UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

Public Version

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

COMPLAINT COUNSEL'S PRETRIAL BRIEF

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes, Regulations and Guidelines

Other Authorities

I. INTRODUCTION

The Federal Trade Commission ("Commission") brings suit to prohibit North Texas Speciality Physicians ("NTSP"), an independent physician association located in the Forth Worth area, from continuing to collectively fix prices in violation of Section 5 of the FTC Act.

The key issue in this matter is whether NTSP, acting with, by, and for its member physicians, restrained price competition among those physicians, and if so, whether these restraints were reasonably ancillary or necessary to achieve cognizable and plausible efficiencies. Not only is the evidence of concerted action relating to price and other terms of competition abundantly clear, but NTSP has offered nothing more than conjecture to carry its burden of proving reasonably ancillary efficiencies. There is overwhelming evidence that NTSP's conduct was anticompetitive and not justified by any procompetitive efficiencies

NTSP was founded for the purpose of negotiating health plan contracts, including reimbursement rates. Originally, NTSP negotiated risk-sharing contracts for managed care plans, under which NTSP and its members physicians accepted monthly payments in exchange for providing whatever medical services covered members required. Over the past four years, however, the market has moved away from such risk-sharing managed care plans, and NTSP has changed its focus to negotiating contracts with fee-for-service reimbursement for non-risk sharing health plans.

NTSP engages in aggressive price negotiations with health plans, in which it attempts to obtain above-competitive-level prices for its [redacted] member physicians. These collective rate negotiations constitute a restraint of price competition among these otherwise-competing physicians, implemented by and through NTSP acting as their agent and representative.

NTSP and its members have engaged in numerous collusive practices in furtherance of this price agreement. NTSP has collected "powers of attorneys" from a number of its individual physicians, giving it the right to negotiate price and other contract terms on behalf of those members. NTSP has used these powers of attorney to strengthen its position in negotiating fees with health plans. The powers of attorney are supplemented by NTSP's Physician Participation Agreement which gives NTSP a first right to negotiate with health plans before members have the right to negotiate with the plan directly. NTSP also conducts polls of its members, through which future price information is collected from its member physicians and disseminated back to its members. Based in part on the poll data, NTSP's Board of Directors, which is made up entirely of member physicians, has established "minimum" acceptable fees, and rejected health plans offers below those minimums. Though holding itself out as a "messenger model" IPA, NTSP regularly refused to "messenger" offers below its minimum contract price to member physicians for individual decisions to opt in or opt out of a specific plan until it had succeeded in negotiating higher fees.

Such price-related collective action by a physician group is unlawful under leading court decisions, and is condemned by the Commission's own *Health Care Statements*. *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999); *Michigan State Medical Soc'y*, 101 F.T.C. 191 (1983); *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986); U.S. Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (August 28, 1996) ("*Health Care Statements*"). The acts of NTSP, taken individually and as a whole (as they must be), restrained price competition among its member physicians. *In re High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d 651, 661 (7th Cir. 2002)

(Posner, J.) ("*HFCS*"). Moreover, the "efficiencies" claimed by NTSP to justify this conduct--which NTSP has the burden of proving--are not plausible, and are not legally cognizable because they are not reasonably related to the price restraints, and could have been achieved without engaging in collective price negotiations and the other price-related conduct at issue here.

II. SUMMARY OF FACTS

A. NTSP Collectively Sets Rates for Medical Services

The primary purpose and activity of NTSP is to engage in collective fee negotiations on behalf of its [redacted] member physicians.[1] NTSP engages in aggressive price negotiations with health plans to obtain supracompetitive prices for its member physicians. These collective rate negotiations constitute a price fixing agreement among these otherwise-competing physicians, implemented by and through NTSP acting as their agent and representative. Whether or not NTSP member physicians directly agree among themselves on their contract prices, they use NTSP as an agent subject to their control to establish fees and to negotiate and execute contracts on their joint behalves. These actions amount to a price agreement among competitors.

NTSP ensures that its physicians will act "collectively" the moment they join the IPA.[2] A physician becomes an NTSP member by entering into a participation agreement with the IPA. Signatories to NTSP's key participation agreement covenant that [redacted]

---

[1] *See e.g.*, CX0275; CX0370 at NTSP000064; CX1196 at 11,12, 15-16 (Van Wagner depo); CX0311 at 10-11; CX0311 at NTSP000029, NTSP000032-34, NTSP000038-39.

[2] CX0 311.

[redacted].[3] Furthermore, they agree that [redacted]

[redacted].[4]

NTSP also relies significantly on polling of its member physicians as an important tool in its price fixing. NTSP polls its member physicians to determine what fees they would accept for current and future contracts with health plans.[5] This data is used for a number of purposes. First, NTSP staff calculates the fees that would be acceptable to the "average" physician (using "mean, median and mode" calculations).[6] NTSP typically then disseminates the aggregated information to member physicians to relay what prices their competitors, on average, will demand in the future.[7] The dissemination of future pricing information encourages individual physicians to maintain a unified front through NTSP to achieve these "average" prices for all physicians, rather than sign individual contracts with health plans at lower fee levels.

---

[3] CX 0276.

[4] Section 2.1 of the Participation Agreement provides that, subject to limited exceptions not pertinent to this discussion, "[redacted] CX0311 at NTSP000032; Section 2.6 of the Participation Agreement provides that "[redacted]" CX0311 at NTSP000034.

[5] CX0274.

[6] CX 0103; CX1196 at 26-29, 43-44, 62:15-21, and 78-80 (Van Wagner depo).

[7] *See e.g.*, CX0393; CX1194 at 87-88; CX1196 at 43-62 (Van Wagner depo).

Second, the Board, which is made up entirely of doctors, also uses the poll results to establish "minimum" prices that it believes would be acceptable to most NTSP members.[8] Based on this minimum, NTSP rejects health plan offers that it considers too low without consulting its members or giving them an opportunity to "opt into" a health plan proposal that is below the Board-established minimum.[9] After NTSP's Board or staff rejects a health plan offer, the health plan sometimes submits a new proposal with higher fees that it thinks may be acceptable to NTSP.[10] This process may continue until NTSP has obtained the fee levels it desires. Only when NTSP has obtained an acceptable fee agreement will it "messenger," or pass on, the health plan proposal to its physician members for individual decisions on whether to participate. NTSP has expressly refused to "messenger" health plan offers that NTSP's Board regarded as too low.

In order to maintain and strengthen its bargaining power, NTSP periodically warns its physicians to abstain from negotiating direct contracts with health plans and to refer any health plan contacts to NTSP staff in accordance with their [redacted].[11] NTSP's physicians then often refer health plans attempting to contract with them directly back to NTSP, with the knowledge that NTSP will reject offers below the collectively established minimum. One health plan received 40 identical letters from physicians directing the health plan to contact

---

8 CX0617.

9 CX1196 at 62:22-63:07 (Van Wagner depo); CX1196 at 153-54 (Van Wagner depo); CX1173 at 26-29 (Deas depo).

10 Quirk depo at 43, 53-54, 64-65; Jagmin depo at 95:04-08; Jagmin depo at 117: 06-118:11; CX1098; CX0627; CX0565; CX0580; CX0582; CX0585; CX0591; CX0104; CX0789; CX0799; CX0790; CX 1012.

11 *See e.g.*, CX0500; CX0942.

NTSP rather than the physicians, because NTSP was acting as their agent in negotiating the non-risk sharing contract in question.[12]

To further strengthen its negotiating power with health plans, NTSP has at times used its power to act on behalf of its members to terminate existing contractual relationships between a health plan and a significant number of NTSP's participating physicians.[13] NTSP also on occasion has gone to a large employer that had signed a contract with a health plan, and warned the employer that NTSP physicians might not participate in the health plan's network unless the employer "assisted" NTSP in obtaining higher fees from the health plan.[14] A health plan has testified that these actions forced it to offer higher fees to physicians in order to assuage the employer's concerns about the adequacy of its network to serve a Fort Worth-based employee population.[15] At various times, NTSP has collected "powers of attorneys" from a number of its individual physicians, giving NTSP the right to negotiate contract terms–including price terms–on behalf of those members.[16] NTSP has used these powers of attorney to strengthen its hand in negotiating fees with health plans. NTSP also has threatened to cancel existing NTSP agreements unless the health plan accepts its demands for higher fees.[17] Actions such as these

---

12 CX0760.

13 Pursuant to powers of attorney, on or about [redacted], NTSP terminated its member physicians' participation in the [redacted] arrangements effective on or about [redacted] *See* CX0546.

14 *See e.g.*, CX1043.

15 Quirk depo at 89:04-12, 134:04-14, 104:21-105:18.

16 CX1065 ; CX0107. *See also* CX1173 at 56-57.

17 CX0786; CX0583; CX0256.

deliver a clear message to health plans that contracting individually with NTSP physicians will likely be met with stiff resistance by NTSP and its physicians and thus is not likely to be successful.

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

Health plans need primary care physicians and specialists from the Fort Worth area in order to market their plans in the Fort Worth area of Tarrant County, and they would not substitute physicians whose services are available in other areas such Dallas County or the Mid-Cities area to avoid a small but significant Fort Worth area price increase. Employers and consumers in Fort Worth require that their health plan offers a broad array of physician services in Forth Worth because they do not want to travel outside of that area on regularly congested roads to visit a physician. For this reason, employers in Fort Worth, including [redacted], have testified to the importance of having Fort Worth doctors in a network.[18] Health plans will testify that they would not be able to effectively market their products to Fort Worth employers, nor would they even try, without a sufficient number of Fort Worth physicians in their network. Health plans also will testify that, even if the price of Fort Worth area physician services increased by five percent or greater, they would still need to have Fort Worth area physicians in their provider panels in order to serve Fort Worth employers and consumers. There is also abundant evidence that NTSP recognizes that it serves a Fort Worth market.[19] Because of

---

[18] CX1188 at 53.

[19] For example, NTSP described itself as being in the Ft. Worth or Tarrant County market; "[redacted]." "The entrance of managed care into the Ft. Worth market..."; [redacted] resigned from NTSP in [redacted], writing: "[redacted]

the necessity of having Fort Worth area physicians to serve employers and consumers in that city, health plans could not switch to Dallas County physicians in order to avoid anticompetitive behavior by a group of Fort Worth area physicians.

C. NTSP Physicians are an Integral Part of a Fort Worth Network

NTSP has approximately [redacted] member physicians, of which about [redacted] are primary care physicians and the remainder specialists.[20] The vast majority of NTSP physicians are located in the Fort Worth area of Tarrant County. To be competitively marketable in the Fort Worth area, a health plan's health insurance plan must include in its physician network a large number of primary care physicians and specialists who practice in the Fort Worth area.

Many of the primary care physicians and specialists who practice in the Fort Worth area are among NTSP's participating physicians NTSP physicians make up a large percentage of Tarrant County practitioners in many medical specialties: [redacted]

[redacted] wrote to a physician in [redacted], [redacted], refusing an application to join NTSP, saying that [redacted] wrote in an email in connection with NTSP's [redacted] contract: "[redacted]" (*sic*) and Dr. Jack McCallum testified regarding NTSP's market: [redacted]. Sources: "Responses to Specifications by Questions", NTSP; CX0268; CX0269; CX1110; CX1187 at 59 (McCallum depo).

[20] CX1196 at 12.

[redacted]; [redacted]; and [redacted].[21]

Moreover, there are two hospitals in Fort Worth -- [redacted] and [redacted] -- that health plans and employers believe are critical in a health plan's network. For some specialties, NTSP physicians account for [redacted] percent of the billing expenditures at these hospitals.

Because of NTSP's substantial percentage of physicians in many specialties, health plans recognized that they need NTSP's physicians to provide complete medical coverage in the Fort Worth area. Accordingly, health plans will testify that NTSP's membership included several critical groups of specialists in the Fort Worth area and that the marketability of their network would be severely compromised if they could not contract with these physicians. [redacted].[22] Not surprisingly, this health plan succumbed to NTSP's demands rather than risk the loss of so many crucial physicians. In fact, health plans typically give into NTSP's contractual demands as a result of NTSP's ability to cripple the health plans' Fort Worth area networks.

NTSP of course recognizes that it has this leverage over the health plans' Forth Worth

---

21 CX1151 at 7 and 8.

22 CX0779.

area health plans and uses this leverage to obtain higher fees from the health plans.[23] For example, NTSP has informed employers that their health plans' network coverage may be at risk unless the employer persuades the health plan to increase its proposed fees to NTSP's physicians. NTSP has also threatened to cancel existing agreements unless the health plan accepts NTSP's demands for higher contract fees. Of course, NTSP would not have made these threats if it did not control a large percentage of the Fort Worth area practitioners in many specialties.

D. NTSP Rates were Significantly Above Individually-Contracted Rates

As would be expected of a cartel, NTSP's price-fixing has significantly increased the prices of medical services in the Fort Worth area by inflating its member physicians' fees. NTSP even admits that its contracted fee schedules, collectively negotiated, are at higher prices than its physicians have agreed upon in direct negotiations. ("[redacted]")[24]

Several health plans have estimated that the price increase that they incurred as a result of NTSP's price-fixing has been substantial. For example, [redacted][26] [redacted]

---

23 "[redacted]." CX0209.

24 CX0518.

25 CX0569.

26 CX0265.

[redacted][27] Moreover, [redacted][28] [redacted].

The indisputable evidence, including admissions by Respondent, that NTSP's collectively-negotiated rates are significantly higher than competitively-negotiated rates refutes NTSP's assertions that health plans can easily: (1) substitute Dallas County physicians for Fort Worth area physicians; (2) build a viable network in the Fort Worth area by contracting with non-NTSP physicians; and (3) avoid contracting with NTSP by negotiating contracts directly with NTSP member physicians. It is illogical to claim that health plans can easily defeat in a variety of ways NTSP's attempt to fix prices when in actuality health plans are paying substantially higher fees as a result of NTSP's cartel.

E. NTSP Has Created Minimal if Any Efficiencies in its Non-Risk Sharing Practices

NTSP claims to have implemented many programs and procedures that have improved the quality and overall cost of medical care in its risk-sharing practices.[29] However, [redacted] of

---

[27] CX0755.

[28] CX0814.

[29] The primary method for sharing risk is for physicians to participate in "risk contracts" where the risk sharing involves accepting payment by capitation for the IPA as a whole. Capitation is a method of payment for medical care under which the capitated entity is paid a fixed amount (usually on a monthly basis) for each patient for whose care the entity is responsible, regardless of the actual number or nature of services provided to the patient. When physicians share capitated risk (the risk that the services provided will outstrip the capitation fees

NTSP's physicians do not participate in risk-sharing contracts and the [redacted] of NTSP's contracts are non-risk fee-for-service contracts. Currently NTSP has [redacted] risk-sharing contracts covering fewer than [redacted] lives while it has approximately [redacted] fee-for-service contracts covering [redacted] lives. Not surprisingly, therefore, NTSP has also claimed that efficiencies in risk-sharing practices have "spilled over" into non-risk sharing practices.

There is no evidence that this spillover has occurred. NTSP physicians admittedly have not integrated financially through NTSP. For the non-risk contracts challenged here, NTSP's members do not share the risk of financial loss. Non-risk contracts involve straight fee-for-service reimbursement, and, therefore, no risk. Indeed, NTSP does not even claim any degree of financial integration from its non-risk contracts. Furthermore, there is no evidence that NTSP's members have integrated their clinical services.

NTSP has not identified any cognizable efficiencies that have flowed to the non-risk sharing physicians, let alone provided a quantitative valuation of these efficiencies. Respondent has not proffered any evidence to demonstrate that NTSP's non-risk physicians perform better than non-NTSP physicians with regard to higher quality and patient satisfaction, and lower overall costs and utilization. In fact, a health plan that analyzed the overall cost performance determined that NTSP's physicians' costs were relatively higher than the costs of non-NTSP

---

paid), through an IPA for example, that creates interdependence among physicians and provides incentives for the doctors to deliver services efficiently. Where individual physicians (or individual integrated physician practices, take but do not share capitated risk, no such interdependence and mutual incentives for efficient care delivery are created. Capitation stands in contrast to the more traditional "fee-for-service" practice of medicine, under which physicians are paid only for the actual services they give a patient (and thus bear no risk).

physicians in the Fort Worth area.[30] Health plans will testify that, while NTSP *might* effectively manage its few risk-sharing arrangements, there is no credible evidence – and they do not believe – that efficiencies spilled over to the fee-for-service arrangements, and certainly not to the [redacted] of all NTSP physicians who never share risk.

Faced with this glaring lack of evidence necessary to meet its evidentiary burden, Respondent relies on general concepts of group teamwork and communication to support the proposition that its non-risk sharing physicians have benefitted from NTSP's risk-sharing practices. NTSP asserts that efficiencies from its risk-sharing practices somehow must have found their way over to NTSP's non-risk physicians due to improved communication and teamwork among members. Respondent, however, cannot explain how exactly NTSP has promoted communication and teamwork nor point to any tangible benefits that resulted from these alleged efficiencies.[31] For example, NTSP has not pointed to any risk-sharing initiatives or programs, such as the analysis of data from risk contracts and other activities, that would transfer the potential efficiencies gained from the risk-sharing practices to its non-risk physicians. In sum, Respondent cannot show that non-risk sharing physicians, and more importantly, their patients, have realized any efficiencies as a result of the NTSP's organizational structure or programs.

---

30 CX0750.

31 One of NTSP's experts testified that NTSP physicians communicate when they bump into each other in the hallways and cafeteria. Hughes depo at 97:16-21, and 99:14-100:09.

F. NTSP's Price Fixing Was Not Ancillary to the Alleged Efficiencies

Even assuming arguendo that NTSP's conduct results in some efficiencies, these alleged efficiencies are legally insufficient to justify NTSP's horizontal price-fixing agreements. Any efficiency spillover from the risk-sharing contracts to the fee-for-service contracts is unrelated to NTSP physicians' joint setting of medical service fees. In fact, NTSP makes little attempt to demonstrate why it must set prices collectively to accomplish its alleged efficiency goals.

Respondent asserts that, in order to maintain a continuity of the team, NTSP must negotiate a fee that will attract a substantial number, or critical mass, of physicians. NTSP, however, offers no evidence or analysis to support the proposition that some critical mass of physicians does in fact exist. Nor does Respondent offer any guidance for determining what the critical mass of physicians is.

NTSP apparently believes that a minimum physicians' fee is required in order to insure the same roster of doctors for every NTSP contract. NTSP, however, is unable to cite to any evidence or analysis that demonstrates that there is a correlation between the NTSP physician participation rate and the effectiveness of care. Nor is Respondent able to provide examples of any situations where the effectiveness of healthcare was lessened because a contract did not include a sufficient number of NTSP doctors. Moreover, NTSP offers no evidence to demonstrate that the continuity of care among NTSP doctors compares favorably with the continuity of care among independent doctors. Finally, even if there were some benefit to the health plans of having a majority of NTSP physicians in a health plan network, the health plans should be able to determine through the competitive process the number of NTSP physicians in

their network rather than having their pricing and participation levels dictated by NTSP's price-fixing.

G. NTSP's Anticompetive Behavior is Illustrated in its Dealings with Health Plans

NTSP's interactions with each health plan provide specific descriptions of how NTSP was able to successfully fix medical fees for its member physicians. The evidence shows that NTSP's physicians were able to successfully extract higher fees from the health plans by repeatedly engaging in price-fixing.

1. NTSP's Conduct with [redacted]

[redacted] was introduced to NTSP after purchasing [redacted] in late [redacted] requested that the physicians in [redacted] network assign their contracts to [redacted][32] While virtually all of the doctors accepted [redacted] request, NTSP's physicians were the exception. Instead, the NTSP physicians sent [redacted] identical letters, representing more than [redacted] doctors, to [redacted] refusing assignment and stating that NTSP would represent them as their agent in negotiations with [redacted][33] During these negotiations, NTSP insisted that [redacted] meet the IPA's minimum fee-for-service offers in order to obtain a contract with NTSP's physicians.[34] As a result of NTSP's physicians' collective negotiations, [redacted] agreed to rates that were significantly higher – [redacted] to [redacted] percent – than its individually-negotiated rates.

Over the next few years, NTSP frequently requested that [redacted] meet its changing

---

[32] CX0760.

[33] *Ibid.*

[34] CX0785.

demands for higher fees for the fee-for-service HMO and PPO contracts. When its members began to include primary care physicians, NTSP demanded that [redacted] allow these NTSP members to opt-in to the NTSP's [redacted] contract, even though [redacted] already had an adequate number of primary care physicians in its network.[35] [redacted] determined that, if NTSP physicians were allowed to opt-in to the [redacted] network, its overall costs would increase significantly because the NTSP contracts were at higher rates than [redacted] other contracts. At times during these "negotiations," NTSP threatened to terminate the NTSP contract and at one point actually did terminate a PPO contract until [redacted] succumbed to NTSP's demands.[36]

As a result of NTSP's demand for fees above the competitive level, [redacted] analyzed the importance of having NTSP's physicians in its Fort Worth area network. [redacted] determined that NTSP's physicians made up a high percentage of many specialty practices. [redacted] also frequently performed disruption analyses to determine the effect of losing access to NTSP's physicians. Based on these analyses, [redacted] concluded that it must have NTSP's physicians in its area network. Moreover, [redacted] concluded that, as a result of factors such as its analysis of NTSP's strength and unity, the identical letters designating NTSP as their agent, and the threats by NTSP to terminate its contracts with [redacted], NTSP's physicians would only contract through NTSP and would not agree to contract individually with [redacted].

[redacted] did not see any evidence that NTSP's physicians were more efficient than other physicians who were not collecting NTSP's premium rates. In fact, [redacted] determined that

---

[35] Primary care physicians were not members of NTSP at the time the initial [redacted] contract was negotiated.

[36] CX0802.

NTSP's physicians' costs were greater than the costs of non-NTSP physicians in the Fort Worth area.[37] [redacted] wanted NTSP to justify its significantly higher fees by demonstrating that its physicians were more efficient but NTSP has not provided [redacted] with any such evidence.

2. NTSP's Conduct with [redacted]

Prior to 2000, many NTSP physicians served [redacted] patients in the Fort Worth area through arrangements between NTSP's member physicians and [redacted] ("[redacted]"), [redacted].[38] In 2000, NTSP approached [redacted] to obtain a direct [redacted] contract. In November 2000, [redacted] offered reimbursement rates for both fee-for-service PPO and HMO products.[39] NTSP accepted the offered PPO rates, but demanded a higher rate for its HMO contract.

[redacted] offer later was reported to NTSP's members as NTSP sought to explain to them that, "[redacted] Soon thereafter, NTSP announced that [redacted]."[41]

---

37 CX0750.

38 *See* CX0500

39 CX0627.

40 CX0565 at NTSP005086.

41 CX0500.

During this time, [redacted] was subject to unusual pressure to reach an agreement with NTSP. NTSP had threatened the imminent departicipation of its member physicians from the [redacted] arrangement. That threat subsequently was underscored by NTSP's amassing of some [redacted] powers of attorney from its member physicians, authorizing NTSP to act for those members in all transactions relating to [redacted] and to [redacted] directly. Consequently, in November 2000, NTSP terminated its member physicians' participation in the [redacted] arrangement.[42] [redacted] understood this termination to threaten its Fort Worth area network because it did not believe direct contracting with physicians was feasible given the powers of attorney held by NTSP.[43]

NTSP and its member physicians applied pressure on [redacted], promoting the notion that [redacted] loss of NTSP member physicians was imminent and catastrophic in terms of network inadequacy and patient disruption.[44] As a result, [redacted] was subject to additional pressure from employers and others in the market. These pressures and the pre-existing need to have NTSP member physicians in its network, lead [redacted] eventually to capitulate to NTSP's demands and agree to NTSP's price terms.[45]

---

42 *See* CX0546.

43 Jagmin depo at 147-148.

44 CX0576.

45 CX0589.

In 2001, [redacted] attempted to reduce its rates to NTSP, offering rates that it believed were more in line with the market. NTSP did not messenger [redacted] rate proposal to its member physicians, arguing that NTSP's experience with practice management controls warranted its member physicians receipt of higher-than-market rates. [redacted] weighed NTSP's efficiency claims and found them lacking. [redacted], however, continues to contract with NTSP because it needs NTSP's physicians in its network.

3. NTSP's Conduct with [redacted]

In 2000, NTSP member physicians accessed [redacted] HMO and PPO products through NTSP's affiliation with [redacted].[46] In April 2000, NTSP informed its members that [redacted] had attempted to amend its HMO contract with [redacted] by offering a lower reimbursement rate of [redacted]% of [redacted] RBRVS. NTSP told its members that [redacted] would not agree to the change and had terminated the contract.[47] As a result, [redacted] attempted to contract directly with these physicians at the lower rate.

Many of NTSP's members contacted NTSP requesting that it negotiate a group contract on their behalf. NTSP soon informed its members that [redacted] was unwilling to increase its initial rate offer and that therefore NTSP had refused a group contract. NTSP added that it was, for that reason, recommending against the participation of its members in the [redacted] health plan.[48] However, [redacted] continued to contact doctors individually, so NTSP again entered into

---

[46] Again, [redacted] was an organization of employed as well as contracted physicians covering the Dallas/Fort Worth area. A [redacted] of NTSP members were also members of [redacted].

[47] CX0704.

[48] *Id.*

negotiations with [redacted]. NTSP again requested a rate increase from [redacted]' initial offer, based on NTSP's minimums "[redacted]."[49]

[redacted] held firm to its initial offer and refused NTSP's counter offer. Then, in May 2000, NTSP modified its counter offer by requesting that [redacted] increase its initial offer by basing the fees on the higher Dallas locality reimbursements. [redacted] rejected this attempt as well. Ultimately, the parties failed to reach agreement due to lack of continued interest on both sides.[50] Eventually, NTSP members were still able to access the [redacted] PPO through a renewed [redacted] arrangement with [redacted].

4. NTSP's Conduct with [redacted]

In March 2001, NTSP approached [redacted] in order to reach a group contract.[51] At that time [redacted] had contracts with the majority of NTSP member physicians, either directly or through other physician organizations.[52] Out of those [redacted] physicians, more than [redacted] NTSP member physicians were contracted with [redacted] through [redacted] ("[redacted]").[53] Nevertheless, NTSP was interested in contracting directly (rather than through [redacted], with which NTSP had an affiliation agreement), and [redacted] was interested in expanding

---

49 Proposed CX0715.

50 CX0211; Proposed CX0716.

51 CX1117.

52 CX1045.

53 [redacted], which is a subsidiary of [redacted], was an organization of employed as well as contracted physicians covering the Dallas/Fort Worth area. [redacted] of NTSP members were also members of [redacted].

its Fort Worth physician participation, because [redacted] recently had won significant additional business in Fort Worth, including providing coverage of employees and retirees of [redacted]. [redacted] offered NTSP a competitive reimbursement rate that NTSP immediately rejected because the rates were below NTSP's minimum fees.[54] In a Fax Alert to the members, NTSP's Board acknowledged that [redacted]. NTSP then advised its member physicians that NTSP's Board has "[redacted]."[55]

As a result of the contract dispute with [redacted], NTSP orchestrated a public relations campaign for its members to oppose [redacted] offer. The Board explained that [redacted] was transitioning to [redacted] coverage, and recommended to its member physicians that they write [redacted], stating that [redacted]; that "[redacted]"; that the [redacted] proposal "[redacted]"; and that dire consequences to patients would result if an [redacted] agreement could not be reached.[56] Note as well that NTSP employed similar tactics in seeking to induce fears and generate physician-fee inflating pressures from at least one other employer, [redacted].[57]

---

54 CX0087 at NTSP004311; *see also* CX1042.

55 CX1042.

56 CX1042 (emphasis as in original).

57 CX1053.

When [redacted] did not yield by July of 2001 to the negotiating tactics of and pressures brought about by NTSP, NTSP terminated all of its physicians' participation in [redacted] products through the [redacted] arrangement.[58] This at one swoop reduced NTSP member participation in [redacted] Fort Worth area network by fully [redacted]%. In August, NTSP sent its member physicians a Fax Alert,[59] relaying the [redacted].

On August 24, 2001, NTSP sent another Fax Alert to its member physicians.[60] In it, NTSP explained that [redacted], repeated [redacted], noted that [redacted], and [redacted]." NTSP [redacted][61]

As a result of NTSP's campaign directed towards [redacted] clients, particularly [redacted], [redacted] started questioning the stability of [redacted] network. This concern

---

58 CX1118. *See also* Youngblood depo at 125, 127, and 129. *See also* CX0188: [redacted].

59 CX1062.

60 CX1066.

61 CX1066.

persuaded [redacted] to offer NTSP a fee schedule that was higher than both the fee schedule under which the terminated [redacted] physicians operated and [redacted] original offer. In November 1, 2001, NTSP finally messengered out to its member physicians the [redacted] contract offer.[62]

III. LEGAL AND FACTUAL MATTERS TO BE DECIDED

The legal and factual issues to be decided by the Administrative Law Judge include the following:

A. Elements of the Cause of Action

A violation of Section 5 of the FTC Act, 15 U.S.C. § 45, is established if the Court finds: (1) the existence of a contract, combination, or conspiracy among two or more separate entities, which are subject to the antitrust law, that (2) unreasonably restrains trade, and (3) the acts or practices are in or affecting interstate or foreign commerce.[63]

B. Concerted Action

"[A]n antitrust plaintiff may prove the existence of a combination or conspiracy by providing either direct or circumstantial evidence sufficient to 'warrant a . . . finding that the conspirators had a unity of purpose or common design and understanding or a meeting of the minds in an unlawful arrangement.'" [64]

---

62 CX1098.

63 *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990).

64 *ES Dev., Inc. v. RWM Enterprises, Inc.*, 939 F.2d 547, 554 (8th Cir. 1991), *cert. denied*, 502 U.S. 1097 (1992) (*quoting American Tobacco Co. v. United States*, 328 U.S. 781, 810 (1946)).

Complaint Counsel will offer many types of evidence to demonstrate that NTSP and its member physicians agreed to directly restrain price competition among its member physicians by

- collecting of powers of attorney from members,
- negotiating prices with health plans on behalf of members,
- polling and disseminating aggregated data on current or future prices,
- terminating existing contracts, and
- urging employers to assist NTSP in negotiating higher physician fees with health plans.

The evidence includes testimony and documents showing communications between NTSP and its member physicians, and between NTSP and health plans, invitations to engage in collective action, written participation agreements with member physicians, and subsequent actions by the conspirators acting on suggestions. The totality of this evidence demonstrates that NTSP entered into a "contract, combination or conspiracy" under the antitrust laws.

C. NTSP is a Combination of Competitors Subject to the Antitrust Laws

Trade and professional associations, including NTSP, are "by definition, [an] organization[ ] of competitors, [that] automatically satisf[ies] the combination requirements of § 1 of the Sherman Act."[65] As a result, trade associations are subject to the antitrust laws when those associations attempt to restrain competition.[66] When competitors in such organizations

---

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

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

band together to jointly set terms, including price terms, upon which they will deal with customers, they are vehicles for price fixing. There can be no doubt that NTSP's horizontal price restraints subject it to the antitrust laws because it is an organization whose members have distinct economic interests.

NTSP is not a single entity with a "complete unity of interest," thus incapable of conspiring with itself.[67] Rather, it is an association of individual competing physicians, who have not integrated their practices and thus have separate economic interests. When addressing a similar issue, the court held that the defendant organization "is merely a vehicle for the member MDs to fix prices charged by those MDs as well as other health care providers. . . . It is not sufficient to assert, as defendants do, that a corporation cannot conspire with itself. We must look at substance rather than form."[68]

D. The Challenged Restraints Are Presumptively Anticompetitive

Horizontal price restraints fall within the category of conduct that traditionally has been condemned as *per se* unlawful.[69] As shown by "past judicial experience and current economic

---

[67] *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 769 (1984).

[68] *Addino*, 593 F.Supp. at 896-97. *See also Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022, 1030 (9th Cir. 1989) (denying summary judgment where plaintiff produced evidence demonstrating that the defendant was an organization of physicians). Similarly, in recent years the Commission has authorized complaints against trade associations that engage in anticompetitive conduct. For example, in *In re Fair Allocation System*, the Commission charged an incorporated association of franchised automobile dealerships with acting "in agreement, combination or conspiracy with some of its members to restrain trade . . . by threatening to boycott particular models." Complaint and Order, at http://www.ftc.gov/os/1998/10/9710065cmp.htm and http://www.ftc.gov/os/1998/10/9710065.do.htm. *See also United States v. General Motors Corp.*, 384 U.S. 127 (1966) (noting that car dealers "collaborated, through the [trade] associations and otherwise, among themselves and with General Motors").

[69] *See United States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290 (1897) at ; *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); at 223 and at 224 FN 59.

learning," *per se* unlawful conduct warrants "summary condemnation" due to its "likely tendency to suppress competition."[70] Price restraints by professionals, such as physicians, are subject to the same standard, *i.e.*, they have been subject to *per se* condemnation by the courts.[71] Similarly, the Commission also condemns horizontal price restraints in the health care field:

> [T]here have been arrangements among physicians that have taken the form of networks, but which in purpose and effect were little more than efforts by their participants to prevent or impede competitive forces from operating in the market. . . . Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are per se illegal.[72]

NTSP's conduct fits squarely within the price related conduct that courts and the Commission summarily have condemned. Here, NTSP has engaged in the same type of conduct struck down as *per se* illegal in *Maricopa.*[73]

---

[70] *Polygram Holding, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 15,453 at 22, 456 (FTC 2003) ("*Three Tenors*"), available at http:www.ftc.gov/os/2003/07/polygramopinion.pdf, slip op. at 29.

[71] *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982). *See also Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (lawyer price fixing illegal).

[72] *Health Care Statements* at 73-74. *See also Health Care Statements* at pp 89-92 (illustrative example finding "per se unlawful" a physician network where, *inter alia,* "physicians' purpose in forming network "is to increase their bargaining power with payers," notwithstanding physicians contribution of capital. *Id.* at 91.

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

The documents and testimony demonstrate that NTSP has successfully obtained higher prices for physician services due to NTSP's illegal agreements. Thus, because NTSP's conduct fits squarely within conduct traditionally condemned as *per se* illegal, there is no need to engage in an extensive market definition.[74]

Although horizontal price agreements historically have been labeled *per se* illegal and condemned summarily, Your Honor may choose to look "to the circumstances, details, and logic of a restraint."[75] This analysis, nevertheless, will find NTSP's conduct unlawful. As the Commission explained recently, "the evaluation of horizontal restraints takes place along an analytical continuum in which a challenged practice is examined in the detail necessary to understand its competitive effect."[76]

Extensive market analysis is not required when there is proof of actual anticompetitive effects.[77] The evidence here indeed demonstrates that "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question have an anticompetitive effect on customers and markets."[78] The setting of prices by competitors and the use of those prices in joint negotiations with customers (health plans) "are of a sort that generally

---

74 *See Three Tenors.*

75 *California Dental*, 526 U.S. at 780-81.

76 *Three Tenors* at 22.

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

78 *California Dental*, 526 U.S. at 770.

pose significant competitive hazards," and are thus inherently suspect.[79] The Court in *Indiana Fed'n of Dentists* held that "no elaborate industry analysis is required to demonstrate the anticompetitive character of "horizontal agreements, "absent some countervailing procompetitive virtues - such as, for example, the creation of efficiencies in the operation of a market or the provision of goods and services."[80] Your Honor should treat the restraint as *per se* illegal or, at worst, inherently suspect, and force Respondent to put forth plausible and cognizable justification for the restraint before Your Honor engages in any analysis of circumstances, details and logic of the restraint.

E. The Price Restraint Was Not Necessary for Procompetitive Efficiencies

When a defendant has engaged in "inherently suspect" conduct, such as price fixing, the burden shifts to the defendant who must advance "a legitimate justification" for the challenged practices in order to avoid summary condemnation.[81] The justification must be "both cognizable

---

[79] The Court rejected the argument that the Commission erred in not making elaborate market power determinations, stating "the Commission's failure to engage in detailed market analysis is not fatal to its finding of a violation." *Id.* at 460.

[80] *Indiana Fed'n of Dentists*, 476 U.S. 447. The Court found that a conspiracy among dentists to refuse to submit x-rays to dental insurers for use in benefits determinations constituted an unfair method of competition, at 459.

[81] "If the plaintiff satisfies its initial burden of showing that the practices in question are inherently suspect, then the defendant must come forward with a substantial reason why there are offsetting procompetitive benefits. If the defendant articulates a legitimate (i.e., cognizable and plausible) justification, then the plaintiff must address the justification, and provide the tribunal with sufficient evidence to show that anticompetitive effects are in fact likely, before the evidentiary burden shifts to the defendant." *Three Tenors* at 33. *See also In the Matter of Schering-Plough Corporation, et al.* available at http://www.ftc.gov/os/adjpro/d9297/031218commissionopinion.pdf, at 8: "once Complaint Counsel have demonstrated anticompetitive effects under the standard we apply, Respondents must demonstrate that the challenged provisions are justified by procompetitive benefits that are both cognizable and plausible." *See also id.* at 38: "However, once Complaint Counsel have made out a *prima facie* case of actual anticompetitive effects, Respondents must do more than suggest hypothetical benefits."

under the antitrust laws and at least facially plausible."[82] To be "cognizable," the justification must compatible with the competition-enhancing goal of the antitrust laws. To be "plausible," the justification must "create or improve competition" and the defendant must articulate a "specific link between the challenged restraint and the purported justification."[83]

Price fixing can be plausibly related to an efficiency-enhancing joint venture. In the context of physician IPAs, for example, the Commission has said that a collective fee negotiation by physicians acting through a physician organization is *per se* illegal *unless* it is reasonably ancillary to an efficient integration. The Commission has recognized the potential efficiency benefits of two non-exclusive examples of integration: (1) financial integration through some form of sharing of risk of financial loss or potential gain; and (2) clinical integration among otherwise competing health care providers interdependently providing their services in a more efficient and effective manner.[84] To avoid the dangers embodied in price-fixing, the clinical integration must be achieved "prior to [the network] contracting on behalf of competing

---

82 *Three Tenors* at 30.

83 *Id.* at 31-32. *See also, e.g., United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 281-282 (6th Cir. 1898); *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 20-24 (1979); *National Collegiate Athletic Ass'n. v. Board of Regents of the University of Oklahoma*, 468 U.S. 85, 100-102 (1984). *See also Arizona v. Maricopa County Medical Soc'y*, 457 U.S. at 356-57 (1982) (distinguishing *per se* illegal price fixing agreements among the physicians in that case from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit.").

84 *See Health Care Statements* at 70-74, 107-112. *See also* letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, Federal Trade Commission to John J. Miles (February 19, 2002) (available at http://www.ftc.gov/bc/adops/medsouth.htm); John J. Miles, *Joint Venture Analysis and Provider-Controlled Health Care Networks*, 66 Antitrust L. J. 127 (1997).

doctors."[85] The presence of substantial risk-sharing "generally establishes an overall efficiency goal for the venture and the incentives for physicians to meet that goal. The setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason."[86]

Other kinds of integration among the members of a physician venture also may be likely to produce significant efficiencies, and, if present, similarly would warrant application of the rule of reason to an evaluation of the venture.[87] "Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physicians and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[88] Such a program might include the establishment of cost/quality monitoring and control mechanisms, the selective choice of network physicians to further the efficiency objectives, and the investment of significant capital in infrastructure to realize the efficiency objectives.[89] Only to the extent that price agreements are reasonably necessary to the accomplishment of the efficiencies, however, will they escape the *per se* rule analysis.[90]

As discussed above, NTSP has not integrated financially for the non-risk contracts challenged here, as NTSP's members do not share the risk of financial loss. NTSP physicians

---

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

86 *Health Care Statements* at 20, 817 *et seq.*

87 *Id.*

88 *Id.*

89 *Id.*

90 *Id.*

are not clinically or otherwise integrated for the fee-for-service contracts either. Non-risk contracts involve straight fee-for-service reimbursement and, therefore, no risk. Moreover, roughly half of NTSP member physicians–including most PCPs–do not engage in any risk-sharing. Those who do, do so with respect only to the HMO components of two of the 23 contracts to which NTSP is a party.[91]

In contrast, substantially all of NTSP's member physicians participate in its fee-for-service PPO arrangements. The evidence indicates that the capitated arrangements do not produce significant efficiencies that carry over to the fee-for-service arrangements.[92] Such clinical integration as is present in NTSP is tied to management of its few capitated arrangements, with little or no application to or impact on NTSP's fee-for-service arrangements. Even if, for purposes of argument, NTSP *might* effectively manage its few risk-sharing arrangements, there is no credible evidence–and health plans did not believe–that efficiencies spilled over to the fee-for-service arrangements.

Finally, even if NTSP's conduct results in some efficiencies, these supposed efficiencies are legally insufficient to justify the horizontal price-fixing agreements. The evidence shows no hint to demonstrate why NTSP must set prices collectively to accomplish its goals; therefore NTSP cannot satisfy the burden of proof in this matter. NTSP's efficiencies claims are at best linked to its limited risk-sharing activities and are not ancillary to the its separate and distinct fee-

---

91 CX1151 at 16.

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

for-service contracts; hence, these efficiencies claims are not recognized by law in connection with fixing the prices of those fee-for-service contracts.[93] None of the specific clinical integrations and efficiencies claimed by NTSP, under any economic theory, requires NTSP to engage in collective price negotiations or the other price-related activity that is the subject of this lawsuit.[94] All of NTSP's alleged efficiencies applicable to the NTSP non-risk business could be accomplished equally well in a competitive environment.

F. The Challenged Restraints Affect Interstate Commerce

The Commission's jurisdiction extends to all matters in or affecting commerce. 15 U.S.C. § 45. "[P]roper analysis focuses, not upon actual consequences, but rather upon the potential harm that would ensue if the conspiracy were successful."[95]

Complaint Counsel will offer evidence that NTSP's collective price negotiations activities have had a direct and predictable effect on the fees received by its physician members, and thus inevitably affect interstate commerce. NTSP and/or its individual members contract or negotiate with numerous health plans doing business in the Fort Worth area. At least four of them are national insurers, headquartered outside Texas, who sell policies throughout the United States. Any artificial increase in physician fees in Fort Worth may be expected to affect the volume and destination of health care payments.[96] These health plans in turn, sell insurance

---

93 See *Three Tenors* at 48.

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

95 *Summit Health, Ltd. v. Pinhas*, 500 U.S.322, 330 (1991).

96 *See Hospital Building Co.*, 425 U.S. at 741, where the Supreme Court noted that a large portion of the hospital's revenue came from out-of-state insurance companies. *See also Pinhas*, 500 U.S. at 329-30, where the Supreme Court held that the flow of revenue in interstate commerce was held sufficient to establish that the elimination of the ophthalmological

policies to corporations or employees located in the Fort Worth area. Many of these employers are large national and multinational corporations, with local operations in Fort Worth. Conduct by NTSP that has the effect of raising these employers' health care costs in Fort Worth could affect decisions with respect to the location of operations, the interstate movement of employees, or other competitive actions vis a vis other manufacturers throughout the United States and the world.

In addition, physician members of NTSP routinely receive payments from out-of-state insurance companies, including the federal Medicare and Medicaid programs, which are by their very nature interstate in operation.[97] The increasing of physician fees to private health plans may result in some additional billing to the federally-funded Medicare and Medicaid programs, as private coverage is reduced or made more costly shifting demand at the margin to publicly funded programs.[98] Furthermore, NTSP physician members treat patients from outside Texas. This is one of the factors that courts have cited in finding that the conduct of health care providers falls within the jurisdiction of the antitrust laws.[99] Moreover, the evidence shows that both NTSP and its physician members make substantial purchases from vendors located outside

---

department in a single hospital affected interstate commerce.

[97] *See, e.g., Hospital Building Co.*, 425 U.S. at 741, where the Supreme Court noted that a large portion of the hospital's revenue came from out-of-state sources including the Federal Government (through Medicare and Medicaid); *see also Michigan State Medical Soc'y*, 101 F.T.C. 191 at 250 (1983) (payments from Medicare and Medicaid, as well as the Federal Employees Health Benefits Program, held evidence of interstate commerce).

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

[99] *See, e.g., Oksanen, supra; Miller, supra*

the state of Texas. Under cases such as *McLain, Hospital Building Co.,* and *St. Bernard General Hospital, supra,* such evidence is sufficient to establish antitrust jurisdiction.[100]

IV. PROPOSED CONCLUSIONS OF LAW

1. The Commission has jurisdiction over the subject matter of this proceeding and over NTSP pursuant to Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

2. NTSP is, and at all relevant times has been, a corporation as "corporation" is defined by Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44; and at all times relevant herein, NTSP has been, and is now, engaged in commerce as "commerce" is defined in the same provision.

3. Respondent NTSP, its members, officers and directors, are engaged in a continuing combination and conspiracy to fix prices charged by physicians for providing medical services for health plans' patients.

4. The challenged restraint of trade is in or affecting interstate commerce.

5. Being horizontal price fixing, NTSP's conduct is *per se* unlawful and "inherently suspect" thus, in unreasonable restraint of trade.

6. Although the burden is on NTSP, it has not established that the challenged restraint of trade has a legitimate justification that is both cognizable under the antitrust laws and plausible. Moreover, the price fixing was not ancillary to alleged efficiencies.

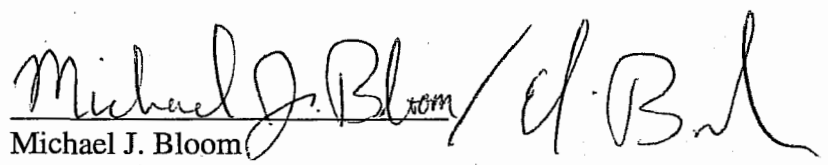
---

[100] In *Hospital Building Co.,* 425 U.S. at 741, the Supreme Court noted that the hospital spent $112,000 in one year on purchases from out-of-state sellers.

7. Therefore NTSP has violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

8. The notice of contemplated relief issued with the Complaint in this matter sets forth provisions appropriate and warranted to remedy Respondent's unlawful activities.

Respectfully submitted,



Michael J. Bloom
Matthew J. Reilly
Mazor Matzkevich

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

Dated: April 14, 2004

CERTIFICATE OF SERVICE

I, Eli Barach, hereby certify that on April 14, 2004, I caused a copy of Complaint Counsel's Pretrial Brief to be served upon the following persons:

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

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

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

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

Eli Barach