

**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**

Proposed Findings of Fact

Respondent

1. NTSP is a 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. (Complaint, ¶ 1; Answer, ¶ 1; RX 1674 (NTSP fact sheet)).
2. NTSP was 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. (Van Wagner, Tr. 1489-90; RX 1674; RX 1676).
3. NTSP is a memberless organization. (Van Wagner, Tr. 1490; RX 1675; RX 1676 (NTSP articles of incorporation)).
4. NTSP was founded in the 1990s to allow a group of specialist physicians to accept economic risk on medical contracts and participate in the medical decision-making process. It has since broadened its activities to include primary care physicians and, as a secondary activity, entering into and messengering non-risk contracts. (Vance, Tr. 587-88; Wilensky, Tr. 2158-59).
5. In the past five years, NTSP has had capitation or other risk contract arrangements with Amcare, Cigna, and PacifiCare. (Van Wagner, Tr. 1758-59, 1761; Lovelady, Tr. 2665, 2668; CX 1195 (Van Wagner, Dep. at 15); CX 1196 (Van Wagner, Dep. at 14)).
6. NTSP's Board of Directors is made up of eight physicians, all with active practices. Under Texas law, NTSP's Directors must be physicians who are actively engaged in the practice of medicine. The Board meets once a week.

(Van Wagner, Tr. 1493-94; TEX. OCC. CODE ANN. § 162.001 (Vernon 2004)).

7. NTSP has a salaried, core administrative staff of eight people, including executive director Karen Van Wagner, provider relations staff, PSN development and contracting staff, data processing staff, credentialing staff, and clerical support staff. (Van Wagner, Tr. 1494-95; RX 1674).
8. In addition to the salaried staff, NTSP has a utilization management staff contracted through Gordian Medical Management, a claims payment resource, and data processors. (Van Wagner, Tr. 1494; RX 1759 (Gordian Medical Management Report)).
9. In 2003, NTSP had approximately 575 “participating physicians,” who had signed NTSP’s non-exclusive Physician Participation Agreement. (CX 311 (physician participation agreement); RX 3118 (Maness Report ¶¶ 4, 19)). Today, there are approximately 480 participating physicians. (Van Wagner, Tr. 1510, 1518).
10. In 2003, there were approximately 575 participating physicians practicing in 26 different specialties. (RX 3118 (Maness Report ¶ 4)).
11. NTSP structures its participating physicians by division. There is a division for each specialty in which NTSP’s participating physicians practice. (Van Wagner, Tr. 1509-10).
12. NTSP has a selection process for participating physicians. Interested physicians apply by writing a letter to the Board. An application is referred to the NTSP division in which the physician has a specialty interest, and the physicians within that division make a recommendation to the Board. NTSP’s Board invites only physicians who are high-quality as estimated by their peers within NTSP and who also understand NTSP’s risk management goals. (Van Wagner, Tr. 1508-11).

13. NTSP is selective in inviting new physicians who are not part of an existing group to participate in NTSP. Physicians must be willing and able to work in a managed care environments and must be interested in issues of measuring quality, receiving feedback and peer review, and improving their practice. (Deas, Tr. 2527). NTSP regularly turns down physicians' applications to participate in NTSP. (Van Wagner, Tr. 1512).
14. NTSP's participating physicians can be deparicipated for quality or utilization problems. (Van Wagner, Tr. 1574). Physicians have voluntarily left NTSP or have had their patient panel limited because of utilization problems. (Van Wagner, Tr. 1973-74; Deas, Tr. 2449-52).

Respondent's Business Model

Risk Contracting and Medical Management

15. NTSP is involved in both risk contracts and non-risk contracts. (Complaint ¶ 14; Answer ¶ 14).
16. Risk contracting includes contracts where physicians or a physician group is paid a set dollar amount every month for each of its customers through a payor. The physician or physician group assumes all medical risk in treating those individuals. (Quirk, Tr. 255; Mosley, Tr. 206).
17. Risk contracts can also include contracts containing withholds, bonuses, and other pay-for-performance provisions. (Mosley, Tr. 132-33; Frech, Tr. 1398-99; Van Wagner, Tr. 1605-06, 1608-11; Lovelady, Tr. 2641-43).
18. NTSP is currently the only multi-specialty entity in the Metroplex taking risk contracts. (Van Wagner, Tr. 1575-76; Casalino, Tr. 2891).
19. NTSP has been the only entity successful at taking risk because its participating

physicians are committed to making the medical management model work. (Van Wagner, Tr. 1575-76).

20. NTSP refers to its panel of risk contracting physicians as the “PSN” (provider service network) or the “risk panel.” (Van Wagner, Tr. 1495).
21. In 2003, NTSP had approximately 300 physicians in its risk panel and approximately 275 additional physicians who participated in one or more non-risk contracts. (CX 1197 (Van Wagner, Dep. at 225, 227-28)). Today, there are approximately 300 physicians in the risk panel and approximately 180 additional physicians. (Van Wagner, Tr. 1510, 1518).
22. NTSP receives most of its operating budget from risk contract revenues. NTSP is paid a PM/PM (per member per month) amount each month for each patient on the risk contract. NTSP receives income based on savings that its business model accrues on patient care, allowing the cost of care to remain below the PM/PM amount received. (Frech, Tr. 1448; Van Wagner, Tr. 1549-51).
23. An IPA can improve quality by performing medical management and utilization review. (Casalino, Tr. 1789-90, 2894-98). NTSP’s business model is effective and beneficial to health care and should be encouraged. (Wilensky, Tr. 2204-05, 2161-62; Deas, Tr. 2452-53).
24. NTSP’s business model is designed to and does achieve efficiencies and quality improvements by using clinical integration techniques on its risk contracts. (Vance, Tr. 587-88; CX 1198 (Vance, Dep. at 117-18); CX 1199 (Vance, Dep. at 287-88)).
25. NTSP’s business model reduces overall medical costs on risk contracts through development and implementation of a comprehensive medical management

process involving all segments of the continuum of care, including facilities and pharmacy. (Frech, Tr. 1407-08; Wilensky, Tr. 2173-79; Deas, Tr. 2453-54, 2490; Lovelady, Tr. 2661-62).

26. The NTSP business model and risk contracts motivate participating physicians to become concerned about utilization and control total medical expense, including facility and pharmacy costs. (Wilensky, Tr. 2176-81).
27. As a result of its risk business, NTSP has developed a relatively high level of clinical and financial integration. (Casalino, Tr. 2877). Clinical integration is one of NTSP's primary goals. (CX 1196 (Van Wagner, Dep. at 19)).
28. NTSP promotes its business model and the use of risk contracts to payors, citing its efficiencies, quality improvements, and the reduction of overall medical cost. (Van Wagner, Tr. 1594-95; Deas, Tr. 2454-56; CX 616; CX 1117).
29. NTSP performs better under risk contracts than other physicians and physician groups, both in terms of cost and quality. (Maness, Tr. 2071, 2073-74).
30. PacifiCare considers NTSP its top performer in the Metroplex. (Lovelady, Tr. 2665, 2668).
31. PacifiCare tracks physician groups on a number of different criteria, including various measures of clinical quality, service quality, and hospital utilization. (Van Wagner, Tr. 1612, 1614-18; Lovelady, Tr. 2664; RX 3118 (Maness Report ¶ 88); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
32. For clinical quality, which generally measures things such as the frequency of cancer screening, immunizations, and percentage of avoidable hospitalizations, NTSP meets or exceeds the whole PacifiCare network in most categories. (Van Wagner, Tr. 1612, 1614-18; RX 3118 (Maness Report ¶ 88); RX 1719; RX 1846;

- RX 3153; RX 3154; RX 3223).
33. For service quality, NTSP has lower levels of access-related complaints per member per year than other PacifiCare physicians. (RX 3118 (Maness Report ¶ 89); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
 34. For hospital utilization, NTSP has average or lower than average hospitalization rates than other PacifiCare physicians. (Van Wagner, Tr. 1612, 1614-18; Lovelady, Tr. 2664; RX 3118 (Maness Report ¶ 88); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
 35. Under the PacifiCare risk contract, NTSP physicians had a lower number of procedures per unique patient and a lower amount paid per unique patient than non-NTSP physicians for each of the last three years in both the commercial and Medicare products. (Van Wagner, Tr. 1787-88; Maness, Tr. 2071-73; RX 3118 (Maness Report ¶ 88); RX 1707; RX 3129).
 36. NTSP's per member per month expense in 2003 under the PacifiCare Medicare risk contract was much lower than the national average. (RX 3139).
 37. NTSP's per member per month expense under its PacifiCare risk contracts has shown less significant increases since the year 2000 than the same expense for other payors and physician groups. (Van Wagner, Tr. 1794-96; RX 3162; RX 3167; RX 3177; RX 3178).
 38. NTSP's per member per month expense under its PacifiCare risk contracts is lower in medical cost, pharmacy cost, and total cost than most other major Texas payors and national averages. (Van Wagner, Tr. 1789-90; RX 3176, *in camera*).
 39. NTSP's commercial HMO population is more intense (i.e., more expensive to treat) than the national average population because NTSP does not provide

pediatric services. Children over the age of two are a good risk because they are generally healthy. (Van Wagner, Tr. 1977-78).

40. When comparing NTSP to another group or a national average, any population adjustment for the types of patients treated would be in NTSP's favor because NTSP's population is higher cost than the average population. (Van Wagner, Tr. 1977-78).
41. NTSP has higher patient satisfaction ratings for specialists than other plans operating in the Metroplex. (Van Wagner, Tr. 1612, 1614-16; RX 3118 (Maness Report ¶ 98); RX 1734). NTSP conducts its own patient surveys. (Van Wagner, Tr. 1541-43, 1803-04; Deas, Tr. 2508; RX 3274; RX 3275; RX 3276). In recent patient surveys, the quality of care of NTSP's doctors and specialists was rated higher than United, Aetna, Cigna, and PacifiCare's non-NTSP networks. (RX 3182, RX 3183).
42. A large portion of NTSP's budget is dedicated to medical management programs used on risk contracts. (Van Wagner, Tr. 1538; Casalino, Tr. 2904-05; CX 1196 (Van Wagner, Dep. at 13-14, 18-19)).
43. NTSP has a medical management committee that supervises implementation of quality improvement strategies and medical management functions for risk contracts. (Vance, Tr. 593; Van Wagner, Tr. 1565).
44. NTSP's medical management committee meets regularly. During those meetings, the committee reviews risk contract information on monthly utilization, referrals, medical review, out of network use, coding compliance, and case management reports. Goals are set annually on a utilization plan and on policies, procedures, and utilization criteria. (Van Wagner, Tr. 1564-66; Deas, Tr. 2438-40, 2443-45;

CX 1198 (Vance, Dep. at 117-18); CX 1199 (Vance, Dep. at 287-88)).

45. NTSP also has three medical directors, who are used to interface with divisions and physicians within NTSP on medical management issues in risk contracts. (Van Wagner, Tr. 1496; Deas, Tr. 2436-37). The medical directors implement the policy changes or interventions decided on by the medical management committee. (Van Wagner, Tr. 1566-67; Deas, Tr. 2436-37).
46. Gordian is a company that provides medical management and utilization management services to NTSP on its risk contracts. Among its duties are performing data runs, overseeing inpatient care, authorizing services, and providing expertise on how to improve utilization. (Van Wagner, Tr. 1520-21, 1528, 1536-37; Deas, Tr. 2440-41; RX 1580; RX 1759 (Gordian medical management report)).
47. NTSP monitors physician performance in its risk contracts using clinical indicators and identifies practice pattern outliers – under-performing physicians – and provides appropriate intervention (Van Wagner, Tr. 1502-03; Deas, Tr. 2443-46; RX 3118 (Maness Report ¶ 87); CX 1170 (Blue, Dep. at 16-17); CX 1177 (Grant, Dep. at 111-12)).
48. Identifying and counseling outliers can reduce total medical expense by changing a physician's behavior to be more consistent with proper utilization and quality of care. (Frech, Tr. 1421-22; Van Wagner, Tr. 1505-06; Wilensky, Tr. 2182; Deas, Tr. 2452; Casalino, Tr. 2891).
49. NTSP's monitoring of physician practice patterns can improve quality by preventing underutilization or overutilization and by promoting better usage of resources. (Casalino, Tr. 2894-98).

50. As part of monitoring physician performance, NTSP regularly conducts division-specific, physician-specific, and diagnostic-specific practice pattern analyses and outcome assessments to ascertain the parameters of care being delivered within the risk network and to improve the delivery of that care. Examples include analyses on appropriateness of testing analysis, performance on HEDIS measures, complications in procedures, unnecessary hospitalization, and appropriate use of pharmaceuticals. (Deas, Tr. 2444-45).
51. When monitoring physician performance in risk contracts, NTSP also considers referrals related to facilities and pharmaceuticals, which are other components of total medical expense. (Deas, Tr. 2453-54).
52. As part of monitoring primary care physician performance, NTSP has developed reports for primary care physicians on topics including breast cancer screening and beta-blocker treatment after a heart attack. (Wilensky, Tr. 2163-65, 2167-68; Deas, Tr. 2447-48; Lonergan, Tr. 2722-23).
53. Individual physician counseling deemed necessary by the medical management committee is conducted by physicians. (Van Wagner, Tr. 1502-03). Having physicians counseled by other physicians is the most effective way to solve outlier problems. (Van Wagner, Tr. 1506-07).
54. Physician counseling involves providing physicians with practice pattern information, including a comparison of that individual's performance to the performance of other physicians. (Deas, Tr. 2445-48).
55. Physician counseling is generally provided orally, rather than in writing, due to concerns of confidentiality and medical malpractice litigation. (Deas, Tr. 2448-49).

56. NTSP develops, distributes, and promotes practice guidelines and clinical protocols to its participating physicians. (Deas, Tr. 2503-06; Casalino, Tr. 2925; RX 3118 (Maness Report ¶ 87)).
57. NTSP has developed over one hundred protocols. (Van Wagner, Tr. 1543).
58. Physicians are organized into specialty divisions to develop clinical protocols, monitor their implementation, and intervene when deviations from evidence-based medicine practice patterns are detected. (Deas, Tr. 2494-95; RX 1590 (NTSP protocol development manual)).
59. Primary care physicians are consulted when NTSP is developing guidelines and protocols. Feedback and interplay between specialists and primary care physicians is important to developing effective guidelines and protocols. (Deas, Tr. 2530-32).
60. There are national practice guidelines and clinical protocols available. NTSP takes a role in examining those thousands of guidelines and protocols to determine which ones should be adopted. Other times, NTSP will adapt national guidelines into its own guidelines. Sometimes NTSP will create guidelines itself. In addition, NTSP's divisions create quality indicators to assist in monitoring compliance with guidelines and protocols. (Deas, Tr. 2503-07).
61. NTSP provides physicians with access to the best and most used practice guidelines and clinical protocols on its website. (Van Wagner, Tr. 1539-40).
62. NTSP recommends, but does not require, that doctors follow protocols because of the individualized nature of treating patients and because of potential medical malpractice liabilities issues. (Van Wagner, Tr. 1972-73).
63. NTSP's participating physicians receive the practice guidelines and clinical

protocols recommended by NTSP and often use those guidelines and protocols in their practice. (Loneragan, Tr. 2721-22).

64. NTSP performs analyses to identify and assist high-acuity patients in its risk contracts. NTSP then implements a case management system to monitor care of high-risk patients with complex medical conditions to have these patients treated at the appropriate level of care, and, under appropriate specialty guidance, to improve quality and reduce overall costs. (Van Wagner, Tr. 1567).
65. NTSP is involved in monitoring pain management, immunoglobulin patients, palliative care, and certain pharmaceuticals in risk contracts. (Van Wagner, Tr. 1568-72).
66. NTSP participates in disease management programs developed internally and by payors. (Van Wagner, Tr. 1567-68). Disease management program are those where an organization identifies individuals with a specific disease and then has certain protocols in place to give extra attention to those individuals to facilitate a more favorable outcome. (Quirk, Tr. 266).
67. NTSP's participating physicians have referred approximately 600 patients of risk contracts to disease management programs this year. (Van Wagner, Tr. 1567-68).
68. NTSP has a website that enhances patient education and professional communication. The website is segmented between patients and providers. (Van Wagner, Tr. 1539; Deas, Tr. 2501).
69. For patients, NTSP provides, among other things, links to appropriate patient education sites, information on what medical resources are available in the area, a "find a doctor" feature, and quality rankings for health plans. (Van Wagner, Tr. 1539-41).

70. For physicians, NTSP provides on its website, among other things, access to the best and most used practice guidelines and clinical protocols as well as links to association materials dealing with the delivery of care. (Van Wagner, Tr. 1539-41).
71. NTSP creates registries to identify patients who have certain problems or conditions, such as diabetes, to facilitate monitoring quality indicators in risk contracts. (Deas, Tr. 2516-17).
72. NTSP creates reminders in conjunction with the risk contract registries to remind a primary care physician that, for patients with certain conditions, the standard of care requires monitoring or a certain service to be rendered. (Deas, Tr. 2518-19).
73. NTSP collects and analyzes detailed medical data from its risk contract payors. (RX 3118 (Maness Report ¶¶ 87, 94), *in camera*). Those payors provide a “flat file” of information on every claim a patient receives, including physician, hospital, and pharmacy claims. (Van Wagner, Tr. 1525-26, 1612).
74. NTSP’s information system used to track risk patient data is a good tool. (Casalino, Tr. 2805-06).
75. NTSP, in conjunction with Gordian, uses risk contract claims files to screen for variables to identify individuals who require case management. Some reports, such as pharmacy data or emergency room visits, are run on a regular basis to identify trends and take appropriate action. (Van Wagner, Tr. 1528-30; Deas, Tr. 2443-45; RX 1759).
76. NTSP uses risk contract data to run reports and identify practice patterns of individual physicians. Reports run include monthly profiles on referral patterns, cost patterns, top utilizers, coding practices, and bundling practices. (Van

- Wagner, Tr. 1530-32, 1789-90).
77. Payors have asked NTSP to assist in interpreting and utilizing data. (Van Wagner, Tr. 1534-35).
 78. NTSP has a quality management committee that deals with risk contract patient issues on a case-by-case clinical basis when necessary. (Van Wagner, Tr. 1574-75).
 79. An organization like NTSP has the potential to develop significant levels of organizational capital beyond the ability to generate contracting cost savings. Organizational capital is the idiosyncratic knowledge that NTSP develops, including the ability and experience NTSP's participating physicians have in working together to provide high quality and cost-effective medical care, that requires effort for others to replicate. (Frech, Tr. 1406-07; Maness, Tr. 2064, 2069; RX 3118 (Maness Report ¶ 84)).
 80. NTSP takes steps to share the information it learns with all of its participating physicians. (Van Wagner, Tr. 1580-81; Deas, Tr. 2458-59, 2522-23; Lonergan, Tr. 2722-23).
 81. NTSP's organizational capital benefits patients because physicians know each other and know the patients. NTSP's network of participating physicians operate as a "team." These relationships and daily interactions lead to medical care rapport and better patient care in terms of cost and quality due to information sharing. (Frech, Tr. 1406-07; Van Wagner, Tr. 1572; Maness, Tr. 2064; Wilensky, Tr. 2191-92; Deas, Tr. 2469-70, 2530-32; Lovelady, Tr. 2685-86; Lonergan, Tr. 2720).
 82. NTSP's organizational capital benefits payors because NTSP has coordinated

financial and clinical decision-making in its risk contracting business, which by its nature demands a high degree of coordination among physicians. This high degree of coordination insures that physicians have a mutual incentive to keep costs low consistent with a high quality of care since any cost savings benefit patients, physicians, and payors. (Van Wagner, Tr. 1580; RX 3118 (Maness Report ¶ 85)).

83. NTSP's high-performing team generates a sense of peer morale and a resulting peer pressure that is powerful and can bring about changes in physician behavior. (Van Wagner, Tr. 1580-81; Wilensky, Tr. 2193-94; Deas, Tr. 2497-98; Lovelady, Tr. 2685-86).
84. Physicians are not a commodity because doctors differ in many ways, including their medical talents and ability to work well as a team. (Wilensky, Tr. 2188-90).

Spillover

85. NTSP's business model is designed to achieve efficiencies and quality improvements by using clinical integration techniques 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. (CX 1198 (Vance, Dep. at 117-18); CX 1199 (Vance, Dep. at 287-88)).
86. The benefits of the clinical integration and medical management techniques NTSP develops for its risk contracts and uses to manage its risk business and to provide its risk patients with high quality and cost effective medical care spill over into NTSP's non-risk business. This "spillover" increases the quality and efficiency of NTSP's participating physicians' non-risk medical care. (Frech, Tr. 1348, 1415, 1441-42; Maness, Tr. 2069, 2082; Wilensky, Tr. 2162-66; RX 3118

(Maness Report ¶ 92)).

87. NTSP actually 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. For each NTSP physician on the risk panel, there are expected to be and there are significant spillover effects from the physician's risk practice to the physician's non-risk practice. Many of the practices that allow NTSP to maintain low medical costs in its risk contracts directly carry over to the non-risk contracts. (Frech, Tr. 1409-11; Van Wagner, Tr. 1971; Maness, Tr. 1990-91, 2075-78; Wilensky, Tr. 2163-70, 2204-05; Deas, Tr. 2460-65, 2480-90, 2494-96, 2498-99, 2507-08, 2535; Lovelady, Tr. 2659-61; Lonergan, Tr. 2720-25, 2731; Casalino, Tr. 2859; RX 3118 (Maness Report ¶ 92); RX 3130

[

], *in camera*).

88. Physicians normally do not change their practice patterns patient-to-patient based on whether the payor is an HMO or PPO or whether their treatment is covered by a risk or non-risk contract. (Deas, Tr. 2463-65, 2485-86; Lonergan, Tr. 2720-21; Casalino, Tr. 2859, 2951-52; CX 1177 (Grant, Dep. at 59); CX 1178 (Hollander, Dep. at 163-64)).
89. There is expected to be some spillover from the risk panel physicians to the NTSP participating physicians who are not on the risk panel. This spillover does occur. (Wilensky, Tr. 2277; Lovelady, Tr. 2685-88).
90. Spillover occurs from HMO contracts to non-HMO contracts regardless of whether the non-HMO contracts are being performed by the same physician or physician group performing under the HMO contracts. (Vance, Tr. 632).

91. Managed care programs are desirable not only for the effects they produce for their own enrollees but also for the effects they can have on the communities in which they are located. (Frech, Tr. 1349-50; Wilensky, Tr. 2162-63).
92. On non-risk contracts, NTSP's participating physicians perform as well or better than other physicians. (Lovelady, Tr. 2665, 2668; RX 3118 (Maness Report ¶ 96)).
93. NTSP's patient days per thousand for commercial HMO care were lower from 2001-2003 than Aetna, Humana, and United's averages. (RX 3158; RX 3159; RX 3160; RX 3174).
94. NTSP has a lower number of procedures per unique Aetna HMO patient than the average for other providers from 1996-99. (RX 3133; RX 3134; RX 3173).
95. NTSP's business model has allowed it to produce medical cost savings in its non-risk contracts similar to those generated in its risk contracts. NTSP's cost of treatment under a non-risk contract is no different than the cost of treatment under a risk contract. (Van Wagner, Tr. 1971-72; Maness, Tr. 2069-70; RX 3130, *in camera*).
96. A study comparing NTSP's per member per month costs between its PacifiCare capitation contract and its Cigna fee-for-service contract show that the medical PM/PMs are virtually identical [

] and that Cigna's total PMPM was lower than PacifiCare's [

] (Maness, Tr. 2075-76; RX 3118 (Maness Report ¶ 95), *in camera*; RX 3130, *in camera*).
97. NTSP's per member per month expense in 2003 under the PacifiCare Medicare risk contract was much lower than the national average. (RX 3139).

98. NTSP's per member per month expense under its PacifiCare risk contracts has shown less significant increases since the year 2000 than the same expense for other payors and physician groups. (Van Wagner, Tr. 1794-96; RX 3162; RX 3167; RX 3177; RX 3178).
99. NTSP's medical cost per member per month on the PacifiCare capitation contract and the Cigna fee-for-service contract is lower than the Texas average for Aetna, Humana, and United, and lower than the national average. (Van Wagner, Tr. 1786, 1789-90; RX 3176, *in camera*).
100. NTSP's commercial HMO population is more intense (i.e., more expensive to treat) than the national average population because NTSP does not provide pediatric services. Children over the age of two are a good risk because they are generally healthy. (Van Wagner, Tr. 1977-78).
101. NTSP physicians generally perform equally as well on non-risk contracts as they do on risk contracts. For instance, one group of neurosurgeons that participates in NTSP compared its performance across several plans, including the PacifiCare risk contract, United, Aetna, Blue Cross, and Cigna. The results show that the number of procedures per unique patient are very similar across all plans. In addition, RVU per unique patient tends to be similar across patients. (Maness, Tr. 2077-78; RX 3118 (Maness Report ¶ 97); RX 3135; RX 3136; RX 3137; RX 3138). Data provided by an NTSP participating ophthalmology group showed similar results. (Maness, Tr. 2077-78; RX 3118 (Maness Report ¶ 97); RX 3168; RX 3169; RX 3170; RX 3171).
102. A clinical cost/outcome comparison for one NTSP primary care physician group shows that the group's cost per prescription on a non-risk contract with United is

- lower than United's average cost. (Van Wagner, Tr. 1792-93; RX 3179).
103. NTSP's patient satisfaction rating for specialists exceeds that of payors as a whole operating in the Metroplex. (RX 3118 (Maness Report ¶ 98)).
104. In recent patient surveys, the quality of care of NTSP's physicians and specialists was rated higher than United, Aetna, Cigna, and PacifiCare's non-NTSP networks. (RX 1734; RX 3182; RX 3183; RX 3274; RX 3275; RX 3276).
105. NTSP has had much lower complaint rates from patients than the averages for Aetna, Cigna, PacifiCare, and United. (RX 3183).
106. NTSP's philosophy is to apply medical management and other utilization techniques it has developed to reduce total medical expense in all of its contracts. NTSP markets this clinical integration proposal and the spillover benefits of its business model to payors. (Quirk, Tr. 424; Roberts, Tr. 550-551, 555-56; Van Wagner, Tr. 1595-99; Wilensky, Tr. 2158-59, 2164-65; CX 616; CX 1084; CX 1117). This kind of proposal is unique. (Roberts, Tr. 558; Wilensky, Tr. 2187-88).
107. NTSP can utilize data under a non-risk contract to improve the quality and efficiency of care the same way it does under a risk contract. But in a non-risk contract, the data is under the control of the payors. (Grizzle, Tr. 945-46, *in camera*; Van Wagner, Tr. 1532-33, 1604, 1789-90; RX 3158; RX 3159; RX 3160; RX 3176, *in camera*).
108. Many payors have not yet chosen to provide their data to NTSP. (Deas, Tr. 2434-35; Casalino, Tr. 2869, 2939).
109. [{

}] United HealthCare has contractually agreed to provide data under its

fee-for-service contract to NTSP for use in documenting NTSP's ability to lower costs, but United has not yet provided any data. (Van Wagner, Tr. 1525-56; RX 3118 (Maness Report ¶ 94), *in camera*).

110. NTSP's protocols and guidelines are available and being used in non-risk contracts. (Deas, Tr. 2503-04, 2507; Lonergan, Tr. 2721-24; CX 1182 (Johnson, Dep. at 40-41)).
111. NTSP is unable to utilize many medical management systems and techniques only because payors have been unwilling thus far to provide NTSP with the necessary data or to delegate to NTSP the necessary responsibility. (Deas, Tr. 2434-35, 2510-15, 2517-18; Casalino, Tr. 2869, 2909, 2912-12, 2939).
112. Complaint Counsel's expert, Dr. Casalino, testified that it is unrealistic to expect a physician organization to implement some medical management activities unless the payor agrees to pay the cost of those services. (Casalino, Tr. 2904).
113. Maintaining continuity of NTSP's participating physicians is important to achieving efficiencies. (Van Wagner, Tr. 1638; Maness, Tr. 2078-79; Wilensky, Tr. 2170-73, 2176-77; Deas, Tr. 2533-34; Lovelady, Tr. 2685-86; RX 3118 (Maness Report ¶¶ 83-100), *in camera*).
114. It is more likely NTSP will be able to carry over the efficiencies gained on its risk contracts to non-risk contracts if the same physicians are involved in both types of contracts. Spillover effects will be greater if there is more continuity among the physicians who practice under NTSP's risk contracts and non-risk contracts. (Frech, Tr. 1411; Wilensky, Tr. 2168-69).
115. NTSP's participating physicians can still be part of the NTSP "team" as long as they are on the same payor contract, even if some are contracted directly or

- through other entities. (Deas, Tr. 2534-35; CX 1197 (Van Wagner, Dep. at 193)).
116. NTSP needs to maintain its efficiencies on its non-risk contracts in order to preserve the low-cost and high-quality reputation that allows it to interest payors in future risk contracts. (Wilensky, Tr. 2168-72).
117. NTSP's organizational capital benefits payors, even in a non-risk setting, because of the high degree of coordination and teamwork among the participating physicians. (Frech, Tr. 1410-11; Van Wagner, Tr. 1580; Maness, Tr. 2078-79; Wilensky, Tr. 2191-92; RX 3118 (Maness Report ¶ 85)).
118. NTSP's participating physician interaction and information sharing, as well as the positive effects of high morale and peer pressure, spill over to NTSP's behavior in non-risk contracts. NTSP is more successful at altering physician behavior than payors. (Roberts, Tr. 554-55; Frech, Tr. 1406-07; Van Wagner, Tr. 1580-81; Wilensky, Tr. 2172-73, 2192-94; Deas, Tr. 2411-13, 2480-82; Lovelady, Tr. 2685-86)
119. Spillover can also flow from NTSP's non-risk contracts to its risk contracts. NTSP's non-risk contracts provide an opportunity for physicians to become comfortable with the abilities and practice patterns of other physicians with the hope that the physicians might later decide to participate in risk contracts. In addition, the non-risk business provides a way for physicians to familiarize themselves with NTSP's policies, procedures, and methods for managing risk and can make physicians more amenable to participating in risk contracts through NTSP when the opportunity arises. In this sense, NTSP's non-risk business acts as an incubator for developing physicians who are willing and able to participate in risk contracts through NTSP. (RX 3118 (Maness Report ¶ 100)).

120. As of January of 2004, all NTSP participating physicians who are eligible to take risk must participate in risk contracts or, after a short period of time, the physician will no longer be associated with NTSP. (Van Wagner, Tr. 1517-19; Wilensky, Tr. 2181).

The Poll

121. NTSP periodically polls its participating physicians to estimate at what level a majority of the physicians, including those on the risk panel, will likely be interested in non-risk contracts. (Complaint, ¶ 17; Vance, Tr. 613; Van Wagner, Tr. 1638-39).

122. Conducting the poll allows NTSP to try to meet its objective of providing its “team” or network of high-quality doctors who are committed to managing costs and providing good care to payors who are seeking non-risk contracts. (Van Wagner, Tr. 1637-38).

123. The poll is sent to all NTSP participating physicians. Those who choose to respond return written forms to NTSP. (Van Wagner, Tr. 1639-40).

124. Because NTSP has limited resources and because NTSP does not want to expend its resources or efforts on offers that will not involve a significant percentage of its risk panel physicians, the Board instructs NTSP’s staff not to expend their time and resources on payor offers below a threshold rate. (CX 1173 (Deas, Dep. at 21-22, 25); CX 1174 (Deas, Dep. at 37-38); CX 1187 (McCallum, Dep. at 121-22, 124); CX 1178 (Hollander, Dep. at 27-28)).

125. NTSP incurs costs each time it is approached with a new contract offer. Costs to NTSP include analyzing contract language from both operational and legal perspectives, communicating with payors about the terms of the contract,

determining the payor's payment policies and timing, mailing contracts to participating physicians, determining when physicians accept a given contract, and establishing and updating systems to track physician and plan member participation in a given contract. (Van Wagner, Tr. 1648-49; Wilensky, Tr. 2195-96; RX 3118 (Maness Report ¶ 76); CX 1196 (Van Wagner, Dep. at 56-57)).

126. NTSP has limited funds and managerial resources to analyze contracts and carry out messenger model functions. The costs of managing the messenger model are borne directly by NTSP. (Van Wagner, Tr. 1647-48; RX 3118 (Maness Report ¶ 76); CX 1196 (Van Wagner, Dep. at 56-57); CX 1173 (Deas, Dep. at 30)).
127. What funds NTSP does have are generated from two sources—(1) a one-time \$1000 fee when a physician's application to NTSP is accepted and (2) NTSP's share of the profits from its risk contracts. Thus, the costs of operating the messenger model are funded by activities unrelated to NTSP's non-risk business. (Van Wagner, Tr. 1548-51; RX 3118 (Maness Report ¶ 76); CX 1196 (Van Wagner, Dep. at 13)).
128. The Board requires more than 50 percent of the risk panel physicians to respond to a poll for the results to be used. There is no return requirement for non-risk panel physicians. (Van Wagner, Tr. 1646).
129. Not all participating physicians respond to the poll. In the 2001 poll, 57% of the risk panel physicians responded and 34% of all the participating physicians responded. (Van Wagner, Tr. 1645-46; RX 14, RX 15). In the 2002 poll, 55% of the risk panel physicians responded and 34% of all the participating physicians responded. (Van Wagner, Tr. 1645-46; RX 16, RX 17).
130. The responses of the approximately 190 physicians who respond to each poll are

aggregated into the single statistics of mean, median, and mode. NTSP calculates these statistics separately for HMO and for PPO types of offers. (Complaint, ¶ 17; CX 1194 (Van Wagner, Dep. at 16-19)).

131. The NTSP poll spans all specialties, and the mean, median, and mode statistics are aggregated across all specialties. (RX 3118 (Maness Report ¶ 56)).
132. These statistical calculations are performed by NTSP's staff in conjunction with an independent third-party CPA firm. No physician is involved in these calculations. (Van Wagner, Tr. 1640).
133. NTSP's participating physicians, including those on NTSP's Board, are not given any information about the poll results other than the single, aggregated statistics of mean, median, and mode. The physicians are not aware of the overall response rate. The physicians are not informed which physicians responded or did not respond. No information is provided on the rates that are acceptable to specific physicians or specific specialties of physicians. (Van Wagner, Tr. 1640-42, 1644; RX 3118 (Maness Report ¶ 56)).
134. The dissemination of market information can potentially benefit competition. Complaint Counsel's expert believes payors conduct surveys and know what other payors are offering in a given market. (Frech, Tr. 1437-38).
135. Only a small percentage (no more than 16%) of the participating physicians respond at the specific rate that is used as the threshold by NTSP's Board. (Frech, Tr. 1384).
136. Given the way in which NTSP administers, collects, and summarizes its poll results, it is highly unlikely that the poll itself or NTSP's dissemination of the highly-aggregated results could be used by physicians to determine what any

other physician's poll response was or to coordinate individual pricing decisions. (Frech, Tr. 1436-37; Maness, Tr. 2046-47; RX 3118 (Maness Report ¶¶ 55-56)).

NTSP does not negotiate rates for non-risk contracts

137. NTSP is unable to conduct and does not conduct any binding negotiation on behalf of any physicians on a non-risk offer. (Palmisano, Tr. 1240; Van Wagner, Tr. 1777; Deas, Tr. 2605).
138. NTSP has no power to bind and does not bind any participating physician or physician group to a non-risk contract. (Frech, Tr. 1363-64; Van Wagner, Tr. 1637, 1777; Deas, Tr. 2605).
139. NTSP's Physician Participation Agreement is non-exclusive and allows physicians to contract on their own on non-risk contracts. NTSP, under the agreement, is given an opportunity to review only certain non-risk offers from payors with whom NTSP already has an existing contract. (Van Wagner, Tr. 1554-55; CX 311 (Physician Participation Agreement at pp. 7-8, 20); CX 370 (amendments to PPA); CX 901 (amendments to PPA)).
140. NTSP's Board establishes a minimum rate required for NTSP to become involved by using the mean, median, and mode results from the poll. (Van Wagner, Tr. 1642-43). This minimum is meant to predict when the participation rate of NTSP's participating physicians will be high enough to activate NTSP as a network. (Maness, Tr. 2079-80; Deas, Tr. 2433).
141. NTSP informs payors, if asked, of the Board minimum. (Van Wagner, Tr. 1776). Payors are told this is the threshold rate level for NTSP's involvement and are given the opportunity to make an offer that will activate the NTSP network and fall within NTSP's authorization to act. (CX 1196 (Van Wagner, Dep. at 62-63)).

142. If a payor offer is at or above Board minimums and is otherwise acceptable, NTSP will sign the offer and activate the messenger model. NTSP does not attempt to raise the offered rate on a non-risk contract to or above the threshold levels for its involvement. (Frech, Tr. 1370; CX 1196 (Van Wagner, Dep. at 24-25); CX 1173 (Deas, Dep. at 73)).
143. NTSP does not negotiate rates with payors on non-risk contracts. (Vance, Tr. 595). On non-risk contracts, NTSP only negotiates noneconomic terms. (Van Wagner, Tr. 1636-37).
144. When NTSP uses the terms “negotiate” or “negotiation” relating to a non-risk contract, they apply only to the noneconomic terms of the contract. (Van Wagner, Tr. 1775-76). There is no other use of the terms “negotiate” or “negotiation” in any of NTSP’s Board Minutes or Fax Alerts relating to non-risk contracts. (Van Wagner, Tr. 1779-80). Some of NTSP’s documents may refer to negotiating economic terms related to risk contracts. (Van Wagner, Tr. 1775-76).
145. NTSP follows the messenger model. All non-risk offers in which NTSP has chosen to become involved as a contracting party are messengered to NTSP’s participating physicians. (Van Wagner, Tr. 1706).
146. NTSP has not told or asked a payor or employer to take any specific action with respect to fee levels. (Mosley, Tr. 195; Quirk, Tr. 340).
147. NTSP has not made any threats to payors relating to rates. (Roberts, Tr. 513-14).
148. Some payors require the use of powers of attorney when contracting with IPAs. (Jagmin, Tr. 1136-1137, 1139, 1141-42; Frech, Tr. 1379; CX 548 (Aetna individual provider addendum, including power of attorney)).

149. The powers of attorney solicited on occasion by NTSP are either used in non-binding negotiation of noneconomic terms or are unrelated to any negotiations. (Quirk, Tr. 341-42, 417-18; Van Wagner, Tr. 1690-92; CX 1083 (United notes of NTSP Board meeting)). These powers of attorney are limited to use “in any lawful way,” and payors were informed of this. Use “in any lawful way” does not include negotiation of rates in a non-risk contract. (Quirk, Tr. 419; Jagmin, Tr. 1141-42; Van Wagner, Tr. 1706).

No collusion

150. No NTSP participating physician or physician group knows what any other physician or physician group will do in response to a non-risk payor offer or how a physician or physician group responded to the poll. (Frech, Tr. 1436-37; Maness, Tr. 2044-46; Deas, Tr. 2423).
151. The dissemination of NTSP’s poll results does not tell a participating physician what any other physician will do in response to a payor offer. NTSP provides only the mean, median, and mode of the poll responses. (Van Wagner, Tr. 1641-42, 1644). Given that there can be wide variations in pricing, both within and across specialties, and the fact that NTSP groups all specialties into a narrow set of highly-aggregated, summary statistics measuring only a central tendency, a participating physician in a given specialty cannot glean information from these statistics that would predict another physician’s response to a payor offer. (Frech, Tr. 1436-37; Maness, Tr. 2046-47; Deas, Tr. 2423; RX 3118 (Maness Report ¶¶ 55-56)).
152. No NTSP participating physician has colluded with anyone else or has refused to entertain any payor offer that was tendered directly by a payor or through another

- IPA. (Frech, Tr. 1368; Van Wagner, Tr. 1564; Deas, Tr. 2406-07).
153. There are no agreements between one or more NTSP participating physicians to reject a non-risk payor offer. (Frech, Tr. 1365; Maness, Tr. 2048).
 154. There are no agreements between NTSP and any participating physician to reject a non-risk payor offer. (Frech, Tr. 1365-66, 1368; Maness, Tr. 2048-49; CX 1178 (Hollander, Dep. at 147)).
 155. No NTSP participating physician has given up the right to independently accept or reject a non-risk payor offer. (Frech, Tr. 1363-64; Van Wagner, Tr. 1637, 1777; Maness, Tr. 2047-48; CX 1178 (Hollander, Dep. at 147)).
 156. No NTSP participating physician has rejected a non-risk payor offer based on a power of attorney granted to NTSP. (Frech, Tr. 1368-69; Maness, Tr. 2049, 2053; CX 1187 (McCallum, Dep. at 48-49)).
 157. No NTSP participating physician has refused to negotiate with a payor because of NTSP's Physician Participation Agreement. (Frech, Tr. 1368).
 158. There are no agreements between one or more NTSP participating physicians and any entity to reject a non-risk payor offer. (Frech, Tr. 1365; Maness, Tr. 2048).
 159. NTSP's participating physicians and physician groups do not consult with each other when making decisions on non-risk payor contracts or responding to the poll. (Maness, Tr. 2049-50; Lonergan, Tr. 2718).
 160. NTSP's participating physicians accept offers both above and below the minimum rates established by the poll. (Frech, Tr. 1372-73; Maness, Tr. 2042-43; Lonergan, Tr. 2717-18; CX 1170 (Blue, Dep. at 51-52, 84); CX 1182 (Johnson, Dep. at 25, 27); RX 10, RX 11, CX 1155).
 161. NTSP's participating physicians make their own independent decisions whether

to accept an offer from a payor and do not rely on NTSP's aggregated poll results or even their own poll responses. (Maness, Tr. 2042-43, 2047-48; Deas, Tr. 2423; Lonergan, Tr. 2716-17; CX 1182 (Johnson, Dep. at 25-26, 30)).

162. Many of NTSP's participating physicians participate in only a few contracts through NTSP. The average number of NTSP contracts that NTSP's participating physicians participate in is 7.47 out of 24 available contracts. (Frech, Tr. 1364-65, 1394-95; Van Wagner, Tr. 1558; Maness, Tr. 2028, 2056; RX 13 (NTSP physician participation chart)).

NTSP has Valid Reasons to Refuse to Participate in a Payor Offer

163. There are many reasons an entity might refuse to deal with another entity, including just not liking the other entity. (Frech, Tr. 1405).
164. NTSP is concerned with avoiding the use of its resources in reviewing and servicing contracts where only a minority of its participating physicians are going to be involved. (Vance, Tr. 613, 819; CX 1178 (Hollander, Dep. at 27-28); CX 1187 (McCallum, Dep. at 121-22)).
165. NTSP avoids contracts where only a minority of its physicians would be involved because its business model relies upon a "team" approach to provide high-quality and efficient services. (Maness, Tr. 2080-81). If NTSP were forced to pass on any and all contracts, it would jeopardize its reputation as a high-quality, efficient network. Maintaining the continuity of the "team," the NTSP network, increases productivity and ensures the continuing value of the network. (RX 3118 (Maness Report ¶ 93)).
166. NTSP is very concerned with which contracts it messengers because NTSP, the entity, signs those contracts and becomes a party to those contracts. (Van

- Wagner, Tr. 1657-58).
167. The process of reviewing contracts is very complex and time-consuming for NTSP to perform with the necessary due diligence. (Van Wagner, Tr. 1647-48).
 168. Payors contracts are long and complicated. (Frech, Tr. 1376; Lonergan, Tr. 2714-15). There are many legal and practical pitfalls NTSP has to avoid. (Van Wagner, Tr. 1648-50; Wilensky, Tr. 2160; Lonergan, Tr. 2714-15).
 169. The compensation methodologies used by payors can be complex and potentially risky for physicians. NTSP may refuse to deal to avoid draining the time and resources of itself and its participating physicians through the use of incomprehensible compensation methodologies. (Frech, Tr. 1405-06, 1424; Van Wagner, Tr. 1649-50, 1652; Deas, Tr. 2415-17).
 170. NTSP may refuse to deal to avoid illegal, potentially illegal, or legally risky contracts. Legal issues frequently arise during contract related to: (1) compliance with the Texas Patient Bill of Rights; (2) prompt pay and clean claim definitions; (3) prompt pay and clean claim appeal processes; (4) termination provisions; (5) gender discrimination; (6) hold harmless clauses; (7) all products clauses; (8) gag provisions preventing physicians from speaking with patients and other physicians; and (9) provisions relating to medical malpractice insurance. (Van Wagner, Tr. 1656-57, 1659, 1661-62, 1664-67, 1679-80). Many of these legal issues have also been investigated or addressed by the Texas Department of Insurance or the Department of Justice, which had the effect of intensifying NTSP's contract review. (Van Wagner, Tr. 1664, 1667, 1772-73).
 171. NTSP may refuse to deal to avoid medical plans which appear risky from a medical treatment standpoint. (Frech, Tr. 1405-06; Van Wagner, Tr. 1679-80;

- Deas, Tr. 2413-14).
172. NTSP may refuse to deal to avoid other situations which appear legally risky to NTSP from a financial, administrative, or standard-of-care standpoint. (Grizzle, Tr. 770-771; Van Wagner, Tr. 1651, 1676-79).
 173. There can also be problems with payors that cause NTSP to refuse to deal. NTSP may refuse to deal to avoid involvement with payors who are not financially sound. (Mosley, Tr. 232; Grizzle, Tr. 959-60, *in camera*; Jagmin, Tr. 1170-72; Van Wagner, Tr. 1672-73; Deas, Tr. 2419-20; RX 1556 (article regarding MSM bankruptcy); CX 104 (Board minutes related to MSM bankruptcy)).
 174. NTSP may refuse to deal to avoid involvement with payors who are currently breaching a contract or have a history of breaching contracts. (Grizzle, Tr. 797, 799, 940, *in camera*; Van Wagner, Tr. 1652, 1772; Deas, Tr. 2419-20).
 175. NTSP may refuse to deal to avoid involvement with payors who have engaged in deceit or other conduct condemned by state or federal officials. (Jagmin, Tr. 1171-72; Van Wagner, Tr. 1652, 1667-68, 1673, 1772; RX 1805 (indictment of MSM officer); RX 3101 (press release regarding indictment of MSM officer); RX 3103 (press release regarding TDI fines of payors for misconduct); CX 104 (Board minutes related to MSM bankruptcy); CX 586 (fax alert regarding TDI network adequacy investigation of MSM and Aetna); RX 451 (DOJ suing Aetna over merger and improper market power; CX 57 (DOJ investigating Aetna's use of certain contract provisions); CX 505; RX 1301 (Assurance of Voluntary Compliance with Aetna); RX 339 (Texas Attorney General notice of breach of Assurance of Voluntary Compliance to Aetna medical director for misrepresentations); RX 1660 (article regarding Aetna fine by TDI); RX 1666

(Aetna consent order summary); RX 1651 (articles reporting Texas Attorney General investigation of HMO payment practices).

176. NTSP's review of payor contracts intensified and NTSP demanded that payors comply with state law after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-73).
177. NTSP may refuse to deal to avoid involvement with payors who discriminate or are attempting to discriminate against NTSP's participating physicians. (Roberts, Tr. 523-24; Grizzle, Tr. 940, *in camera*; Jagmin, Tr. 1165; Van Wagner, Tr. 1771; CX 775; CX 791 (correspondence with Cigna about carve-outs)).
178. NTSP may refuse to deal to avoid involvement with payors who refuse to share with NTSP medical data that NTSP needs to further its medical management goals. (Jagmin, Tr. 1132; Deas, Tr. 2434-35).
179. NTSP may refuse to deal to avoid involvement with payors who refuse to delegate utilization management and other medical managements functions to NTSP. NTSP may also refuse to deal to avoid involvement in contracts where utilization and medical management programs are not clear. (Van Wagner, Tr. 1661; Deas, Tr. 2434-35).
180. NTSP may refuse to deal if NTSP's participating physicians already have access to the same payor health plan on better terms. (Van Wagner, Tr. 1723, 1725).
181. NTSP may refuse to deal if NTSP is seeking a risk contract with that payor. (Jagmin, Tr. 1125; CX 764 (correspondence with Cigna regarding risk contract), *in camera*).
182. NTSP may refuse to deal if a payor is undermining a NTSP risk contract. (Quirk, Tr. 365).

NTSP's Right to Speak

183. NTSP has legitimate reasons to speak out and communicate with others about payors. NTSP has the right to and does advise patients and their employers about changes in service, compensation arrangements, and other healthcare issues. Employers and patients want to know about these issues. (Complaint Counsel Stipulation, Tr. 1149-50; Mosley, Tr. 186-88; Vance, Tr. 856-58; Jagmin, Tr. 1170; Van Wagner, Tr. 1659-60, 1729-33, 1741; Deas, Tr. 2424-25, 2429-32; RX 24.002 (Aetna contract containing provision including this right); TEX. INS. CODE § 843.363).
184. NTSP may speak out to prevent payor deception or violations of the law. (Van Wagner, Tr. 1462, 1651-53, 1772).
185. In May of 1999, 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. (RX 451; RX 3099). NTSP assisted the Department of Justice in that investigation. (RX 451). In December of 1999, Aetna signed a consent order. (RX 3100).
186. In June of 1999, NTSP was the class representative for its participating physicians in a class action against Harris Methodist Select and Medical Select Management for breach of contract and failure to pay claims properly. (Van Wagner, Tr. 1652-53; RX 335; RX 849; CX 1172 (Collins, Dep. at 6-9)).
187. Aetna represented to NTSP that MSM was solvent and able to fulfill its obligations. (Jagmin, Tr. 1172-73). In July of 2001, the Texas Department of Insurance placed MSM under supervision, and, one week later, MSM filed for bankruptcy. (RX 1556).

188. MSM's chief operating officer was convicted of fraud, money laundering, and tax evasion. (RX 1805; RX 3101).
189. In May of 2000, the Department of Justice investigated Aetna's use of an all-product requirement in its contracts. NTSP was asked to and did assist in this investigation. (CX 57).
190. The Texas Attorney General issued an Assurance of Voluntary Compliance to Aetna in April of 2000. (RX 1302; CX 505). Chris Jagmin, an Aetna medical director, was disciplined in August of 2001 for violating the AVC by making false representations. (RX 339). NTSP was notified of the Assurance of Voluntary Compliance with Aetna and Jagmin's disciplinary notice. (CX 103).
191. The Texas Commissioner of Insurance issued admonishment letters to Aetna in December of 2000 and October of 2001 questioning misrepresentations Aetna and MSM were making in contract discussions and questioning the adequacy of Aetna's provider network. (CX 586.001-.003; RX 3105 (Aetna ordered to pay restitution and fines for violations through October of 2001); CX 508 (Aetna response referencing Commissioner's letter)).
192. NTSP reported several payors to the Texas Department of Insurance in 2000 and 2001 for prompt pay violations, noncompliance with contracts, and predatory pricing concerns. (Van Wagner, Tr. 1772).
193. In November of 2001, the Texas Department of Insurance fined payors including Aetna, Blue Cross, Cigna, and United, millions of dollars and ordered the payors to pay restitution to providers for failing to follow Texas laws on prompt payment and clean claims. (RX 1660; RX 1666; RX 3105).
194. In 2002, NTSP made complaints about Aetna's contracting practices to the Texas

Department of Insurance. NTSP also sent a complaint letter to Aetna, with a copy to the Texas Department of Insurance. (CX 507; CX 509; CX 512; CX 513; RX 2325).

195. NTSP has advised physicians about the meaning of contractual terms or background on the contracting process. (CX 701 (fax alert advising physicians not to sign contracts without attached fee schedules); RX 777 (fax alert explaining to physicians the different types of PPO contracts)).
196. NTSP has advised physicians on whether NTSP will be involved with a payor's offer and whether the physicians need to do anything about an offer. (CX 643 (fax alert advising physicians that NTSP/Aetna discussions were terminating and providing other Aetna contracting options); CX 703 (fax alert advising physicians of HTPN Blue Cross contract termination and what actions physicians could take); RX 861 (fax alert providing list of NTSP contracts)).

Relevant Geographic and Product Markets

Complaint Counsel has not defined any relevant geographic or product market.

197. Complaint Counsel's expert, Dr. Frech, has not defined or posited any relevant geographic or product market in this case. (Frech, Tr. 1393-94, 1424-25).
198. Complaint Counsel's expert, Dr. Frech, has not calculated any concentration ratios or performed any concentration analysis. (Frech, Tr. 1394).
199. Complaint Counsel's expert, Dr. Frech, has not performed any entry analysis. (Frech, Tr. 1394).

A relevant geographic market would include at least Dallas and Tarrant Counties and would be probably as large as the Dallas–Fort Worth Metroplex.

200. Dallas County is only 15 miles from Fort Worth. (RX 3118 (Maness Report ¶

- 25)). Dallas is a large city with a large and well-recognized medical community located only about 30 miles from Fort Worth. (RX 3118 (Maness Report ¶ 27)).
201. The “Mid-Cities” area contains a large population located between Fort Worth and Dallas. The Mid-Cities consists of a group of cities in 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. (RX 3118 (Maness Report ¶ 29)). It would be especially easy for many of these patients to switch between Dallas and Fort Worth physicians because the cities are roughly equidistance for many Mid-Cities residents. (Maness, Tr. 2350; RX 3118 (Maness Report ¶ 29)).
202. In many cases, the driving time from one of the Mid-Cities to Dallas is less than or equal to the driving time to Fort Worth. (Maness, Tr. 2023, 2350; Lovelady, Tr. 2690-91; RX 3118 (Maness Report ¶ 29); RX 3124 (driving distances)).
203. Census Bureau data shows 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. The Mid-Cities population of Tarrant County represents over 40 percent of the population of Tarrant County. (Frech, Tr. 1426; Maness, Tr. 1998-99, 2022-23; RX 3118 (Maness Report ¶ 29); RX 3123 (showing populations)).
204. The existence of a significant population in the Mid-Cities around the border of Dallas and Tarrant Counties acts to tie Dallas and Tarrant Counties together as a market. (Frech, Tr. 1426-27; Maness, Tr. 1997-98).
205. The Department of Justice, in its review of the Aetna-Prudential merger, defined

the relevant geographic market for physician services as the Dallas–Fort Worth Metropolitan Statistical Area. This area included the Metroplex plus one other county. (Maness, Tr. 2018-19; RX 3118 (Maness Report ¶ 30)).

206. The Dallas–Fort Worth “Metroplex” is the metropolitan statistical area that is used by the Census Bureau. It encompasses the cities of Dallas and Fort Worth and includes 11 surrounding counties. (Maness, Tr. 2000)
207. Any relevant geographic market including Tarrant County (where Fort Worth is located) would also include at least Dallas County, most likely the 11 counties included in the Metroplex, and possibly other outlying counties. (RX 3118 (Maness Report ¶ 30)). Using the Department of Justice and Federal Trade Commission Merger Guidelines, other physicians within the Metroplex are viable substitutes for Tarrant County physicians and effectively constrain physician prices in Tarrant County. (Maness, Tr. 2010-13; RX 3118 (Maness Report ¶ 24)).
208. The geographic market for specialists includes at least Dallas County and Tarrant County, and probably the entire Metroplex. (Maness, Tr. 1999-2000; RX 3118 (Maness Report ¶¶ 27)).
209. NTSP has participating physicians in eight counties in and around the Metroplex, including 35 physicians located in Dallas County. (RX 3118 (Maness Report ¶ 22); Van Wagner, Tr. 1469-70).
210. NTSP has primary care physicians located in six different counties, including 28 primary care physicians located in Dallas County. (RX 3118 (Maness Report ¶ 23)).
211. Physicians in any county in and around the Metroplex are eligible to join NTSP if invited by the Board. (Van Wagner, Tr. 1472).

212. NTSP's participating physicians draw patients from a wide geographic area, including, in most cases, the Mid-Cities and Dallas, and, in some cases, the Metroplex and beyond. (Maness, Tr. 2005; Deas, Tr. 2398-99; Lonergan, Tr. 2708; CX 1170 (Blue, Dep. at 14-15); CX 1172 (Collins, Dep. at 12); RX 3118 (Maness Report ¶ 29)).
213. Many of NTSP's participating physicians and physician groups have more than one office, with some offices located outside of Tarrant County. (Van Wagner, Tr. 1470; Lonergan, Tr. 2710).
214. The geographic market for specialists, particularly advanced specialists like neurosurgery or oncology, is broader than for other physicians because people will travel farther for specialty care. Geographic markets tend to become larger the more specialized the specialty. (Frech, Tr. 1428; Maness, Tr. 1993, 1999; Lovelady, Tr. 2631; RX 3118 (Maness Report ¶ 23)).
215. That Dallas County is included in the relevant geographic market for NTSP specialists is also supported by the fact that Dallas has both physicians and hospitals that have been recognized as outstanding in areas of specialty covered by NTSP physicians. Two Dallas-based hospitals made U.S. News and World Report's list of Best Hospitals. These hospitals were specifically recognized in specialties where NTSP has a high proportion of Tarrant County-based physicians. There are also a number of "Top Doctors" recognized in Dallas. (Maness, Tr. 2002-03; RX 3118 (Maness Report ¶ 27); RX 3122 (list of DFW Top Doctors)).
216. A physician's geographic service area will tend to parallel a hospital's geographic service area the more hospital-oriented a physician's practice is. (Frech, Tr.

1430).

217. The Dartmouth Atlas of Health Care specifically defines hospital referral regions (HRRs), which are “regional health care markets for tertiary medical care.” HRRs are also defined by assigning hospital service areas (HSAs). A HRR is suggestive of both the referral patterns for specialist physicians and patient mobility. (Maness, Tr. 2003-05; RX 3118 (Maness Report ¶ 28)).
218. The Dartmouth Atlas defines the Fort Worth HRR as including the following counties: Bosque, Dallas, Erath, Hamilton, Hill, Hood, Jack, Johnson, Palo Pinto, Parker, Somerville, Tarrant, Wise, and Young. (RX 3118 (Maness Report ¶ 28)).
219. The Dartmouth Atlas defines the Dallas HRR as including 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. (RX 3118 (Maness Report ¶ 28)).
220. 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 County. (Maness, Tr. 2003-05; RX 3118 (Maness Report ¶ 28)).
221. The hospitals located in the Metroplex include: Harris Methodist in downtown Fort Worth (300 beds); Baylor All Saints in downtown Fort Worth (300-400 beds); Medical Plaza in Fort Worth; Cook’s Children’s Hospital in Fort Worth; TCOM Hospital in downtown Fort Worth (300 beds); Medical Plaza in Fort Worth (300 beds); John Peter Smith Hospital in downtown Fort Worth (300 beds); HEB Columbia in eastern Fort Worth; Harris Southwest; Hughley Hospital in southern Tarrant County (200 beds); Harris Northwest in Azle; Presbyterian

Hospital in downtown Dallas; Medical City in Dallas (700 beds); the Baylor Hospitals in Dallas, Irving, Grapevine, and Plano; Presbyterian Hospital in Plano; Lewisville Hospital near Dallas County and Denton County line; Harris HEB in the Mid-Cities (300 beds); Medical Plaza in Arlington; Arlington Memorial Hospital (400 beds); Arlington Medical Center (300-400 beds); Medical Plaza in Denton; Decatur Hospital in Wise County (100 beds); Walls Community Hospital in Johnson County (177 beds); Stephenville Hospital in Erath County; Scott and White in Templeton; and Granbury Hospital in Hood County (70 beds). (Van Wagner, Tr. 1473-1475, 1478-80, 1482-84, 1487-88).

222. Harris Methodist Hospital in downtown Fort Worth has a service area for secondary services that generally extends two counties to the north, west, and south, and at least to Grand Prairie to the east. For more specialized services, hospital service areas can extend even farther. (Van Wagner, Tr. 1480, 1488-89).
223. Employees of companies located in Fort Worth also live in outlying cities and counties. (Mosley, Tr. 229-30; Roberts, Tr. 569; Grizzle, Tr. 764-65).
224. People often seek care where they live. This is especially true for spouses and dependents of employees who work in Fort Worth, but live elsewhere. (Quirk, Tr. 402-03, 434-35; Grizzle, Tr. 761). Therefore, employees and others whose health plan is provided through a Fort Worth employer will be using physicians located throughout the Metroplex. (Mosley, Tr. 229-30; Quirk, Tr. 402-03).
225. Payors consider the location of employees when developing physician networks. Considering employees, retirees, and dependents, these locations will usually be spread throughout the Metroplex. (Roberts, Tr. 569).
226. Payors use a broader area than the city of Fort Worth or Tarrant County when

establishing their networks. The service areas established by payors for their plans include the entire Metroplex, or at least both Dallas and Tarrant Counties. Payors also consider the Metroplex to be the relevant geographic area for determining adequate network coverage. (Maness, Tr. 1993, 2002; RX 3118 (Maness Report ¶ 26); RX 295).

227. Prices set by payors in the Metroplex are often based on Dallas RBRVS, regardless of the county in which the physician is located. (Roberts, Tr. 494-95; Jagmin, Tr. 1122; Frech, Tr. 1428; Maness, Tr. 2002).
228. United HealthCare's service area for North Texas is the Metroplex. (Quirk, Tr. 236-37).
229. Aetna Health's service area for North Texas is a 14-county area centered around Dallas and Fort Worth. It includes the Metroplex as well as some outlying counties. (Roberts, Tr. 469; Jagmin, Tr. 972-73).
230. Cigna's service area covers the Metroplex and includes 12-14 counties. (Grizzle, Tr. 759).
231. PacifiCare considers Dallas and Tarrant Counties as one market. (Lovelady, Tr. 2623).
232. PacifiCare's service area and market for most products is a 13-county area including Dallas, Tarrant, Collin, and Denton Counties. (Lovelady, Tr. 2623-25).
233. The Texas Department of Insurance regulations define the geographic area where physician services must be provided to members of health insurance plans. Texas regulations for fully insured commercial products require that all covered lives have a primary care physician within 30 miles and a specialist within 75 miles for the network to be adequate. (Quirk, Tr. 274; Maness, Tr. 1999-2000; RX 6

(Texas statute); RX 3118 (Maness Report ¶ 25)).

234. Federal regulations are similar to Texas regulations – they require a PCP within 30 miles or 30 minutes and a specialist within 50 miles or 50 minutes. (RX 3118 (Maness Report ¶ 25)).
235. Payors consider federal and state regulations when establishing networks. (Lovelady, Tr. 2628-2630).

Relevant product markets in this case would encompass various areas of specialty.

236. Complaint Counsel has not posited relevant product markets in this case. (Frech, Tr. 1393-94, 1424-25).
237. In 2003, there were approximately 575 NTSP participating physicians practicing in 26 different specialties. Many of these specialties are not in competition with each other, and, therefore, these physicians are in separate relevant product markets. (Frech, Tr. 1424; Maness, Tr. 2017; RX 3118 (Maness Report ¶ 19)).
238. For example, an increase in the prices charged by orthopedic surgeons would not cause patients needing knee surgery to switch to cardiologists or dermatologists. (RX 3118 (Maness Report ¶ 19)).
239. 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. (RX 3118 (Maness Report ¶ 19)).
240. There can also be significant crossover of services between some specialties. In these circumstances, the relevant product market may be broader than a single specialty. (Frech, Tr. 1424-25; Maness, Tr. 2014, 2017; RX 3118 (Maness Report ¶ 20); RX 7; RX 8 (CPT code lists showing crossover between

specialties).

241. Medical care performed by ear, nose, and throat doctors can often be provided by family practice physicians or pediatricians, among others. (RX 3118 (Maness Report ¶ 20); RX 7; RX 8).
242. Medical procedures performed by PCPs can often be performed by gynecologists, pediatricians, pulmonologists, cardiologists, and others. (Maness, Tr. 2017-18; Lonergan, Tr. 2700-02; RX 3118 (Maness Report ¶ 19); RX 7; RX 8).
243. Some medical procedures performed by gastroenterologists can be performed by PCPs or colorectal surgeons. (Deas, Tr. 2396; Lonergan, Tr. 2701).

NTSP Does Not Have Market Power in Any Relevant Market

NTSP's Market Share is Low

244. NTSP does not possess sufficient market power to raise prices above competitive levels in any relevant product market in the Metroplex. (Maness, Tr. 1990, 2032; RX 3118 (Maness Report ¶ 33)).
245. NTSP's participating physicians are only 22 percent of the licensed physicians in Tarrant County. (Frech, Tr. 1395-96; RX 306 (TBME data for Tarrant County)).
246. NTSP's number of participating physicians is small when compared to payors' provider panels in the Metroplex. United's provider panel is approximately 8,000 physicians. (Quirk, Tr. 353-54). Aetna's provider panel is approximately 7,000 physicians. (Roberts, Tr. 569). Cigna's provider panel is approximately 6,500 physicians. (Grizzle, Tr. 759).
247. Even considering only Tarrant County, NTSP's number of participating physicians is small compared to payors' provider panels. United's provider panel is over 2,000 physicians. (Quirk, Tr. 354-55). Aetna's provider panel is

approximately 2,500 physicians. (Jagmin, Tr. 1121-22). Cigna's provider panel is more than 1,000, and possibly as high as 2,000. (Grizzle, Tr. 759). NTSP's participating physicians are only 10% of PacifiCare's provider panel. (Lovelady, Tr. 2636).

248. In the Metroplex, NTSP's participating physicians are less than 30 percent of the physicians in any specialty. (Maness, Tr. 2019-20; RX 3118 (Maness Report ¶ 33); RX 3125 (calculation of percentages)).
249. Considering Dallas and Tarrant Counties, NTSP's participating physicians are less than 32 percent of the physicians in any specialty. (Maness, Tr. 2020; RX 3118 (Maness Report ¶ 33); RX 3126 (calculation of percentages); RX 305; RX 306 (TBME data for Dallas and Tarrant Counties)).
250. In Tarrant County, NTSP's participating physicians are less than 50 percent of the physicians in every specialty except nephrology, pulmonology, hematology/oncology, colon and rectal surgery, and endocrinology. (Maness, Tr. 2020-21; RX 3118 (Maness Report ¶ 35); RX 3127 (calculation of percentages); RX 306 (TBME data for Tarrant County)).
251. In each of these five specialties, there are a number of factors that demonstrate that even for these specialties, NTSP does not possess market power. All five are advanced specialties, and a patient would be more likely to travel further distances when this specialized care is required. Thus, these are specialties for which Tarrant County is most unlikely to represent the relevant geographic market. (RX 3118 (Maness Report ¶¶ 35-36)).
252. For the nephrology specialty, market share is less important because the vast majority of nephrology business is paid for by the U.S. government under the End

Stage Renal Disease program, contracts in which the government dictates price and NTSP's participating physicians have no pricing power. Private insurance is not a major customer for these physicians, indicating that NTSP likely represents a small fraction of their income. These nephrologists are also non-exclusive to NTSP. On average, nephrologists participate in less than 30 percent of NTSP's contracts. Seven of these nephrologists are currently in Aetna's network even though NTSP currently has no contract with Aetna. (Maness, Tr. 2025-26; RX 3118 (Maness Report ¶ 36)).

253. For each of the other specialties, most of the services provided are also available from other types of physicians. For example, many types of colon and rectal surgery are also performed by general surgeons. (RX 3118 (Maness Report ¶ 37)). A comparison of the most frequently used diagnosis and treatment codes used by these five specialties shows that NTSP physicians in other specialties performed those same procedures, indicating that the relevant market for these specialties often includes other types of physicians. (RX 3118 (Maness Report ¶¶ 37-38); RX 7; RX 8).
254. NTSP's market share must be viewed in the context of market share possessed by physician groups that participate within NTSP because a single physician group will likely act together regardless of NTSP's involvement. For example, 56 radiologists participate in NTSP—giving NTSP an apparent share of 45 percent of all Tarrant County radiologists. However, since these 56 radiologists are part of a single group, their participation in NTSP does not in any way alter the competitive landscape for radiologists. (Maness, Tr. 2032-33; RX 3118 (Maness Report ¶ 40); RX 1714 (NTSP distribution of physicians by practice size)).

255. A payor does not need a large number of physicians for most of the advanced specialties represented by NTSP because the need for the specialists is not high. (Maness, Tr. 2034-35).
256. NTSP's market share must be reduced because many of NTSP's participating physicians participate in only a few contracts through NTSP. Some physicians are involved in no NTSP contracts. The average number of contracts that NTSP's participating physicians participate in is 7.47 out of 24 available contracts. (Frech, Tr. 1394-95; Van Wagner, Tr. 1558; Maness, Tr. 2028; RX 13 (NTSP physician participation chart); RX 3118 (Maness Report ¶ 43)). Even Dr. Tom Deas, the President and Chairman of the Board of NTSP, has participated in only 10 to 12 of NTSP's contracts. (Deas, Tr. 2402).
257. Complaint Counsel's expert did not perform any analysis of the revenue received by NTSP's participating physicians through NTSP. His calculations used all physicians from NTSP's roster, even those who participated in no NTSP contracts. (Frech, Tr. 1434-35). But NTSP contracts with only a limited number of entities and the average physician participates in less than a third of NTSP's contract, and, thus, NTSP does not constitute a large share of most participating physicians' incomes. (RX 3118 (Maness Report ¶ 43)).
258. NTSP's share of physicians may also be overestimated. The Texas Board of Medical Examiners (TBME) data used to calculate these percentages may not include all available physicians because the provider panel lists of payors often include more physicians in a specialty than listed by the TBME. For example, TBME lists 18 available nephrologists in Tarrant County, while one payor's provider panel for Tarrant County lists 25 available nephrologists. (Maness, Tr.

2027, 2032; RX 306). In hematology, TBME lists 24 available hematologists in Tarrant County, while one payor's provider panel for Tarrant County lists 75 available hematologists. (Maness, Tr. 2031-32; RX 306).

259. The services provided by hospitals are considered primary, secondary, tertiary, or quaternary services. Quaternary hospital services include transplants. Tertiary hospital services include high-level traumas. Secondary hospital services include obstetrics, most surgeries, and subspecialty intensive care units. Primary hospital services are the basic range of hospital services. (Van Wagner, Tr. 1475-77).
260. The hospitals utilized by NTSP's participating physicians are not determinative of any market power. There are many hospitals located in Tarrant County, including Harris Methodist in downtown Fort Worth (300 beds, primary through quaternary services), Harris HEB in the Mid-Cities (300 beds, primary through tertiary services), Harris Southwest, Harris Northwest in Azle, Baylor All Saints in downtown Fort Worth (300-400 beds), Hughley Hospital in southern Tarrant County (200 beds), Medical Plaza in Fort Worth, HEB Columbia in eastern Fort Worth, Cook's Children's Hospital in Fort Worth (primary through tertiary services), TCOM Hospital in downtown Fort Worth (300 beds, primary and secondary services), Medical Plaza in Fort Worth (300 beds), and John Peter Smith Hospital in downtown Fort Worth (300 beds, primary through tertiary services). There is an even larger list of hospitals available in the Metroplex, including others in Tarrant County as well as Scott and White in Templeton; Presbyterian Hospital in downtown Dallas; Presbyterian Hospital in Plano; Walls Community Hospital in Johnson County (177 beds); Stephenville Hospital in Erath County; the Baylor Hospitals in Dallas, Irving, Grapevine, and Plano;

Medical City in Dallas (700 beds, tertiary services); Medical Plaza in Arlington; Medical Plaza in Denton; Arlington Memorial Hospital (400 beds, primary through tertiary services); Arlington Medical Center (300-400 beds, primary and secondary services); Decatur Hospital in Wise County (100 beds, primary and secondary services); Lewisville Hospital near Dallas County and Denton County line (primary and secondary services); and Granbury Hospital in Hood County (70 beds, primary services). (Van Wagner, Tr. 1473-1475, 1478-80, 1482-84, 1487-88).

261. Complaint Counsel's own expert states that one should not put too much emphasis on market share alone. (Frech, Tr. 1436).
262. The ease of entry and low barriers to entry for new physicians in Tarrant County also lowers any potential market power. (Maness, Tr. 2035-36).
263. In general, there are low mobility barriers to physician practices. (Maness, Tr. 2036-37). Previous cases and research have noted that there are low entry barriers for physicians because physicians can and do respond to market incentives by relocating in terms of geography and/or specialty. (Maness, Tr. 2037-38).
264. In Tarrant County, it is not difficult to come into the community and start a new practice. (Deas, Tr. 2398).
265. In Tarrant County, the physician population within the 26 specialties offered by NTSP's participating physicians grew from 1,908 in May 1999 to 2,167 by May 2003 – growth of over 13.5 percent in four years. As of January 2001, there were 2,044 physicians in Tarrant County in these specialties. (Maness, Tr. 2036-37, 2351; RX 3118 (Maness Report ¶ 45); RX 3264).

266. Employers, hospitals, payors, and other health care providers have an interest in maintaining competitive markets for physician services. These entities often actively recruit or otherwise seek to attract physicians into the area, including Fort Worth. (Deas, Tr. 2425-28; Lovelady, Tr. 2635; Maness, Tr. 2037; RX 3118 (Maness Report ¶ 47)).

Payors can and do successfully contract with NTSP's participating physicians directly and through other IPAs

267. As an alternative to dealing with NTSP, payors can and do contract with NTSP's participating physicians directly, through financially integrated physician groups, or through other IPAs. (Quirk, Tr. 288-89; Roberts, Tr. 568; Grizzle, Tr. 692, 764; Van Wagner, Tr. 1564, 1637; Deas, Tr. 2432; Lovelady, Tr. 2652; Lonergan, Tr. 2711).

268. IPAs other than NTSP operating in the Metroplex during the relevant time period include All Saints Integrated Affiliates (ASIA) (550 physicians), Medical Select Management (MSM) (approximately 2,000 physicians), Heritage Southwest, Health Texas Provider Network (HTPN), System Health Providers, Genesis Physician Group (1,288 physicians); Southwest Physician Associates, Pulmonary Specialists of Arlington, TIOPA, Cook's Children's Network (280 physicians), IPA of Denton, Princeton, Care First, Arlington Physician Group (100 physicians), Arcadian, Primary Care Concepts, Allegiance, and Plano Physicians Network (Mosley, Tr. 231-32; Quirk, Tr. 362; Roberts, Tr. 572-73; Grizzle, Tr. 961-62; Van Wagner, Tr. 1556-57; Deas, Tr. 2399-2400, 2608-09; Lovelady, Tr. 2646; Lonergan, Tr. 2711; RX 1689; CX 1174 (Deas, Dep. at 26-27)).

269. Membership in NTSP and other IPAs is nonexclusive. (Frech, Tr. 1390).

270. Messengering contracts is very easy for payors to do. Payors can and do messenger on their own. (Frech, Tr. 1397-98; Lovelady, Tr. 2653-54).
271. All of NTSP's participating physicians participate in a variety of health plans outside NTSP. (RX 3118 (Maness Report ¶ 44)). Payors can and do contract with NTSP's participating physicians either directly or through other physician organizations. (Van Wagner, Tr. 1556; Maness, Tr. 2081-82; CX 1170 (Blue, Dep. at 51-52); CX 1172 (Collins, Dep. at 16-18, 21-22, 36-37); CX 1177 (Grant, Dep. at 70); CX 1178 (Hollander, Dep. at 14-15, 111); CX 1182 (Johnson, Dep. at 25-26, 36)).
272. Aetna had direct contracts and contracts through other IPAs with NTSP physicians. (Lonergan, Tr. 2712; RX 9 (analysis of Aetna's network with and without NTSP contract); RX 319 (analysis of how NTSP physicians contract with Aetna)). After terminating a contract with NTSP, Aetna sent out direct contracts to NTSP's participating physicians. (Roberts, Tr. 544-45). Many of NTSP's physicians signed these direct contracts with Aetna. (Roberts, Tr. 546).
273. United HealthCare had direct contracts and contracts through other IPAs with NTSP physicians. (Quirk, Tr. 288-89). After NTSP terminated a contract with United, United sent out a request for a direct contract to NTSP's participating physicians. (Quirk, Tr. 334). After the termination, NTSP's physicians contracted with United both through direct contracts and other IPAs, including ASIA and TIOPA. (Quirk, Tr. 334; Beaty, Tr. 462-63; Van Wagner, Tr. 1745).
274. PacifiCare has direct contracts with NTSP participating physicians. (Lovelady, Tr. 2652).
275. Even when NTSP enters into non-risk contracts with a payor, many NTSP

participating physicians contract with these same payors outside of NTSP. (CX 1187 (McCallum, Dep. at 136-37); RX 3118 (Maness Report ¶ 42)).

276. One physician group with NTSP members, Gastroenterology Associates of North Texas (GANT), has a direct non-risk contract with Cigna and does not participate in NTSP's non-risk contract with Cigna. (Deas, Tr. 2400). GANT's direct contract rate is higher than NTSP's contract rate. (Deas, Tr. 2409-10).

Payors do not need NTSP to have a viable provider network

277. Payors did not consider NTSP to be particularly important in establishing an effective network in the Dallas–Fort Worth area. (Maness, Tr. 2034; RX 3118 (Maness Report ¶ 33)). Payors have also stated that NTSP does not matter to them or their customers. (Quirk, Tr. 360).
278. Payors' networks are adequate by regulatory standards and company standards without a contract with NTSP. (Quirk, Tr. 289-90, 359; Roberts, Tr. 532).
279. NTSP had a contract with Aetna for only one year. Aetna decided to terminate that contract. (Roberts, Tr. 489). NTSP does not currently have a contract with Aetna. (Roberts, 549). Aetna does not now and has never had an inadequate network. (Roberts, Tr. 532, 576-77; Jagmin, Tr. 1122; RX 9 (analysis of physician network in Tarrant County without NTSP)).
280. Aetna was not particularly concerned with NTSP from a medical standpoint. (Jagmin, Tr. 1123).
281. Cigna requires that two specialists of each type be located within 20 miles of the majority of its membership in Fort Worth. [

] (RX 2887.012, *in camera*; RX 3118 (Maness Report ¶ 41)).

282. United did not need NTSP in its network. (CX 1034 (United correspondence stating NTSP “not critical” to network)).
283. NTSP has never had a direct contract with Blue Cross. (Van Wagner, Tr. 1720).
284. NTSP does not prevent its participating physicians from acting individually and making independent decisions on payor contracts. (Van Wagner, Tr. 1556, 1637; Deas, Tr. 2405, 2407; Lonergan, Tr. 2715-16; CX 337 (fax alert giving options for Blue Cross contracting)).
285. NTSP does not have the authority to make a decision on non-risk contracts on behalf of participating physicians. (Van Wagner, Tr. 1637; Deas, Tr. 2605; CX 311).
286. No physician has refused to participate in a contract offer by a payor because of an IPA. (Frech, Tr. 1368). NTSP’s participating physicians do act independently, as shown by Complaint Counsel’s expert’s analyses of individual physicians contracting behavior. There is no consensus price among NTSP’s participating physicians. Physicians sign up for rates lower and higher than NTSP’s minimums. Physicians sign up for rates lower and higher than the minimum they voted for in the poll. Physicians decide to contract at many different rates and with many different payors. (Maness, Tr. 2042-43; RX 10; RX 11; CX 1155).
287. Participation in NTSP is non-exclusive, and NTSP’s participating physicians have belonged to other IPAs. (Quirk, Tr. 357-58, 443; Frech, Tr. 1390; Van Wagner, Tr. 1557).
288. NTSP reached an agreement with HTPN whereby NTSP’s participating

physicians could choose to participate in any payor offers through HTPN. NTSP had no role in HTPN's discussions with payors about those contracts. (Van Wagner, Tr. 1559-60). HTPN contracts are now available to NTSP's participating physicians because of this arrangement. (RX 13).

289. NTSP did not use powers of attorney to prevent participating physicians from making independent decisions on payor contracts. (Maness, Tr. 2052; Van Wagner, Tr. 1705-06). Nothing in the power of attorney says that a physician commits either to accept or reject an offer. (Frech, Tr. 1368; CX 1196 (Van Wagner, Dep. at 152)). No physician has turned down a contractual offer from a payor in deference to a power of attorney. (Frech, Tr. 1368; Maness, Tr. 2049).

NTSP's rates are not supracompetitive

290. Complaint Counsel's expert never compared NTSP's rates to the rates given to other IPAs. (Frech, Tr. 1448).
291. NTSP's rates and rates offered to NTSP are not above market rates. (Quirk, Tr. 297-98 (offering NTSP market standard)).
292. Payors' standard rates are not necessarily the market rate, especially for IPAs. (Frech, Tr. 1439-40; Van Wagner, Tr. 1805-06). For example, [

] (Grizzle, Tr. 958, *in camera*).

293. Payors only offer NTSP the same or lower rates than those offered to other IPAs or to physicians directly. United gave NTSP the same rate as ASIA. (Quirk, Tr. 348-49; Frech, Tr. 1390; Van Wagner, Tr. 1746). [

] (Grizzle, Tr. 959, *in camera*; CX 768, *in camera*). Aetna gave

NTSP the same rate as MSM. (Compare RX 968 to RX 24.021). Blue Cross

- gave NTSP a lower rate than HTPN. (Van Wagner, Tr. 1723).
294. Payors sometimes offer physicians direct contracts with higher rates than those offered to NTSP. Cigna offered Gastroenterology Associates of North Texas, a NTSP participating physician group, a higher direct rate than NTSP's rate. (Deas, Tr. 2409-10). PacifiCare has offered physicians with direct contracts higher rates than those offered to NTSP. (Lovelady, Tr. 2656-57).
295. The fact that physicians contract outside of NTSP so often, even when NTSP contracts with the same payors, indicates that many NTSP physicians get better terms either with other IPAs or individually. (RX 3118 (Maness Report ¶ 42); RX 13 (NTSP physician participation chart); RX 295 (United chart showing participating through other IPAs)).
296. Some physicians will accept only rates higher than NTSP's rates. (Frech, Tr. 1372).
297. It takes a higher price to activate a majority of physicians on a panel than what is required to activate individual physicians. More physicians will be interested in participating as rates increase. Knowing what a payor is paying a few physicians through direct contracts does not necessarily indicate what the payor would have to pay to activate more physicians in the market. (Quirk, Tr. 435-36; Frech, Tr. 1439-40).
298. Contracting through an IPA reduces the costs of contracting for both physicians and payors. An IPA provides a mechanism by which a payor can contract with a single entity to include a large number of doctors in its network. In the absence of the IPA, the payor would have to negotiate a separate contract with each individual physician or physician group. The opportunity to contract with an IPA

can potentially eliminate hundreds of these separate negotiations, which can significantly reduce the costs of assembling networks. (Quirk, Tr. 427-28; Maness, Tr. 2057-58; RX 3118 (Maness Report ¶ 75)).

299. Under basic economic theory, higher quality can lead to higher prices. More sought-after physicians often seek and obtain higher reimbursement rates. (Quirk, Tr. 435; Frech, Tr. 1438-39).
300. Payors are willing to pay more for more efficient physicians who can perform at a higher level and reduce total medical expense. (Roberts, Tr. 657, *in camera*).
301. Higher rates can also be the result of efficiencies and overall value brought by a physician network. (Vance, Tr. 1227-28; Deas, Tr. 2606-07).
302. The correct outcome measure for the cost of physician services is total medical expense or overall costs. The quantity and mix of services provided, not physician reimbursements and fees, are the biggest drivers of health care costs. Unit cost is not a proper outcome measure. (Maness, Tr. 2060-62; Wilensky, Tr. 2174-75).
303. Complaint Counsel's expert admits total medical expense is an important criterion in determining the cost to payors. (Frech, Tr. 1408-09).
304. Overall costs, or total medical expense, include physician costs, facility costs, and pharmacy costs. A physician, especially a specialist physician, can have an impact on controlling all three types of costs. (Roberts, Tr. 551-53; Maness, Tr. 2062-63; Wilensky, Tr. 2173-76).
305. The NTSP business model and risk contracts motivate participating physicians to become concerned about utilization and to control total medical expense, including facility and pharmacy costs. (Wilensky, Tr. 2176-81).

306. Health care spending has been steadily growing since 2000, and physician costs have not been one of the primary drivers of that spending growth. The single largest factor in health care spending growth is hospital expenses. (Wilensky, Tr. 2184-85).
307. Other appropriate outcome measures are the quality and value of the care received. (Maness, Tr. 2060-62).
308. 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. (Maness, Tr. 2060-62; Frech, Tr. 1408-10).
309. The gap between NTSP's overall costs and the overall costs of other IPAs has increased because NTSP has done a better job of managing costs than its peers. (RX 1708, 1710, 3177, 3178).
310. Complaint Counsel's expert did not study total medical expense or overall costs in this case. (Frech, Tr. 1416, 1422).

Payor Histories

PacifiCare

311. NTSP has current risk and non-risk contracts with PacifiCare. (Lovelady, Tr. 2665, 2668).
312. NTSP is PacifiCare's "top performer in the Metroplex" for both risk and non-risk contracts. (Lovelady, Tr. 2657-59, 2665, 2668).
313. PacifiCare considers NTSP a "valuable contracting partner." (Lovelady, Tr. 2657-58).
314. PacifiCare considers NTSP's performance on the risk contract "positive and favorable." (Lovelady, Tr. 2659).

315. In risk contracts, PacifiCare relies on NTSP to perform medical management functions. (Lovelady, Tr. 2657-58).
316. NTSP regularly receives reports from PacifiCare comparing NTSP's performance to the performance of other physicians under PacifiCare's contracts in the Metroplex. (Van Wagner, Tr. 1614; Lovelady, Tr. 2664; RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
317. PacifiCare's reports comparing NTSP's performance to the performance of other physicians under PacifiCare's contracts in the Metroplex show that NTSP has produced good results and performs better than physicians with direct contracts. (Van Wagner, Tr. 1614; Lovelady, Tr. 2664; RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
318. PacifiCare tracks physician groups on a number of different criteria, including various measures of clinical quality, service quality, and hospital utilization. (Van Wagner, Tr. 1612, 1614-18; Lovelady, Tr. 2664; RX 3118 (Maness Report ¶ 88); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
319. For clinical quality, which generally measures things such as the frequency of cancer screening, immunizations, and percentage of avoidable hospitalizations, NTSP meets or exceeds the whole PacifiCare network in most categories. (Van Wagner, Tr. 1612, 1614-18; RX 3118 (Maness Report ¶ 88); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
320. For service quality, NTSP has lower levels of access-related complaints per member per year than other PacifiCare physicians. (RX 3118 (Maness Report ¶ 89); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).
321. For hospital utilization, NTSP has average or lower than average hospitalization

rates than other PacifiCare physicians. (Van Wagner, Tr. 1612, 1614-18; Lovelady, Tr. 2664; RX 3118 (Maness Report ¶ 88); RX 1719; RX 1846; RX 3153; RX 3154; RX 3223).

322. Under the PacifiCare risk contract, NTSP physicians had a lower number of procedures per unique patient and a lower amount paid per unique patient than non-NTSP physicians for each of the last three years in both the commercial and Medicare products. (Van Wagner, Tr. 1787-88; Maness, Tr. 2071-73; RX 3118 (Maness Report ¶ 88); RX 1707; RX 3129).
323. NTSP's per member per month expense in 2003 under the PacifiCare Medicare risk contract was much lower than the national average. (RX 3139).
324. NTSP's per member per month expense under its PacifiCare risk contracts has shown less significant increases since the year 2000 than the same expense for other payors and physician groups. (Van Wagner, Tr. 1794-96; RX 3162; RX 3167; RX 3177; RX 3178).
325. NTSP's per member per month expense under its PacifiCare risk contracts is lower in medical cost, pharmacy cost, and total cost than most other major Texas payors and national averages. (Van Wagner, Tr. 1789-90; RX 3176, *in camera*).
326. NTSP receives data from PacifiCare to assist in performing its medical management functions. NTSP regularly runs this data and uses it more extensively than PacifiCare does. On occasion, PacifiCare has asked NTSP to assist it in utilizing this data. (Van Wagner, Tr. 1525-26, 1530-32, 1534-35, 1612).
327. PacifiCare believes spillover occurs from NTSP's risk contract performance to NTSP's non-risk contract performance. (Lovelady, Tr. 2659-61, 2685-88).

328. PacifiCare views spillover as an advantage to working with NTSP. (Lovelady, Tr. 2660-61, 2685-88).

Aetna/MSM

329. In 1994, many physicians signed a HMO risk contract and a PPO non-risk contract to treat Aetna patients through another IPA, Harris Methodist Select (HMS). (Van Wagner, Tr. 1692; RX 832; RX 3142; RX 3144).

330. The 1994 HMS contracts with Aetna were exclusive and were not terminable until June 30, 1999. (RX 3146)

331. NTSP was later formed as an entity to engage in risk contracts. Many of the physicians who had contracts with HMS signed participating physicians agreements with NTSP. (RX 832).

332. In 1997, HMS breached the 1994 contracts by attempting to amend those contracts without consent, agreeing to non-exclusivity with Aetna, and failing to make full payments to physicians. (Vance, Tr. 591; Van Wagner, Tr. 1692; RX 309; RX 310; RX 832; RX 3151).

333. As a result of the continuing breach by HMS, the physicians approached NTSP and asked that NTSP attempt to enter into a risk contract with HMS to replace the 1994 contracts. (Vance, Tr. 591-92, 600-01; Van Wagner, Tr. 1653).

334. NTSP negotiated on a risk contract with HMS, but the parties never reached an agreement. (Van Wagner, Tr. 1682-83; RX 308 (1996 offer); RX 312 (1997 term sheet)).

335. Negotiations with HMS were part of an attempt to resolve a contractual dispute. (Vance, Tr. 602-03).

336. A tied offer is a contract that requires acceptance of both capitation and non-

capitation obligations. NTSP has received tied offers from some payors. (Van Wagner, Tr. 1607-08; CX 1178 (Hollander, Dep. at 52-53).

337. Negotiations on the 1994 HMS/Aetna contracts were risk negotiations. The negotiations on the PPO non-risk contract were risk negotiations because the terms of the PPO contract were tied by HMS to the terms of the HMO risk contract. (Vance, Tr. 601-03).
338. The proffered 1997 HMO contract for HMS was a risk contract because it contained a rate adjustment clause that was the equivalent of a floating fee schedule. (Van Wagner, Tr. 1609-12). The proffered 1997 contract was also a tied offer. (RX 3151).
339. NTSP was appointed by its participating physicians to represent them in the breach of contract dispute with HMS. (Van Wagner, Tr. 1681).
340. In 1999, during the time the contract was being breached, HMS became Medical Select Management (MSM). (RX 832).
341. The contracts between the physicians and HMS were assigned to MSM. (RX 832).
342. After the assignment of the HMS contracts to MSM, NTSP continued to try to negotiate a risk contract, but the parties never reached an agreement. (Van Wagner, Tr. 1685).
343. In June of 1999, NTSP, as the class representative for its participating physicians, sued HMS and MSM. The class action lawsuit against HMS and MSM was based on HMS's and MSM's refusal to honor the terms of the 1994 contract. (Van Wagner, Tr. 1652-53; RX 335; RX 849; CX 1172 (Collins, Dep. at 6-9)).
344. MSM continued to breach the contract after the lawsuit was filed by continuing

- not to pay claims. (Van Wagner, Tr. 1692).
345. Despite the continuing breaches by HMS and then MSM, NTSP's participating physicians continued to perform under the 1994 contract so as not to affect patient care. (CX 1177 (Grant, Dep. at 59)).
346. NTSP attempted to negotiate a new risk contract with MSM even after the lawsuit was filed, but MSM wanted any new contract to include NTSP's settlement of the lawsuit. (Van Wagner, Tr. 1685-88, 1691; RX 1300).
347. At the request of certain participating physicians, NTSP terminated those participating physicians from the MSM HMO contract in the fall of 2000. (Jagmin, Tr. 1163-64; Van Wagner, Tr. 1692, 1696-97; CX 556). NTSP received powers of attorney from those physicians to terminate the contract that was in dispute and the subject of the lawsuit where NTSP was the class representative. (Van Wagner, Tr. 1690-91).
348. NTSP informed Aetna that MSM had ongoing difficulties in paying claims. (Jagmin, Tr. 1170-71, 1172-73; Van Wagner, Tr. 1692-93; RX 1039).
349. Aetna represented to NTSP that MSM was solvent and able to fulfill its obligations. (Jagmin, Tr. 1172-73).
350. In July of 2001, the Texas Department of Insurance placed MSM under supervision. (RX 3102).
351. One week after MSM was placed under TDI supervision, MSM filed for bankruptcy. (Grizzle, Tr. 959-60, *in camera*; RX 1556).
352. An Aetna audit uncovered embezzlement by MSM's chief operating officer, Frederick C. Miller. Miller was convicted of fraud, money laundering, and tax evasion. (RX 1805; RX 3101).

353. NTSP eventually reached a settlement with MSM in the bankruptcy court. The settlement was approved by the Court, and the NTSP participating physicians were paid a substantial sum. (Van Wagner, Tr. 1656; RX 1632; CX 656).
354. After MSM's bankruptcy, Aetna assumed the MSM contracts, but ignored the prior breaches of those contracts by MSM. (Jagmin, Tr. 1171-72; RX 1700).
355. Throughout 1999 and 2000, NTSP and Aetna discussed a direct risk contract, without MSM. (Jagmin, Tr. 983-84, 1125, 1167; Van Wagner, Tr. 1692-95, 1700; CX 531).
356. In May of 1999, 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. (RX 451; RX 3099). NTSP assisted the Department of Justice in that investigation. (RX 451). In December of 1999, Aetna signed a consent order. (RX 3100).
357. In May of 2000, the Department of Justice investigated Aetna's use of an all-products requirement in its contracts. NTSP was asked for their assistance in determining the effects of Aetna's all-products policy, and NTSP agreed to help. (CX 57).
358. The Texas Attorney General sued Aetna in May of 2000 over its contracting practices. The Texas Attorney General issued an Assurance of Voluntary Compliance to Aetna in April of 2000. (RX 1302; CX 505). The Assurance of Voluntary Compliance provided minimum standards for contract provisions that Aetna used with providers. (RX 1302; CX 505).
359. Chris Jagmin, a medical director for Aetna, was disciplined in August of 2001 for making false misrepresentations and violating the Assurance of Voluntary

- Compliance. (RX 339).
360. NTSP was notified of the Assurance of Voluntary Compliance with Aetna and Jagmin's disciplinary notice. (CX 103).
361. NTSP and Aetna's risk contract discussions eventually broke down because Aetna would not provide NTSP with the data it needed to perform medical management and utilization management. (Jagmin, Tr. 1132; Van Wagner, Tr. 1694-96; CX 531).
362. In November of 2000, after NTSP and Aetna determined they could not agree on a risk contract, discussions of a non-risk contract began. (Jagmin, Tr. 1132-33).
363. NTSP refused to be involved in an Aetna non-risk contract proposal that proposed different rates for different participating physicians. (Roberts, Tr. 523-24, 568; Jagmin, Tr. 1165; CX 629).
364. In 1999 and 2000, NTSP brought MSM's referral approval and claims payment problems to the attention of both Aetna and the Texas Department of Insurance. (Van Wagner, Tr. 1692-93).
365. The Texas Commissioner of Insurance issued admonishment letters to Aetna in December of 2000 questioning certain misrepresentations Aetna and MSM were making in contract discussions and questioning the adequacy of Aetna's provider network. The letter informed Aetna there had been provider complaints. Aetna decided to contract with NTSP following this letter and other communication with the Commissioner about Aetna's conduct. (CX 586.001-.003).
366. In December of 2000, Aetna and NTSP ultimately entered into a non-risk contract at the same rates as the existing MSM contract. (Jagmin, Tr. 1132-33; Van Wagner, Tr. 1697, 1701-02, 1708-09; RX 24).

367. For contracts with an IPA, Aetna requires the IPA to acquire individual provider addendums from its participating physicians, which includes a clause granting the physicians' power of attorney to the IPA. (Jagmin, Tr. 1135-37, 1139, 1141-42; Van Wagner, Tr. 1702-05, 1707; CX 548; CX 567).
368. NTSP requested that Aetna's individual provider addendum be "amended to recognize the messenger model for non-risk products." (CX 567).
369. Aetna terminated its contract with NTSP in 2001. (Roberts, Tr. 489; Van Wagner, Tr. 1713; CX 504).
370. After terminating the contract, Aetna sent direct offers to NTSP's participating physicians. NTSP's participating physicians were not prevented from dealing directly with Aetna, and Aetna was able to contract directly with most of the physicians who had been part of the NTSP-Aetna contract. (Roberts, Tr. 544-46; RX 1076; RX 9).
371. In 2001, NTSP made a non-risk contract proposal to Aetna incorporating NTSP's medical management and utilization management functions. NTSP also provided data showing NTSP's performance on other contracts. (Roberts, Tr. 508, 550-51, 560; Van Wagner, Tr. 1709-12; CX 553; CX 616).
372. Aetna would like to receive more proposals like NTSP's proposal that incorporate utilization management. (Roberts, Tr. 558).
373. Problems with Aetna's own internal data prevented Aetna from evaluating NTSP's claims of high performance with its own data. (Roberts, Tr. 560-62).
374. The Texas Commissioner of Insurance issued admonishment letters to Aetna in October of 2001 as a result of Aetna's contracting practices. This occurred after NTSP had reported Aetna to the Texas Department of Insurance in 2000 and 2001

for prompt pay violations, noncompliance with contracts, and predatory pricing concerns. (Van Wagner, Tr. 1772; RX 3105 (Aetna ordered to pay restitution and fines for violations through October of 2001); CX 508 (Aetna response referencing Commissioner's letter)).

375. NTSP's review of Aetna contracts intensified and NTSP demanded that Aetna comply with state law after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-73).
376. In November of 2001, the Texas Department of Insurance fined Aetna \$1.15 million and ordered it to pay restitution to providers for failing to follow Texas laws on prompt payment and clean claims. (RX 1660; RX 1666; RX 3105).
377. In December of 2001, Aetna came to NTSP with a non-risk contract proposal that was below Board minimums. NTSP was not able to be involved in this contract. (Van Wagner, Tr. 1713; CX 643).
378. In 2002, NTSP made complaints about Aetna's contracting practices to the Texas Department of Insurance. NTSP also sent a complaint letter to Aetna, with a copy to the Texas Department of Insurance. Aetna was aware of NTSP's complaints. (CX 507; CX 509; CX 512; CX 513; RX 2325).
379. In April of 2002, NTSP received notice of a Senate Special Committee Hearing on prompt payment. (RX 1152).
380. There is no current contract between NTSP and Aetna. (Roberts, Tr. 549; Van Wagner, Tr. 1718-19).

United Healthcare

381. Health Texas Provider Network (HTPN) and NTSP entered into a group agreement for physician services under which NTSP could make available to its

eligible physicians the payor contracts HTPN participated in. NTSP's eligible physicians could then either opt in or out. NTSP did not participate in discussions with payors regarding HTPN contracts. (Frech, Tr. 1444; Van Wagner, Tr. 1559-60; RX 1947).

382. One of the contracts made available to NTSP's participating physicians through HTPN was a United contract. (Van Wagner, Tr. 1726-27).
383. United only made offers on a non-risk contract that were below NTSP's Board minimums or the rates already available to NTSP participating physicians through the HTPN contract. (Van Wagner, Tr. 1726-27; CX 87). As a result, NTSP did not act on United's direct proposal, and its participating physicians contracted with United through HTPN. (CX 1012).
384. NTSP treated patients for the City of Fort Worth under a risk contract with PacifiCare. In 2001, the City of Fort Worth decided to become self-insured and began accepting bids from payors to become the administrator of its health plan. (Mosley, Tr. 148-49).
385. One of the bidders against PacifiCare was United. (Mosley, Tr. 203-05; Van Wagner, Tr. 1743). United planned to replace PacifiCare's risk contract with NTSP. (Mosley, Tr. 206-07; Quirk, Tr. 363-65). United's actions would have the effect of removing a major employer's patients from NTSP's risk network and substituting in its place a four-year-old non-risk contract NTSP had through HTPN. (Van Wagner, Tr. 1728-29; CX 1042).
386. NTSP had the right to terminate its contractual relationship with HTPN for treating United patients and did so. NTSP's termination affected approximately 100 of the approximately 600 physicians eligible to participate on NTSP's

- contracts. (Quirk, Tr. 356; Van Wagner, Tr. 1727-29; CX 1068).
387. United told physicians that termination of the HTPN contracts with NTSP was “the result of a mutual decision.” (CX 1068).
388. United was not interested in dealing with NTSP and admits it does not need NTSP. (Quirk, Tr. 288-90, 297-98, 360, 433; CX 1034 (United correspondence stating NTSP is “not critical” to the network)).
389. NTSP, as an existing provider for the City of Fort Worth, communicated with the City its concerns about the adequacy of United’s network and utilization management for the City’s patient population. (Van Wagner, Tr. 1729-30; Deas, Tr. 2425; CX 1075).
390. NTSP arranged a meeting with the City. NTSP informed the City of the termination of the HTPN contract. NTSP expressed concerns about United being able to provide care to the City. (Mosley, Tr. 185-87; Van Wagner, Tr. 1730-33; Vance, Tr. 856-57; Deas, Tr. 2424-25, 2429-30; CX 1031; CX 1075).
391. NTSP expressed concern that the City would rely on United to monitor and control utilization. NTSP explained the importance of utilization management and offered its data and utilization management services to the City. (Mosley, Tr. 227-28; Van Wagner, Tr. 1730-33, 1741-42, 1744; Deas, Tr. 2424-25, 2429-31; RX 2051; CX 1075).
392. NTSP never asked the City to take any action with respect to fee levels. (Mosley, Tr. 195).
393. NTSP predicted to the City that their overall health care costs would increase using United because of the change from a risk to non-risk contract and United’s inadequate panel. (Deas, Tr. 2431-32; CX 1075).

394. United had significant cost overruns in excess of \$10 million over its estimation. The City's total medical costs under the United contract greatly exceeded its costs under the PacifiCare risk contract. The City considered the problem of "claims escalating at such an alarming rate" as "a matter of concern." (Mosley, Tr. 211-12, 224-25; Quirk, Tr. 376-78; RX 195; RX 197; RX 199).
395. To deal with United's cost overruns, the City had to discontinue its HMO programs and raise co-pays. (Mosley, Tr. 224-25).
396. The approximately 100 physicians who had been contracted with United through NTSP's arrangement with HTPN initially gave NTSP powers of attorney to try to enter a new contract with United. (Van Wagner, Tr. 1749; CX 1065).
397. The powers of attorney allowed NTSP to 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. (Van Wagner, Tr. 1706; CX 1083; CX 1065.003)
398. NTSP explained the meaning of the powers of attorney to United and informed United that any non-risk contract would have to be messengered to the physicians using the messenger model. (Quirk, Tr. 341-42, 419; Deas, Tr. 2432; CX 1122; CX 1083; CX 1086; RX 283).
399. NTSP explained its messenger model to United, including its use of the poll and Board minimums. (Quirk, Tr. 300-01; Deas, Tr. 2433; CX 1083).
400. United HealthCare representatives never saw an executed power of attorney and had no personal knowledge of interactions between NTSP and its participating physicians concerning powers of attorney. (Quirk, Tr. 328).
401. The powers of attorney were never delivered to United or used. (Quirk, Tr. 328,

- 418-19; Van Wagner, Tr. 1749).
402. After the termination of the HTPN contract in July of 2001, United did not make NTSP an offer above Board minimums that was able to activate the network and be messengered. (Van Wagner, Tr. 1745).
403. NTSP reported United to the Texas Department of Insurance in 2000 and 2001 for prompt pay violations, noncompliance with contracts, and predatory pricing concerns. (Van Wagner, Tr. in 1772). In November of 2001, the Texas Department of Insurance fined United \$1.25 million and ordered it to pay restitution to providers for failing to follow Texas laws on prompt payment and clean claims. (RX 3103).
404. NTSP's review of United contracts intensified and NTSP demanded that United comply with state law after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-73).
405. United broke off negotiations with NTSP and signed new non-risk contracts directly with physicians and at least one other IPA – ASIA. Through these other contracts, United was able to contract with many NTSP participating physicians. NTSP's participating physicians were never prevented from dealing with United directly or through another IPA. (Quirk, Tr. 334, 411; Beaty, Tr. 462, 464; Van Wagner, Tr. 1745; CX 1074 (fax alert telling NTSP physicians to contact ASIA or United directly for contracting opportunities)).
406. Ultimately, United approached NTSP again. United offered NTSP the same rates it offered ASIA and MCNT. The offer was above Board minimums, and NTSP messengered the contract. (Quirk, Tr. 348-49, 411-12; Van Wagner, Tr. 1745-46; CX 1119 (United correspondence regarding NTSP rates same as ASIA and

MCNT)).

407. United agreed to provide NTSP with claims data to assist in its medical management activities. United has not yet provided any such data. (Van Wagner, Tr. 1533, 1695-96).

Cigna

408. Cigna acquired Health Source in 1999. Cigna requested that Health Source assign its contracts to Cigna. Many NTSP participating physicians had direct contracts with Health Source and received a letter asking their permission for assignment of the contract to Cigna. (Grizzle, Tr. 767-70).
409. There were questions concerning whether physicians could refuse assignment, what would happen if a physician already had a contract with Cigna, and what would happen when Health Source ultimately went out of business. (Grizzle, Tr. 769-771; Van Wagner, Tr. 1752-54).
410. Some NTSP participating physicians went to NTSP regarding the Health Source situation and requested that NTSP contact Cigna. (Van Wagner, Tr. 1752). NTSP did contact Cigna regarding these issues. (Van Wagner, Tr. 1753-54).
411. NTSP sought a risk contract with Cigna, beginning in 1999. (Grizzle, Tr. 775; Van Wagner, Tr. 1754-55; CX 763, *in camera*).
412. Most of NTSP and Cigna's discussions from the time period 1999-2003 related to risk contract proposals. (Grizzle, Tr. 775-76, 942-43, *in camera*; Van Wagner, Tr. 1756).
413. NTSP and Cigna entered into a Letter of Agreement (LOA) in October of 1999. (Van Wagner, Tr. 1756; CX 782A, *in camera*).
414. NTSP's intentions at the time it entered into the LOA with Cigna was to quickly

convert the LOA into a risk contract. Cigna was unable to enter a risk contract at that time because of specialty carve-out policies and problems with contractual language in its standard risk agreements. (Van Wagner, Tr. 1759-61).

415. The LOA was entered into by NTSP and Cigna in anticipation of a risk contract. The LOA specifically called for the establishment of a risk contract within a short time. (Van Wagner, Tr. 1757-58; CX 784; CX 782A, *in camera*).
416. Cigna and NTSP were never able to agree on the terms of a risk contract, and the LOA continues to operate. (Van Wagner, Tr. 1758).
417. The 1999 LOA was amended in January of 2000 (first amendment) to add a PPO product. (CX 769).
418. Cigna breached the LOA by not paying NTSP's participating physicians in accordance with the fee schedules attached to the first amended LOA. NTSP complained to Cigna regarding its continued failure to pay in accordance with the agreed upon schedule and considered the failure a material breach. (Grizzle, Tr. 797; Van Wagner, Tr. 1769; RX 497 (Board minutes regarding fee schedule problems); RX 960, *in camera*; RX 1486 (correspondence with Cigna), *in camera*).
419. Cigna's payment problems continued until December of 2000, when NTSP requested a schedule of compliance. (CX 792, *in camera*).
420. Cigna breached the LOA by not adjusting the fee schedule to current year RBRVS as provided in the contract. (Grizzle, Tr. 799-800; Van Wagner, Tr. 1979-80).
421. The 1999 LOA was amended in May of 2000 (second amendment) [
] (CX 770, *in camera*).

422. [

] (Grizzle, Tr. 927,

in camera; Van Wagner, Tr. 1764-66).

423. Cigna breached the LOA [

] Instead, Cigna claimed to be

“assigning” the carve-out contract, not terminating it. (Grizzle, Tr. 928-30, *in camera*; Van Wagner, Tr. 1766-68; CX 775; CX 784; CX 785, *in camera*; CX 786, *in camera*).

424. Cigna told NTSP to work out an agreement with APN, the cardiologists who were “assigned” the cardiology contract. (Grizzle, Tr. 929-30, *in camera*; Van Wagner, Tr. 1768; CX 784; CX 785, *in camera*).

425. The contract between Cigna and APN was a risk contract. (Grizzle, Tr. 930-33, *in camera*). The subsequent contract discussions between NTSP and APN related to a risk contract because the proposed contract had a floating fee schedule. (Van Wagner, Tr. 1609-11, 1770; Lovelady, Tr. 2643-44).

426. NTSP’s contract with Cigna provided, [

] (RX 20, *in camera*).

427. Family practice physicians and internal medicine physicians are specialists. (Grizzle, Tr. 781; Deas, Tr. 2529-30; Lonergan, Tr. 2696).

428. Cigna breached the LOA by not allowing family practice and internal medicine specialists on NTSP’s primary care physician panel to participate in the contract. (Grizzle, Tr.780-81, 940-42, *in camera*; Van Wagner, Tr. 1762-64; Deas, Tr. 2529-30; Lonergan, Tr. 2696).

429. [

] (Grizzle,

Tr. 940-42, *in camera*).

430. In June of 2001, due to Cigna's breach of contract refusing to allow certain specialists to participate, NTSP sent a termination notice for the PPO portion of the second amended LOA. (Van Wagner, Tr. 1771; CX 756).

431. The 1999 LOA was amended in August of 2001 (third amendment) [

] (Grizzle, Tr. 942-43, *in camera*; Van Wagner, Tr. 1771; CX 809, *in camera*).

432. Cigna subsequently breached the LOA by not paying the primary care physician capitation payments in accordance with the contract. (Van Wagner, Tr. 1770).

433. NTSP did reach a different kind of risk arrangement with Cigna than originally anticipated. NTSP's current Cigna contract includes risk elements: PCP capitation payments, a pay-for-performance provision, and a withhold provision. (Van Wagner, Tr. 1758-59, 1761).

434. The risk elements in NTSP's Cigna contract provide significant incentives that classify NTSP's Cigna contract as a risk contract. (Maness, Tr. 2054-56). Pay-for-performance provisions are a form of risk contract. (Frech, Tr. 1398-99; Van Wagner, Tr. 1608-09; Lovelady, Tr. 2641-42). Withhold provisions are a form of risk contract. (Mosley, Tr. 132-33; Frech, Tr. 1398; Van Wagner, Tr. 1605-06, 1609; Lovelady, Tr. 2642-43).

435. [] (Grizzle, Tr. 946-47, *in camera*; Van Wagner, Tr. 1974).
436. [] (Grizzle, Tr. 946-47, *in camera*; Van Wagner, Tr. 1974). NTSP missed the bonus by only \$3 PM/PM. (Van Wagner, Tr. 1974-75).
437. [] because high medical inflation rates make these [] impossible to reach. (Grizzle, Tr. 947-48, *in camera*; Van Wagner, Tr. 1974-76).
438. [] (Grizzle, Tr. 886, 945-46, *in camera*; Van Wagner, Tr. 1525-26).
439. Based on Cigna's data, NTSP runs cost analyses, code patterns, and high-acuity patient reports for individual providers. (Van Wagner, Tr. 1532).
440. In September of 2001, the Texas Attorney General investigated Cigna's payment methodology. (CX 108 (Board minutes reporting OAG letter); RX 1290; RX 1651).
441. NTSP has also reported Cigna in 2000 and 2001 to the Texas Department of Insurance for prompt pay violations, noncompliance with contracts, and predatory

pricing concerns. (Van Wagner, Tr. 1772). In August of 2001, TDI took action against Cigna for violations of Texas claims payment laws. Cigna was fined \$1.25 million and ordered to pay restitution to providers as a result of its failure to comply with clean claims laws. (RX 3103).

442. NTSP's review of Cigna contracts intensified and NTSP demanded that Cigna comply with state law after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-73).

Blue Cross

443. NTSP tried to negotiate risk contracts with Blue Cross, but the parties never agreed upon terms. (Van Wagner, Tr. 1719-20; RX 1421 (memorandum regarding Blue Cross risk proposal); CX 84 (Board minutes reporting Blue Cross risk proposal)).
444. NTSP is currently in discussions with Blue Cross regarding a risk contract. (Van Wagner, Tr. 1719-20).
445. Blue Cross has never brought NTSP a non-risk contract proposal that met Board minimums for NTSP to participate and messenger the offer. (Van Wagner, Tr. 1721).
446. In May of 2002 and July of 2003, NTSP messengered a HTPN/Blue Cross offer of 125%/130% that fell below Board minimums. (RX 1275; CX 416).
447. NTSP participating physicians had access to a Blue Cross contract through HTPN. NTSP had no part in the determination of the rates on the HTPN contract. (Van Wagner, Tr. 1720-21). The rates on the HTPN contract were more favorable than any offer Blue Cross made to NTSP. (Van Wagner, Tr. 1723; CX 306).

448. Blue Cross does not need NTSP. Blue Cross has no current contract with NTSP and does not have any contracting needs in Tarrant County. (Van Wagner, Tr. 1720; CX 709 (letter describing Blue Cross’s refusal of a NTSP offer and statement that they have no contracting needs in Tarrant County)).
449. NTSP’s participating physicians were never prevented from dealing directly with Blue Cross. (CX 705 (fax alert reporting Blue Cross direct contracts); CX 73 (fax alert offering direct option for physicians for Blue Cross through HTPN)).
450. 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 clean claim laws. (RX 3103).
451. NTSP’s review of Blue Cross contracts intensified after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-73).

Proposed Conclusions of Law

Jurisdiction

Interstate Commerce

1. The FTC Act prohibits unfair methods of competition “in or affecting commerce.” 15 U.S.C. § 45. The FTC Act defines commerce as meaning “commerce among the several states.” 15 U.S.C. § 44. In finding jurisdiction under Section 5, the Commission has applied the same legal standards as federal courts have applied under the Sherman Act. *See McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 241-42 (1980).
2. Complaint Counsel has the burden to 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).

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. "To establish jurisdiction a plaintiff must allege the critical relationship in the pleadings and if these allegations are controverted must proceed to demonstrate by submission of evidence beyond the pleadings either that the defendants' activity is itself in interstate commerce or, if it is local in nature, that it has an effect on some other appreciable activity demonstrably in interstate commerce." *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 242 (1980) (citing *Gulf Oil Corp. v. Copp Paving Co.*, 419 U.S. 186, 202 (1974)).
5. Complaint Counsel alleges that an effect on interstate commerce is demonstrated because: (1) the collective price negotiations and other conduct of NTSP affects interstate commerce; (2) NTSP physicians accept payments from the federal government through the Medicare and Medicaid programs; (3) NTSP physicians provide medical services to patients from outside the state of Texas; and (4) both NTSP and its physician members make substantial purchases from vendors located outside the state of Texas.

6. Complaint Counsel cannot prove an effect on interstate commerce under any of its four theories for the following reasons: (1) there is no evidence of any collusion among NTSP and participating physicians; (2) there is no evidence that the actions of the participating physicians can be attributed to NTSP; (3) there is no evidence that NTSP the entity has provided any medical services to patients outside the state of Texas; (4) there is no evidence that NTSP's dealings with the Texas offices of insurers, and indirectly, with employers, affects the out-of-state business decisions of the insurers and employers; and (5) there is no evidence that any of the conduct at issue occurred outside the state of Texas.

Corporation for Profit

7. The "Commission has only such jurisdiction as Congress has conferred upon it by the Federal Trade Commission Act." *Community Blood Bank v. FTC*, 405 F.2d 1011, 1015 (8th Cir. 1969). When the jurisdiction of the Commission is challenged, the Commission bears the burden of establishing its jurisdiction. *Community Blood Bank v. FTC*, 405 F.2d 1011, 1015 (8th Cir. 1969).
8. Under Section 5 of the FTC Act, the Commission has jurisdiction to prevent "corporations" from using unfair methods of competition. 15 U.S.C. § 45. The FTC Act defines "corporation" to include "any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members." 15 U.S.C. § 44. Complaint Counsel must prove that NTSP is an association acting for the pecuniary interest of its participating physicians. 15 U.S.C. § 45.
9. NTSP is incorporated under Section 162.001 of the Texas Occupations Code, formerly Section 501(a) of the Texas Medical Practice Act, as an organization

with no members. TEX. OCC. CODE ANN. § 162.001 (Vernon 2004).

10. Because NTSP is a memberless organization, it is not a “corporation” under the FTC Act, and the FTC lacks jurisdiction over NTSP.
11. NTSP is also a nonprofit corporation that 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).
12. To determine whether a nonprofit entity is organized to carry on business for its own profit or that of its members, there is no “threshold percentage of activity” of the nonprofit entity’s total activities which must be aimed at its members’ pecuniary benefit. *Cal. Dental Ass’n v. FTC*, 526 U.S. 756, 766 (1999). Courts look to the pecuniary benefit received by members of nonprofit organizations. *See, e.g., In re Mich. State Med. Soc’y*, 101 F.T.C. 191 (1983).
13. Because NTSP is a memberless organization, it cannot as a matter of law provide pecuniary benefits to any members. Alternatively, even if NTSP had any members, there is no evidence in the record that NTSP provided any tangible, pecuniary benefits to them as to the conduct at issue.

Burden of Proof

14. 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).

15. “[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).

Relevant Geographic and Product Market

16. 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. *Cal. 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).
17. 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.”).
18. 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.” *Cal. Dental Ass’n v. FTC*, 526 U.S. 756, 771 (1999).

19. Complaint Counsel has not even attempted to prove a relevant market in this case. *See* RPF 197-99, 236. The following has been determined regarding the relevant market:

Product Market

20. 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).
21. 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).
22. 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. *See* RPF 237-239.

Geographic Market

23. 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).
24. 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. *See* RPF 208-09, 212.

25. 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. *See* RPF 207-08.

Violations of the Complaint

The Legal Framework for Analysis of Horizontal Restraints

26. For the Administrative Law Judge to find such a violation, Complaint Counsel must prove: (1) the existence of a contract, combination, or conspiracy among two or more separate entities, which entities are subject to the antitrust law, that (2) unreasonably restrains trade, and that (3) the acts or practices are in or affecting interstate or foreign commerce. *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990).
27. 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. *Cal. 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 Cal. Dental Ass'n*, 526 U.S. at 763 n.3.
28. 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. *Cal. 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).

The Per Se Approach Is Not Applicable

29. “[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.” 526 U.S. at 779.
30. 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.” *Cal. 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.
31. 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. 526 U.S. at 771.

The Quick Look Approach is Not Applicable

32. 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.” *Cal, 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.

33. 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. *Cal. Dental Ass’n v. FTC*, 526 U.S. 756, 778 (1999).

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

Complaint Counsel has not proven a relevant market.

34. 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).
35. The Merger Guidelines analysis for defining relevant markets applies in non-merger contexts. *E.g.*, *C.F. Indus., Inc. v. Surface Trans. Bd.*, 255 F.3d 816, 824 (D.C. Cir. 2001) (upholding Surface Transportation Board decision regarding market dominance based, in part, on the Merger Guidelines); *Todd v. Exxon Corp.*, 275 F.3d 191, 208-09 (2d Cir. 2001) (disagreeing with district court’s conclusion based on application of Merger Guidelines in section 1 case to define relevant market, but not criticizing district court’s use of Merger Guidelines to define market); *United States v. Visa U.S.A., Inc.*, 163 F. Supp. 2d 322, 335 (S.D.N.Y. 2001) (relying on Merger Guidelines in section 1 case); *Anti-Monopoly v. Hasbro, Inc.*, 958 F. Supp. 895, 902 (S.D.N.Y. 1997) (relying on Merger

Guidelines in non-merger case); *Virtual Maintenance, Inc. v. Prime Computer, Inc.*, 735 F. Supp. 231, 235 (E.D. Mich. 1990) (denying summary judgment in tying case based, in part, on expert testimony regarding market definition under the Merger Guidelines).

36. Complaint Counsel has not proven a relevant market in this case. Complaint Counsel's expert did not posit a relevant market. Further, Complaint Counsel's expert did not calculate any concentration ratios, did not perform any other type of concentration analysis, and did not perform any type of entry analysis. *See* RPF 197-99. Therefore, liability against NTSP under a rule of reason analysis fails.

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

37. 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 Cal. 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).
38. 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 Cal. 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).

39. 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).
40. 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. *Cal. Dental Ass'n v. FTC*, 526 U.S. 756, 770 (1999).
41. Although not necessary, NTSP has shown justifications for its conduct based on its efficiency-directed "spillover" business plan and NTSP's legal, financial, and operational reasons for refusing to be involved in payor's offers. *See* RPF 85-120, 163-82.

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

42. 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).

43. 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. *See* RPF 153-58, 160-62.
44. 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).
45. 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. *See* RPF 137-38, 159-62.
46. 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.
47. 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”).

48. NTSP’s conduct in exercising its *Colgate* right to refuse to deal need not be economically justified because that is a legal right.
49. 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.
50. 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).
51. 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.
52. 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).

53. 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. *See* RPF 85-96.
54. A trade association is not "by its nature a 'walking conspiracy'." *Viazis v. Am. Ass'n of Orthodontists*, 314 F.3d 758, 764 (5th Cir. 2002).
55. "In medical care, it must be remembered, a provider's higher prices are not necessarily indicative of a less competitive market; they may correlate with better services or more experienced providers." *Doctor's Hospital, Inc. v. Southeast Med. Alliance, Inc.*, 123 F.3d 301, 310 (5th Cir. 1997).
56. Texas law allows physicians to communicate with their patients about network adequacy issues and compensation rates. *See* TEX. INS. CODE ANN. § 843.363 (Vernon 2004).
57. Texas law imposes certain duties on health plans and related entities: "A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health

care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.” *See* TEX. CIV. PRAC. & REM. CODE § 88.002(a).

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Gregory S.C. Huffman, hereby certify that on June 16, 2004, I caused a copy of the foregoing to be served upon the following persons:

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