOJ).

[220] CX 57.003 [redacted].

[221] CX 56.004 [redacted]; RX 3103 (TSI press release on situation); CX 104.002 [redacted].

197. NTSP has the right to ensure that a payor's offer and a payor's conduct under a contract do not constitute legal violations.

198. NTSP was exercising its First Amendment right to make statements regarding issues of public importance – in this case, healthcare and legal disputes. NTSP was preventing Aetna's deception and breach of contract.[222]

199. NTSP physicians have the right to advocate for, provide information to, and otherwise advise patients about issues that affect their healthcare.[223]

200. In a recent Advisory Opinion to a physician group in Dayton, the FTC acknowledged that, "The collection and public dissemination of accurate information and expressions of opinion on matters of public interest usually do not raise concerns under the antitrust laws, even when physicians...do so collectively."[224]

J. United

201. Health Texas Provider Network, a subsidiary of Baylor Health Care System, is a physician-governed organization that was designed to provide a comprehensive network of physicians to provide practice management services.[225]

202. HTPN entered into a group agreement for physician services with NTSP. Under this agreement, HTPN agreed that NTSP could make available to

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[222] *See* note 198, 210 and 211, *supra*.

[223] CX 540.005 (Aetna primary care physician agreement detailing policy).

[224] Letter from Jeffrey W. Brennan to Gregory G. Binford, February 6, 2003, which can be found at http://ftc.gov/bc/adops/030206dayton.htm.

[225] Youngblood Deposition at 13-14.

its eligible physicians every payor contract HTPN participated in. NTSP's eligible physicians could then either opt in or out. One of the contracts HTPN made available to NTSP was a United contract with HTPN.[226]

203. United and NTSP had contract discussions in 1998 which did not result in a direct contract.

204. [redacted][227]

205. As a result, NTSP did not act on United's direct proposal and its participating physicians treated United patients through HTPN.[228]

206. HTPN is an independent entity.[229] HTPN handles its own contract discussions with payors, including its contract discussions with United.[230]

207. In 2001, United submitted a competitive bid to replace risk contracts NTSP had to treat the City of Fort Worth's patients..[231]

208. Until 2001, the City of Fort Worth was insured through PacifiCare contracts. NTSP was a risk provider under those contracts.[232]

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[226] Youngblood Deposition at 24-25, 32, 112.

[227] *See* CX 87 [redacted].

[228] *See* RX 98 (fax alert regarding United offer and HTPN contract).

[229] Youngblood Deposition at 13-14.

[230] Youngblood Deposition at 49-51.

[231] [redacted]; RX 84..

[232] Mosley Deposition at 19-20; [redacted]; RX 84.

209. The City of Fort Worth sought bids from payors to become the administrator of its health plan. United and PacifiCare were two of the main competitors for that contract.

210. United intended to replace NTSP's risk contract with PacifiCare under which NTSP treated the City's employees with the 1997 contract United had with NTSP through HTPN.[233] [redacted][234] NTSP's termination affected approximately 100 of the approximately 600 physicians eligible to participate on NTSP's contracts.[235]

211. [redacted][237]

212. The approximately 100 physicians who had been contracted with United through HTPN initially gave NTSP powers of attorney to try to enter into a new contract with United. The powers of attorney allowed NTSP to

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[233] [redacted]; CX 1068 (letter from United to physicians); Van Wagner Deposition taken on August 29, 2002 at 141.

[234] Youngblood Deposition at 123-24.

[235]

[236]

[237] *See* RX 44 and RX 233 [redacted].

contract with United "in any lawful manner," which meant that NTSP was able to handle any non-risk offer by United to the physicians only in accordance with the messenger model requirement of the Participating Physicians Agreement.

213. NTSP discussed the possibility the possibility of a non-risk contract. United was not interested in a risk contract and never offered rates on a non-risk proposal which were at or above NTSP's Board minimums. NTSP was willing to do a contract with United at the minimums whereby it had the authority to activate its network, but United chose not to do so.[238] [redacted][239]

214. United broke off contract discussions with NTSP and entered into new non-risk contracts through a large Fort Worth IPA, All Saints Integrated Associates ("ASIA"). United also contracted with other medical groups and physicians, including a number of the 109 who had initially given NTSP a power of attorney.

215. [redacted][240] [redacted][241]

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[238] *See* CX 1034 (United correspondence regarding offer).

[239] RX 281; RX 283; RX 286 [redacted].

[240] Quirk Deposition at 108.

[241] *See* RX 282 [redacted].

216. Doctors were never prevented from dealing directly with United or through another IPA.[242] And the powers of attorney were never used.

217. United [redacted] does not need NTSP.[243]

218. Powers of attorney obtained by NTSP for physicians were subject to the messenger-model requirement of the Participating Physician Agreement, and could only be used "in any lawful way."[244] The powers of attorney were never delivered to United.

219. United was fined by the Texas Attorney General for prompt pay violations and failure to follow state clean claim law.[245]

220. Subsequent to the time United took over the City of Fort Worth contract, medical costs for the City skyrocketed by approximately ten million dollars over what they had been when the City was using NTSP's contracts.

K. Blue Cross

221. NTSP tried to negotiate risk contracts with Blue Cross, but the parties never agreed upon terms.[246]

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[242] *See* CX 1074 (fax alert telling members to contact ASIA or United directly for contracting opportunities).

[243] RX 306, 307, and 308 (TBME data for physicians by county); CX 1034 [redacted]

[244] CX 1051.039 (example power of attorney).

[245] CX 1051.054 (correspondence where United rejected NTSP's concern about United's non-compliance with state law).

[246] *See* RX 1421 (memo regarding BCBS risk proposal); CX 84 [redacted].

222. NTSP participating physicians had access to a Blue Cross contract through HTPN.[247] [redacted][248]

223. [redacted][249]

224. NTSP's participating physicians were never prevented from dealing directly with Blue Cross.[250]

225. Blue Cross has not complied with Texas laws regarding claims payments. It was fined $1.5 million and ordered to pay restitution to providers as a result of its failure to comply with the clean claim laws.[237]

226. NTSP is currently in discussions with Blue Cross regarding a risk contract.

L. Cigna

227. In connection with acquiring the Health Source operations and contracts, Cigna requested that Health Source assign the contracts to Cigna. [redacted][238]

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[247] [redacted]; RX 1275.

[248] *See* CX 85 [redacted].

[249] CX 709 [redacted].

[250] CX 705 (fax alert reporting Blue Cross direct contracts); [redacted].

[237] RX 3103.

[238] *See* CX 763 [redacted].

228. [redacted][239]

229. By March, 2000, Cigna was not paying the NTSP Physicians in accordance with the fee scheules attached to the March 28, 1999 letter agreement, as amended.[240]

230. On July 17, 2000 NTSP Board was formally advised of Cigna's failure to pay in accordance with the agreed upon fee schedules.[241]

231. Cigna made NTSP aware that specialists would not be allowed to participate in the Cigna contract.

232. NTSP complained to Cigna regarding its continued failure to pay in accordance wtih the agreed upon schedule and clasified same as a material breach.[242]

233. Cigna's problems with failing to pay in accordance with agreed fee schedules continues into December, 2000 and NTSP again requests a schedule of compliance.[243]

234. In April 2001, Cigna submitted to NTSP a risk proposal.

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[239] [redacted]. RX1898-01

[240] Emails to Cigna (CX0785-001).

[241] Minutes of North Texas Specialty Physicians Board of Directors Meeting RX0497_001 - 06

[242] Various emails (RX 1486-001 - 09)

[243] Varous emails (CX0792-003 - 007)

235. [redacted][244]

236. On August 10, 2001, NTSP and Cigna enter into a third amendment to October 28, 1999 letter agreement, wherein Cigna agreed to honor the contract by allowing PCP Physicians to opt into the agreement.

237. On August 13, 2001, NTSP submits amendment to current Cigna arrangement for rates on risk product and PPO Rates previously approved by the members.

238. [redacted][245]

239. NTSP contracted only at the same rates that other IPAs were given.[246]

240. Cigna engaged in numerous instances of payor malfeasance. [redacted][247] Cigna failed to pay physicians on the correct fee schedule per the contract.[248] [redacted][249] The

[244] [redacted] (CX0756-001)

[245] *See* CX 764 and 782 [redacted].

[246] CX 768 (NTSP offered 2000 rate same as for HTPN).

[247] CX 756 and 791 ([redacted].

[248] *See* RX 497.004 (Board minutes reporting problem).

[249] CX 782 and 775.002 (correspondence with Cigna).

Texas Office of the Attorney General also investigated Cigna's payment methodology.[250]

M. NTSP does not need to show but has shown justification

1. Justification is not necessary

241. NTSP does not engage in collective price negotiation. There is no collective price negotiation to justify.

242. NTSP follows a business model of being involved in payor offers which are likely to activate its existing network of physicians. That is a unilateral refusal to deal which is legal under the Colgate doctrine and needs no justification.

243. NTSP has numerous legal reasons to refuse to be involved with a payor offer, including avoiding illegal or legally risky contracts and refusing to abdicate legal rights of NTSP, the physicians, or their patients. Such reasons are legal decisions which need not be economically justified.

244. NTSP has created a network of physicians who have been organized to work cooperatively with each other. Absent a showing of monopoly power (which Complaint Counsel has not made), NTSP has no legal obligation to make available its network to free riders or anyone else, and hence need not justify economically such a refusal.

245. NTSP's activities as a class representative are Constitutionally-protected and hence need not be economically justified.

246. NTSP's activities in enforcing contracts, preventing legal violations by others, and advising patients and their employers of matters having to do

[250] *See* CX 108.002-.003 [redacted].

with healthcare issues is Constitutionally and legally-protected conduct and need not be economically justified.

2. NTSP's spillover model is economically-justified

247. NTSP's spillover model is a credibly-designed effort to achieve and transfer efficiency and quality improvements from NTSP's risk contract medical care to its non-risk medical care.

248. NTSP has established superior performance in providing medical care.

(1) [redacted][251]

(2) [redacted][252]

(3) [redacted][253]

(4) [redacted][254]

(5) [redacted][255]

[251] RX 3176.

[252] RX 3288.

[253] RX 3174

[254] RX 3280.

[255] RX 3280.

(6) [redacted][256]

(7) [redacted][257]

(8) [redacted][258]

(9) [redacted][259]

(10) [redacted][260]

(11) [redacted][261]

(12) [redacted][262]

[256] RX 3177 and RX 3287.

[257] RX 3139.

[258] RX 3162.

[259] RX 3162.

[260] RX 3162.

[261] RX 3167.

[262] RX 3134 and 3173.

(13) [redacted][263]

(14) [redacted]

II. Conclusions of Law and Analysis

A. Jurisdiction

1. Interstate Commerce

1. Complaint counsel must show that NTSP's actions affect interstate commerce. 15 U.S.C. § 45. To satisfy this jurisdictional requirement, Complaint Counsel must show that the actual conduct of NTSP at issue affected interstate commerce or that NTSP operates in interstate commerce. *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 242 (1980). Further, this effect must be considered in proportion to NTSP's business as a whole. *Musick v. Burke*, 913 F.2d 1390, 1395 (9th Cir. 1990).

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[263] RX 3183.

[264] RX 3130 [redacted].

[265] Maness report ¶ 95.

[266] Maness affidavit ¶ 7 and Attachment 1.

2. Complaint Counsel concedes that NTSP does not operate in interstate commerce and can provide no evidence of such allegations.

3. To meet the effect on commerce theory, a specific aspect of interstate commerce must be identified and it must be proven that NTSP's actions had a substantial effect on that aspect of commerce. *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 242 (1980); *Estate Constr. Co. v. Miller & Smith Holding Co.*, 14 F.3d 213, 221 (4th Cir. 1994). Complaint Counsel must show a factual nexus between the alleged restraint and the effect on commerce, and the effect on commerce must either be shown to actually exist or be present as a matter of practical economics. *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 331 (1991).

4. Complaint Counsel's allegations regarding NTSP's connection with interstate commerce concern NTSP's dealings with payors, and indirectly employers, outside of the state of Texas. But there is no effect on commerce by direct proof or practical economics as a result of those activities because Complaint Counsel's allegations concern contact with independently-operated Texas offices of payors and a few instances of contract with isolated out of state vendors. Considering that NTSP has only one office, located in Texas, that NTSP deals only with insurers located in Texas, that none of the conduct at issue took place outside of Texas, and that Complaint Counsel cannot point to one example of a specific or even possible effect on interstate commerce, jurisdiction over NTSP cannot be shown.

2. Corporation for Profit

5. Complaint Counsel must prove that NTSP is an association acting for the pecuniary interest of its participating physicians. 15 U.S.C. § 45. NTSP is a memberless, nonprofit corporation, however, and makes no money from the non-risk contracts entered into by its participating physicians – the contracts at issue in this case. TEX. REV. CIV. STAT. ANN. Art. 1396-1.02(A)(6). Therefore, the FTC does not have jurisdiction over NTSP under the FTC Act.

6. Furthermore, even if NTSP was considered to be organized to act for the profit of its members, this case concerns only NTSP's refusals to act. Such refusals to act do not constitute "acting" for the pecuniary interest of NTSP's participating physicians and, therefore, jurisdiction cannot be proven.

B. Burden of Proof

7. An initial decision must be supported by "reliable, probative, and substantive evidence." Commission Rule 3.51(c); 16 C.F.R. § 3.51(c)(1). "Substantial evidence is more than a mere scintilla. It means such evidence as a reasonable mind would accept as adequate to support a conclusion. It must be of such character as to afford a substantial basis of fact from which the fact in issue can be reasonably inferred. It excludes vague, uncertain, or irrelevant matter. It implies a quality and character of proof which induces conviction and makes a lasting impression on reason." *Carlay Co. v. FTC*, 153 F.2d 493, 496 (7th Cir. 1946).

8. "[T]he antitrust plaintiff must present evidence sufficient to carry its burden of proving that there was [an anticompetitive] agreement."

Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 763 (1984). The government bears the burden of establishing a violation of antitrust law. *United States v. E.I. duPont de Nemours & Co.*, 366 U.S. 316, 334 (1961).

C. Relevant Geographic and Product Market

9. The determination of the relevant market is essential to Complaint Counsel's case. Establishing the relevant market is the starting point in a rule of reason case. *California Dental Ass'n v. FTC*, 224 F.3d 942, 952 (9th Cir. 2000) (proof of relevant geographic and product market necessary for proving injury to competition in rule of reason case).

10. The plaintiff bears the burden of proof of defining the relevant market. *Jayco Sys., Inc. v. Savin Bus. Machs. Corp.*, 777 F.2d 306, 319 (5th Cir. 1985) ("[A] showing of relevant market is also necessary to assess anticompetitive effects in rule of reason analysis under § 1."); *Hornsby Oil Co. v. Champion Spark Plug Co.*, 714 F.2d 1384, 1392 (5th Cir. 1983) ("Proof that the defendant's activities, on balance, adversely affected competition in the appropriate product and geographic markets is essential to recovery under the rule of reason."); *Brokerage Concepts v. US Healthcare, Inc.*, 140 F.3d 494, 513 (3d Cir. 1998) ("The burden is on the plaintiff to determine both components [geographic and product] of the relevant market.").

11. As discussed in Section D, *infra*, a rule of reason analysis is required in this case.

12. Complaint Counsel has not even attempted to prove a relevant market in this case. The following has been determined regarding the relevant market:

1. Product Market

13. In defining a relevant product market, courts look to determine if products are "reasonably interchangeable." Courts consistently look to reasonable interchangeability as the primary indicator of a product market. *See United States v. Continental Can Co.*, 378 U.S. 441, 453-57 (1964).

14. Another relevant product market inquiry is whether certain products are sufficiently substitutable that they could constrain each others prices. *See, e.g., Int'l Assoc. of Conference Interpreters*, 123 F.T.C. 465, 640 (1997) (Section 2 case) (the Commission generally examines what products are reasonable substitutes for one another through a consideration of price, use, and qualities).

15. Relevant product markets in this case include a primary care physician market and a number of specialty area markets. One medical specialty is not necessarily a good substitute for another. And an increase in prices by one specialty may not cause patients to switch to another specialty.

2. Geographic Market

16. The relevant geographic market is the region "in which the seller operates, and to which the purchaser can practicably turn for supplies." *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961).

17. NTSP has participating physicians in eight counties in and around the Dallas-Fort Worth metropolitan area. Other physicians within this

metropolitan area are also viable substitutes for NTSP physicians. NTSP physicians draw patients from a wide area, and it is easy for patients to switch physicians within Dallas and other close counties.

18. Therefore, any relevant geographic market is at least as large as the Dallas-Fort Worth metropolitan area. Further, any relevant geographic market including Tarrant County must also include Dallas and other counties.

D. Violations of the Complaint

1. The Legal Framework for Analysis of Horizontal Restraints

19. The FTC Act's prohibition of "unfair methods of competition" encompasses violations of other antitrust laws, including Section 1 of the Sherman Act, which prohibits agreements in restraint of trade. *California Dental Ass'n v. FTC*, 526 U.S. 756, 763 n.3 (1999). The Commission relies on Sherman Act law in adjudicating cases alleging unfair competition. *See Id.*

20. Restraints of trade can be considered under three separate theories: (1) *per se*, (2) rule of reason, or (3) truncated or "quick look" rule of reason. *California Dental Ass'n v. FTC*, 526 U.S. 756, 763 (1999); *Viazis v. Am. Ass'n of Orthodontists*, 314 F.3d 758, 765 (5th Cir. 2002).

2. The Per Se Approach Is Not Applicable

21. "[M]ost antitrust cases are analyzed under a 'rule of reason'... ." *State Oil Co. v. Kahn*, 522 U.S. 3, 10 (1997) (citations omitted). Courts are free to depart from this analysis only in limited circumstances, after they have had sufficient experience with a particular type of restraint to know that it is manifestly anticompetitive. *Broadcast Music, Inc. v. Columbia Broad.*

Sys., Inc., 441 U.S. 1, 9 (1979); *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 50 (1977) (the per se rule should only apply to conduct that has a "pernicious effect on competition" and "lack[s] ... any redeeming virtue"). *California Dental* advocates "considerable inquiry into market conditions" before "application of any so-called '*per se*' condemnation is justified." *See id.*

22. A rule of reason analysis should be applied if the conduct at issue "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition." *California Dental Ass'n v. FTC*, 526 U.S. 756, 771 (1999). Where "any anticompetitive effects of given restraints are far from intuitively obvious, the rule of reason demands a more thorough enquiry." *Id.* at 759.

23. Under *California Dental*, there is no doubt NTSP's conduct "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition," for which reason a full rule of reason analysis must be used.

3. The Quick Look Approach is Not Applicable

24. An abbreviated or "quick look" analysis under the rule of reason may only be utilized when "the great likelihood of anticompetitive effects can easily be ascertained." *California Dental Ass'n v. FTC*, 526 U.S. 756, 770 (1999). Where anticompetitive effects are not "intuitively obvious," an abbreviated rule of reason analysis is inappropriate. *Id.* at 759.

25. The case presented by Complaint Counsel fails to present a situation in which the likelihood of anticompetitive effects is obvious. Given the

plausibility of competing claims about the effects of NTSP's conduct, the obvious anticompetitive effect that triggers abbreviated analysis has not been shown. *California Dental Ass'n v. FTC*, 526 U.S. 756, 778 (1999).

4. Under the Rule of Reason, Complaint Counsel Has Not Demonstrated That the Challenged Conduct Is Illegal.

a. Complaint Counsel has not proven a relevant market.

26. To prevail in a rule of reason case, Complaint Counsel "must define the market and prove that [NTSP] had sufficient market power to adversely effect competition." *Hornsby Oil Co. v. Champion Spark Plug Co.*, 714 F.2d 1384, 1392 (5th Cir. 1983).

27. Complaint Counsel has not proven a relevant market in this case. Complaint Counsel's expert report did not posit a relevant market. Further, Complaint Counsel's expert did not calculate any concentration ratios, did not perform zip code analysis, and did not perform any type of entry analysis. Therefore, liability against NTSP under a rule of reason analysis fails.

b. Complaint Counsel has not proven a net anticompetitive effect on competition.

28. In a rule of reason case, Complaint Counsel must prove that the challenged conduct had the effect of injuring competition. "The Supreme Court has made clear that the rule of reason contemplates a flexible enquiry, examining a challenged restraint in the detail necessary to understand its competitive effect." *In re California Dental Ass'n*, 121 F.T.C. 190, 308 (1996). "An analysis of the reasonableness of particular restraints includes

consideration of the facts peculiar to the business in which the restraint is applied, the nature of the restraint and its effects, and the history of the restraint and the reasons for its adoption." *United States v. Topco Assoc., Inc.*, 405 U.S. 596, 607 (1972).

29. The fact that a case proceeds under Section 5 of the FTC Act does not alter the requirement that anticompetitive effects must be proved with evidence. *See California Dental Assoc. v. FTC*, 224 F.3d 942, 958-59 (9th Cir. 2000) (FTC's failure to demonstrate substantial evidence of a net anticompetitive effect resulted in remand with direction that the FTC dismiss its case).

30. The burden is on the complaining party to demonstrate that the challenged conduct has a net anticompetitive effect. *Viazis v. Am. Ass'n of Orthodontists*, 314 F.3d 758, 766 (5th Cir. 2002).

31. Complaint Counsel has not shown a net anticompetitive effect. Its conjecture of anticompetitive effects does not outweigh the procompetitive effects and efficiencies of NTSP's conduct. Further, Complaint Counsel has not demonstrated that a "great likelihood of anticompetitive effects" from NTSP's conduct "can easily be ascertained." Therefore, the burden has not shifted to NTSP to come forward with plausible procompetitive justifications. *California Dental Ass'n v. FTC*, 526 U.S. 756, 770 (1999).

32. Although not necessary, NTSP has shown justifications for its conduct based on its efficiency-directed "spillover" business plan and NTSP's legal reasons for refusing to be involved in payor's offers.

c. Complaint Counsel has not proven collusion among NTSP and its participating physicians.

33. Regardless of the method of analysis employed, Complaint Counsel must prove some form of collusion or concerted action to establish an antitrust violation. "Section 1 of the Sherman Act [like Section 5 of the FTC Act] does not proscribe independent conduct." *Viazis v. Am. Ass'n of Orthodontists*, 314 F.3d 758, 761 (5th Cir. 2002); *see also In re Baby Food Antitrust Litig.*, 166 F.3d 112, 117 (3d Cir. 1999).

34. To prove there was "concerted action" or collusion, Complaint Counsel must submit either direct or circumstantial evidence of an agreement between competitors. *In re Baby Food Antitrust Litig.* 166 F.3d 112, 117 (3d Cir. 1999). Complaint Counsel concedes there is no direct evidence of conspiracy.

35. Circumstantial evidence of conduct that is as consistent with lawful competition as with conspiracy will not support an inference of collusion. *Matsushita v. Elec. Indus. Co., Ltd.*, 475 U.S. 574, 588 (1986). Evidence must be presented that "tends to exclude the possibility that the alleged conspirators acted independently." *Id.* (citations omitted).

36. The evidence does not tend to exclude the possibility that physicians acted independently, and therefore, there is no evidence to support collusion. The evidence shows that physicians do not rely on NTSP's poll results to make rate decisions, that physicians make independent decisions whether to accept offers individually, and that physicians accept offers below threshold rates established by NTSP's board. Further, NTSP has no authority to accept non-risk contracts on behalf of physicians.

37. The evidence is consistent with lawful competition because the collection and dissemination of market information, including market prices, can potentially benefit competition. *See* FTC Staff Advisory Opinion Letter, dated November 3, 2003, from Jeffrey W. Brennan to Gerald Niederman regarding Medical Group Management Association.

38. The evidence is also consistent with lawful competition because NTSP's refusals to deal are proper under the *Colgate* doctrine. *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919) (cited by *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 761 (1984) for the proposition that "[a] manufacturer of course generally has a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently").

39. NTSP's conduct in exercising its *Colgate* right to refuse to deal need not be economically justified because that is a legal right.

40. NTSP's conduct in refusing to deal based on its legal concerns about possible liability need not be economically justified because that is a legal right.

41. NTSP's conduct in refusing to make available its network need not be economically justified because that is a legal right. NTSP has created a network of physicians who have been organized to work cooperatively with each other. Absent a showing of monopoly power (which Complaint Counsel has not made), NTSP has no legal obligation to make available its network to free riders or anyone else. *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 124 S. Ct. 872, 880-81 (2004).

42. NTSP's conduct in representing physicians in their legal disputes as a class representative need not be economically justified because that is a legal right and Constitutionally-protected.

43. NTSP's conduct in enforcing contracts, preventing legal violations by others, and advising patients and employers of matters having to do with healthcare issues is Constitutionally and legally-protected conduct and need not be economically justified. FTC Advisory Opinion regarding Primed Physicians, letter from J. Brennan to G. Binford, February 6, 2003 (stating that providing "accurate information and expressions of opinions on matters of public interest" by physicians collectively usually does not raise antitrust concerns. CX 540.005 (contract with Aetna giving physicians right to advocate for, provide information to, and otherwise advise patients on issues that affect healthcare); *see Video Int'l Prod, Inc. v. Warner-Amex Cable Communications*, 858 F.2d 1075, 1082-83 (5th Cir. 1988 (explaining Noerr-Pennington antitrust immunity for interactions with government); *Delta Marina, Inc. v. Plaquemine Oil Sales, Inc.*, 644 F.2d. 455, 458 (5th Cir. 1981) (finding a contract enforceable despite allegations of antitrust violations).

44. NTSP's spillover model is a credibly-designed and adequately-demonstrated effort to achieve and transfer efficiency and quality improvements from NTSP's risk contract medical care to its non-risk medical care, and justifies the type of conduct which Complaint Counsel has shown by its proof.

45. Such other points as may appear to be applicable following the hearing.

Respectfully submitted,

_____

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CERTIFICATE OF SERVICE

I, Gregory D. Binns, hereby certify that on April 22, 2004, I caused a copy of the foregoing to be served upon the following persons:

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