PUBLIC

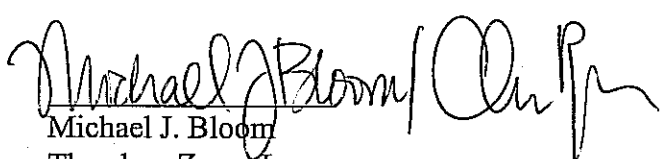
UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of NORTH TEXAS SPECIALTY PHYSICIANS, a corporation.	**DOCKET NO. 9312**

To: The Honorable D. Michael Chappell
Administrative Law Judge

CORRECTED COMPLAINT COUNSEL'S RESPONSE TO
RESPONDENT'S POST-TRIAL PROPOSED FINDINGS OF FACT

Respectfully submitted,



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Introductory Matter

Complaint Counsel files these Reply Findings in response to Respondent's Proposed Findings of Fact filed June 16, 2004.

The format of this document is intended to comply with the directions set forth in the Order on Post Trial Briefs, dated May 26, 2004. The Respondent's headings and numbered proposed findings are reproduced, single-spaced. Following each numbered proposed finding of the Respondent is Complaint Counsel's response, double-spaced.

These Reply Findings use the forms of citation set forth in Complaint Counsel's Proposed Findings of Fact filed June 16, 2004. In addition, the following forms of citation are used:

- Respondents's Proposed Findings of Fact are cited by paragraph, as follows: (RPF 507) or (RPF 743-745).
- These Complaint Counsel's Reply Findings are cited by paragraph, as follows: (CRF 507) or (CRF 743-745).
- Complaint Counsel's Proposed Findings of Fact are cited by paragraph as follows: (CPF 507) or (CPF 743-745).

Complaint Counsel's responses follow.

* * *

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)).

   Response to Finding No. 1.:

   Complaint Counsel has no specific response.

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).

Response to Finding No. 2.:

Complaint Counsel has no specific response.

3. NTSP is a memberless organization. (Van Wagner, Tr. 1490; RX 1675; RX 1676 (NTSP articles of incorporation)).

Response to Finding No. 3.:

RPF 103 is incomplete, misleading and irrelevant. NTSP is organized under the stated terms of its own bylaws as a "memberless" corporation, according to Texas corporation law. The evidence, including NTSP's own documents and testimony regarding NTSP participating physicians, shows that NTSP's participating physicians are in fact NTSP members, and NTSP even uses the term "members" in its ordinary course of business. (*See* CPF 8). Complaint Counsel looks at the substance, rather than the form of incorporation, and NTSP's physicians are "members" in the usual and general accepted definition of the word. (*See* Complaint Counsel Post-Trial Brief, ¶¶ II D. 1 at 22-24). Thus, NTSP's physicians are its "members" as that term is used in the Federal Trade Commission Act.

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).

Response to Finding No. 4.:

RPF 4 is incomplete and misleading. Since its foundation, NTSP's role in non-

risk contracting has long supplanted NTSP's risk contracting as NTSP's primary activity. (CPF 54). In fact, in March 2001, NTSP's Board of Directors discussed the fact that "risk business is a small part of the business" and concluded that NTSP's "focus should center on how to benefit members on fee-for-service contracts as well." (CX0083 at 3). Indeed, NTSP member physicians participate in approximately 20 fee-for-service non-risk contracts (CPF 57), while only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract with PacifiCare. (CPF 55-58, 78). NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. NTSP's primary care physicians participate in non-risk contracts, and under the terms of some of these contracts NTSP primary care physicians are individually capitated and their payment is guaranteed directly by the health plan. NTSP primary care physicians do not share risk with each other nor do they directly share risk with NTSP's specialists. (CX1195 at 8, 9, 15-16, 25-27).

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)).

Response to Finding No. 5.:

RPF 5 is incomplete, misleading and irrelevant. NTSP's contract with CIGNA does not involve the sharing of any risk among NTSP's physician members. (*See* CRF 433-434.) Under the CIGNA-NTSP contract, NTSP's primary care physicians are individually capitated for CIGNA's HMO product and do not share risk with other NTSP members. (CX1195 at 8-9.)

{[redacted]} (CPF 258-292; CX0810 *in camera (Order on Non-Party CIGNA's*

Motion for In Camera Treatment, 06.29.04)(NTSP Fax Alert listing CIGNA's specialist contract as fee-for-service)). {[redacted]} (CPF 285, *in camera (see Grizzle, Tr. 752-754)*). RPF 5 is irrelevant because NTSP's sole risk contract is not at issue in this proceeding. It does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, and it does not justify those actions. Moreover, there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Even if there were an impact, there is no evidence that the price-fixing at issue here was necessary to generate such alleged efficiencies. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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)).

Response to Finding No. 6.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 7.:

RPF 7 is incomplete. With respect to data, NTSP personnel expend all or

substantially all of their efforts on NTSP's sole risk contract with little or no responsibilities involving NTSP's approximately 20 non-risk contracts (for which data is not provided to NTSP, and NTSP does not possess such data). (CPF 419).

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).

Response to Finding No. 8.:

RPF 8 is incomplete and irrelevant. NTSP's utilization management staff work exclusively on NTSP's sole risk contract and do not have any involvement or responsibilities with regard to NTSP's non-risk contracts, which are the core of this proceeding. In addition to having the economic incentive to perform utilization management, NTSP is paid by the risk health plan, PacifiCare, to perform utilization management. (Van Wagner, Tr. 1853; Deas, Tr, 2553, 2567, 2568).

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).

Response to Finding No. 9.:

RPF 9 is inaccurate and misleading. NTSP's agreements with its physicians do provide for a period of exclusivity during which NTSP member physicians agree to refuse to deal with a health plan directly while the health plan is in negotiations with NTSP and *until* NTSP notifies its physicians that they "have the right" to directly contract with the health plan. (CX0311 at 10; CPF 99).

10. In 2003, there were approximately 575 participating physicians practicing in 26 different specialties. (RX 3118 (Maness Report ¶ 4)).

Response to Finding No. 10.:

Complaint Counsel has no specific response, other than to add, for the sake of completeness, that NTSP physicians within each specialty are competitors. (CPF 77).

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).

Response to Finding No. 11.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 12.:

RPF 12 is incomplete and misleading. The phrase "risk management goals" is vague and misleading. NTSP has admitted that about half of its member physicians do not participate in NTSP's sole risk contract. (CPF 78). As such, they cannot and do not contribute to NTSP's alleged "risk management goals." NTSP has also admitted that among these non risk-sharing physicians are those who have no interest in accepting risk. NTSP has recognized that its physicians who have no interest in accepting risk enjoy the great benefit of receiving NTSP's higher fee-for-service rates without participating in NTSP's risk contract. (CPF 78-79; Van Wagner, Tr. 1880-1883). The proposed finding that NTSP only invited physicians who "understand" NTSP's risk management goals is therefore irrelevant. RPF 12 is supported

exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 13.:

RPF 13 is vague, irrelevant, and misleading. The terms "managed care environments" and "interested" are not defined and to the extent they do not involve active risk-sharing among NTSP members, they are irrelevant. RPF 13 is also misleading because the cited testimony refers to actions taken by NTSP in late 2003, well outside the relevant time period and after Complaint Counsel had filed its Complaint. (Van Wagner Tr. 1882). RPF 13 is also irrelevant because NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 13 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contract, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). RPF 13 is only supported by the self serving testimony of Dr. Deas and Karen Van Wagner, both of whom have personal and financial interests in the outcome of this proceeding. (CPF 74; 66).

14. NTSP's participating physicians can be departicipated 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).

Response to Finding No. 14.:

RPF 14 is misleading and irrelevant. RPF 14 is misleading because NTSP has never removed any physician member from NTSP for failing to meet performance goals. (Van Wagner, Tr. 1847-1848). RPF 14 is irrelevant because NTSP at best only has information about its member physicians' performance in the sole risk-sharing contract, which has no bearing on NTSP's actions to negotiate and fix prices in its risk contracts, nor does it justify these actions. RPF 14 is supported exclusively by the self serving testimony of Van Wagner and Dr. Deas, witnesses with substantial personal and financial interest in the outcome of this proceeding, and entirely unsupported by any documentation, much less contemporaneous documentation.

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).

Response to Finding No. 15.:

RPF 15 is incomplete and misleading. NTSP offers over 20 fee-for-service non-risk contracts to its members but has only one risk contract. (CPF 56-57). NTSP's risk contract covers only approximately 32,000 lives, while its non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 16.:

RPF 16 is vague and misleading. Respondent fails to differentiate between "risk contracting" and contracts under which physicians *share risk.* Only contracts that require physicians to share risk are capable of generating relevant efficiencies related to cost or quality. (CPF 423). A single physician may assume risk by directly receiving a capitation payment, and can be individually capitated. However, while this physician does have an incentive to control his own utilization, he has no incentive to cooperate with, or improve the practice behavior of other physicians. In fact, he has a disincentive to do so, because the physician remains in direct competition with other physicians. By contrast, contracts under which multiple physicians assume and share risk cooperatively drive the physicians to work cooperatively to improve cost and quality. (Frech, Tr. 1294).

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).

Response to Finding No. 17.:

RPF 17 is vague, incomplete, and misleading as to the undefined terms "bonuses" and "other pay-for-performance provisions." In order for a contract – other than a capitation contract – which provides for a "withhold" to be considered a risk contract, the withhold must be in the range of 25 to 30 percent of the total fee-for-service reimbursement amount. Only a withhold of this magnitude can effectively encourage cooperation, collaboration, and interdependence among members of an IPA. (CPF 44; Frech, Tr. 1296-1297). NTSP's

Physician Participation Agreement similarly defines a risk contract as either a capitation contract or a contract with "at least 20% financial risk" on NTSP and its members. (CX0311 at 10).

18. NTSP is currently the only multi-specialty entity in the Metroplex taking risk contracts. (Van Wagner, Tr. 1575-76; Casalino, Tr. 2891).

Response to Finding No. 18.:

RPF 18 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts, the contracts at issue in this proceeding. Thus, RPF 18 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 19.:

RPF 19 is vague, misleading, and irrelevant. NTSP's alleged success in taking risk, or the reasons for that alleged success, are irrelevant because they do not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts. Moreover, there is no reliable evidence upon which to conclude that any alleged success in taking risk has any impact on NTSP's non-risk contracts. Even if there were an impact, there is no evidence that the price-fixing at issue here was necessary to generate such alleged success.

RPF 19 is contrary to the weight of the evidence. The evidence demonstrates that NTSP's non-risk physicians have no interest in accepting risk, and recognize that they enjoy the great benefit of receiving NTSP's higher fee-for-service rates without participating in NTSP's risk contract. (CPF 78-79; Van Wagner, Tr. 1880-1883). There is no reliable evidence to support the proposition that NTSP is *successful* at taking risk or to indicate the causal basis for the alleged success except the self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

20. NTSP refers to its panel of risk contracting physicians as the "PSN" (provider service network) or the "risk panel." (Van Wagner, Tr. 1495).

Response to Finding No. 20.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 21.:

RPF 21 is misleading and irrelevant. During the course of the relevant time period, NTSP had as many as 652 physicians with 300 or more of these physicians accepting no risk through NTSP. (CX0209 at 2 ("NTSP has become a 'gorilla network' with 124 PCP's . . . and 528 specialists."); CPF 78). RPF 21 is also misleading because NTSP's "risk panel" has only one risk contract which is not at issue in this proceeding and does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Moreover, there is no reliable evidence upon which to conclude that any

alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Even if there were an impact, there is no evidence that the price-fixing at issue here was necessary to generate such alleged efficiencies. Indeed, NTSP's risk contracts covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 22.:

RPF 22 is vague and misleading. NTSP's "business model" is undefined. In addition, NTSP's capitation payment from its PacifiCare sole risk contract have not always generated savings. According to statements from NTSP's former president during the relevant time period, this NTSP PSN network risk contract was left underfunded by 35%, leading to an increase in premiums and a decrease in the risk that NTSP would accept. (CX0256).

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).

Response to Finding No. 23.:

RPF 23 is vague and misleading because the term "NTSP business model" is not defined. RPF 23 is contrary to the weight of the evidence in its assertion that NTSP's business model is beneficial to health care and should be encouraged. For example, United, a large

purchaser of healthcare services in the Fort Worth area, has been harmed by NTSP's business practices. (Quirk, Tr. 348-349). CIGNA, another large purchaser of healthcare services in the Fort Worth area, estimates that NTSP's business practices have increased its costs [redacted] } (CX0814, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04; Grizzle, Tr. 877-879, in camera (see Grizzle, Tr. 752-754)).*} Likewise, Aetna concluded that NTSP's rates were not competitive and terminated its NTSP contract, resulting in harm to Aetna in that its provider network was disrupted. (CX0640; Jagmin, Tr. 997-1002). NTSP's business plan includes horizontal price collusion and horizontal boycotts, practices which, as explained by rudimentary principles of economics, harm consumers. (Frech, Tr. 1305-1317). NTSP's non-risk physicians include those who have no interest in accepting risk, but enjoy the great benefit of receiving NTSP's higher fee-for-service rates without participating in NTSP's risk contract. (CPF 78-79; Van Wagner, Tr. 1880-1883). This makes non-risk contracts artificially attractive to physicians, and creates inefficiency in the market. (Frech, Tr. 1349). As for performing medical management and utilization review, these tasks are only done with respect to NTSP's sole risk contract.

NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 23 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

Complaint Counsel does not disagree that an IPA can improve quality by performing medical management and utilization review. (Casalino, Tr. 1789-90, 2894-98).

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)).

Response to Finding No. 24.:

RPF 24 is incomplete and misleading. NTSP's alleged "business model" is vague and undefined, though Complaint Counsel agrees it would include, as described in CX1117 (cited in RPF 28 by Respondent), the fact that NTSP members "rely on" and can direct NTSP to negotiate contracts on their behalf. NTSP's "business model" also includes collective price negotiation (CPF 125-128), collective refusals to deal (CPF 129-142), threats of and actual departicipation of its members to increase its negotiating leverage, coordination of targeted campaigns at health plans' customers to increase its negotiating leverage (CPF 129-142), and the collection and use of powers of attorney to increase its negotiating leverage (CPF 129-142).

As RPF 24 pertains to NTSP's claimed efficiencies, it is irrelevant because Respondent has put forth absolutely no evidence that any health plan that has contracted with NTSP agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or cost reductions. In fact, health plans rejected NTSP's efficiency claims. (CPF 288, 399). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227).

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).

Response to Finding No. 25.:

RPF 25 is vague and misleading because the term "NTSP business model" is not defined.

RPF 25 is irrelevant because it does not distinguish between shared-risk and non-risk contracts. NTSP's performance for its shared-risk contract has no bearing on NTSP's price-fixing conduct in its non-risk contracts which are the subject of this litigation, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 25's performance claims do not demonstrate that any efficiencies from the shared-risk contract "spilled over" to its non-risk contracts, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

RPF 25 is incomplete and misleading. NTSP has a shared-risk contract with only one health plan, PacifiCare. (CX1177 (Grand, Dep. 19)). NTSP's HMO risk contract with PacifiCare covers only 32,000 lives of NTSP's total of 660,000. (CX0616 at 2; CX0265 *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 06.29.04)*). For patients under this contract, disease management programs are operated by PacifiCare, not NTSP itself. (Casalino, Tr. 2809-2810). {[redacted]

[redacted]}

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).

Response to Finding No. 26.:

RPF 26 is vague and misleading because the term "NTSP business model" is not defined.

RPF 26 is irrelevant because it does not distinguish between shared risk and non-risk contracts. NTSP's performance for its shared-risk contract has no bearing on NTSP's price-fixing conduct in its non-risk contracts which are the subject of this litigation, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 26's performance claims do not demonstrate that any efficiencies from its shared-risk contract "spilled over" to its non-risk contracts, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

RPF 26 is misleading in that it implies that NTSP is fully at risk for its facility and pharmacy costs under its shared-risk contract. NTSP has a shared-risk contract with only one health plan, PacifiCare. (CX1177 (Grand, Dep. 19)). Under its HMO contracts with PacifiCare, some pharmacy costs are excluded from the risk shared with NTSP. (Lovelady, Tr. 2639). Under these contracts, hospital costs are excluded from the risk shared with NTSP. (Deas, Tr. 2489; Casalino, Tr. 2903)

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)).

Response to Finding No. 27.:

RPF 27 is inaccurate and misleading. RPF 27 misstates Dr. Casalino's testimony.

The only statement that Dr. Casalino made with respect to NTSP's integration on the cited page is as follows: "I would conclude that NTSP ought to be regarded as clinically integrated for its risk patients but clearly does not function as a clinically integrated organization for its non-risk patients." The record is consistent that NTSP is not clinically integrated for its non-risk patients. (Frech, Tr. 1351-1352; Van Wagner, Tr. 1877).

Complaint Counsel has no specific response to NTSP's statements of its goals. However NTSP's goals are not relevant.

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).

Response to Finding No. 28.:

RPF 28 is incomplete and misleading. NTSP's alleged "business model" is vague and undefined, though Complaint Counsel agrees it would include, as described in CX1117 (cited in RPF 28 by Respondent), the fact that NTSP members "rely on" and can direct NTSP to negotiate contracts on their behalf. NTSP's "business model" also includes collective price negotiation (CPF 125-128), collective refusals to deal (CPF 129-142), threats of and actual departicipation of its members to increase its negotiating leverage, coordination of targeted campaigns at health plans' customers to increase its negotiating leverage (CPF 129-142), and the collection and use of powers of attorney to increase its negotiating leverage (CPF 129-142).

As RPF 28 pertains to NTSP's claimed efficiencies, it is irrelevant because Respondent has put forth absolutely no evidence that any health plan that has contracted with NTSP agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or cost reductions. In fact, health plans rejected NTSP's efficiency claims. (CPF 288, 399). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an

adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227). In fact, in the two instances where NTSP negotiated non-risk contracts with Aetna and CIGNA and claimed to offer reductions in health care cost, both health plans concluded that the claims were not supported by credible data. (CPF 288, 399). Aetna and CIGNA analyzed relevant data and they concluded that the data does not support NTSP's alleged efficiency claims. Such claims are not supported by credible evidence even now. [redacted] } Moreover NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 28 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 29.:

RPF 29 is misleading. The data upon which Dr. Maness relies in reaching this conclusion is compiled by PacifiCare. (Maness, Tr. 2071, 2073-2074). Quantitative analyses which address an IPA's performance for controlling costs or improving quality cannot be relied upon unless the analyses are properly adjusted for demographic differences, such as age and sex, and "case mix," that is, the illness status of patients. (Casalino, Tr. 2827- 2828). The PacifiCare data fails to control for any demographic differences like age, sex, or case mix (illness of

patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). No conclusions should be drawn from such data. (Casalino, Tr. 2829).

The evidence cited in support of RPF 29 is not reliable. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' testimony is entitled to little or no weight and does not support RPF 29.

30. PacifiCare considers NTSP its top performer in the Metroplex. (Lovelady, Tr. 2665, 2668).

Response to Finding No. 30.:

RPF 30 is incomplete and does not adequately support Respondent's finding. Lovelady's assessment of NTSP's value may be influenced by "political issues" or "community ties" that NTSP has. As Lovelady testified, PacifiCare "use[s] those and find[s] those to be valuable." (Lovelady, Tr. 2658, 2681-2682 (acknowledging that NTSP has lobbied on PacifiCare's behalf); Van Wagner, Tr.1727-1732 (discussing why NTSP lobbied the City of Fort Worth to renew a risk contract with PacifiCare instead of switching to United)).

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).

Response to Finding No. 31.:

RPF 31 is inaccurate and misleading. The PacifiCare data does not control for any demographic differences such as age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). Thus, it cannot reliably compare NTSP's performance to the performance of other physicians. (*See* CPF 462).

RPF 31 is misleading because it fails to distinguish between risk and non-risk performance. Dr. Casalino testified, "data without risk adjustment just isn't very useful, if useful at all. It can be extremely misleading." (Casalino, Tr. 2834-2836). Indeed, PacifiCare does not track per member per month costs for NTSP's non-risk PPO patients (Lovelady, Tr. 2678), and does not run any utilization reports under the non-risk PPO contract with NTSP (Lovelady, Tr. 2677). In fact, Maness' report states that RPF 31 relates only to NTSP's risk contract with PacifiCare. Hence RPF 31 is irrelevant because NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 31 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract with PacifiCare covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 32.:

RPF 32 is inaccurate and misleading because it makes no distinction between risk and non-risk contracts and also does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (*See* CCRF 31). To the extent that the data is derived from the risk contract, RPF 32 is also irrelevant because it has no bearing on NTSP's price-fixing in non-risk contracts. (*See* CCRF 31). Furthermore, Dr. Casalino testified that for rates of medical procedures in particular, the PacifiCare data lacks case mix adjustment and suffers from potential selection bias. (Casalino, Tr. 2827-2828). Dr. Casalino determined that no conclusions should be drawn from that data. (Casalino, Tr. 2829).

Moreover, the evidence cited in RPF 32 does not adequately support Respondent's finding: RX1719, RX1846, RX3153, RX3154 and RX3223 are nearly five hundred pages of raw PacifiCare data and Van Wagner inappropriately provides self-serving testimony to interpret it. (*See* CPF 66). Moreover, Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding concerning PacifiCare's own data. Dr. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 32 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26,

2004 Order on Post Trial Briefs.

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).

Response to Finding No. 33.:

RPF 33 is inaccurate and misleading because it makes no distinction between risk and non-risk contracts and also does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (*See* CCRF 31). To the extent that the data is derived from the risk contract, RPF 33 is also irrelevant because NTSP's activity under its sole risk contract has no bearing on NTSP's price-fixing activity in non-risk contracts, nor does it justify it. (*See* CCRF 31). RPF 33 does not demonstrate that any alleged efficiencies or quality from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the approximately half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

Moreover, the evidence cited in RPF 33 does not adequately support Respondent's finding; RX1719, RX1846, RX3153, RX3154 and RX3223 are nearly five hundred pages of raw data and Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding concerning PacifiCare's own data. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 33 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago*

Bridge and Iron Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 34:

RPF 34 is irrelevant, inaccurate and misleading. RPF 34 is irrelevant because the hospital utilization data only include data for PacifiCare's risk contract, and it does not include data for PacifiCare's non-risk contracts, or any of NTSP's other 20 non-risk contracts. (Lovelady, Tr. 2677). Thus, RPF 34 has no bearing on NTSP's price-fixing in non-risk contracts (*See* CCRF 31). RPF 34 does not demonstrate that any alleged efficiencies from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423). Thus, RPF 34 is misleading in making no distinction between risk and non-risk contracts and failing to control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (*See* CCRF 31).

The evidence cited in RPF 34 does not adequately support Respondent's finding. RX1719, cited in RPF 34, does not support the finding that NTSP has below average hospitalization rates. In fact, on its face RX1719 actually demonstrates that NTSP's hospitalization rates are above average for Medicare-eligible risk patients. (Van Wagner, Tr. 1719). Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provides self-serving testimony to interpret such data. (*See* CPF 66). Dr. Maness is not an expert regarding organizational capital or physician organizations; it is

neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' report is entitled to little or no weight in its support for RPF 34. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 34 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 35.:

RPF 35 is irrelevant, inaccurate and misleading. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any

alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 35 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

Dr. Casalino determined that no conclusions should be drawn from the PacifiCare data. (Casalino, Tr. 2829). It fails to control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). The evidence, including the expert testimony of Dr. Casalino, demonstrates that for rates of medical procedures in particular, the PacifiCare data lacks case mix adjustment and suffers from potential selection bias. (Casalino, Tr. 2827-2828). Thus, the data cannot reliably compare NTSP's performance to the performance of other physicians. (*See* CPF 462). Moreover, Dr. Casalino testified that procedure rates do not correlate to total cost of care for patients because the same procedure can vary widely in cost for various reasons. (Casalino, Tr. 2827-2829).

RPF 35 is incomplete. Even if NTSP does keep total costs of patient care down on its risk contracts, such cost-cutting measures do not necessarily indicate better quality of care. (Casalino, Tr. 2808). Specifically, Casalino found NTSP lacking in processes to ensure that patients get needed procedures in a reasonable amount of time (Casalino, Tr. 2808-2809).

The evidence cited in RPF 35 does not adequately support Respondent's findings. Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding concerning PacifiCare's own data. Maness' purported expert analysis was wholly lacking in

analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 35 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 36.:

RPF 36 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 36 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

The evidence does not adequately support RPF 36. No one, not even PacifiCare's witness, testified with respect to its accuracy. Moreover RX3139 itself does not support RPF 36; it does not label the per member per month comparison as being a national average as RPF 36 states.

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).

Response to Finding No. 37.:

RPF 37 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts, the contracts at issue in this proceeding. Thus, RPF 37 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

RPF 37 is not adequately supported by the evidence. Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding. Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provided self-serving testimony to interpret the PacifiCare data. *(See* CPF 66).

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*).

Response to Finding No. 38.:

RPF 38 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 38 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF

55-58, 78).

RPF 38 is not adequately supported by the evidence. Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding. Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provided self-serving testimony to interpret the data. (*See* CPF 66).

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).

Response to Finding No. 39.:

RPF 39 is vague, irrelevant and not adequately supported in evidence. RPF 39 is vague as to what HMO contracts have been included in the population cited. The testimony cited in support is the self-serving testimony of Van Wagner–a lay witness with substantial personal and financial interest in the outcome of this litigation. (CPF 66). Van Wagner has no medical or economics expertise regarding the cost of treatment for different population groups.

As it pertains to the risk HMO population, RPF 39 is also irrelevant because NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 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).

Response to Finding No. 40.:

RPF 40 is vague as to what has been included in the population cited. RPF 40 is supported exclusively by self-serving testimony of Van Wagner – a lay witness with substantial personal and financial interest in the outcome of this litigation. (CPF 66). Van Wagner has no medical or economics expertise regarding the cost of treatment for different population groups.

As it pertains to risk contracts, RPF 40 is irrelevant because NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 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).

Response to Finding No. 41.:

RPF 41 is irrelevant. Patient surveys and their results do not have any bearing on NTSP's actions to negotiate and fix prices on its non-risk contracts, nor do they justify such actions. Respondent offers no evidence and does not even contend that Aetna, CIGNA, or United paid NTSP's higher rates on the basis of NTSP's own patient surveys. The uncontroverted evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227). Respondent's use of the cited

evidence mentioned in RPF 41 as some measure of quality of medical care is improper expert testimony and is irrelevant. RPF 41 cites only survey results from unqualified out-of-court lay declarants. The greater weight of the evidence, in particular the expert testimony of Dr. Casalino, supports the proposition that NTSP lacked meaningful quality improvement processes and that fact is directly determinative of issues relating to quality of medical care. (CPF 422-429).

Furthermore, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 41 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 42.:

RPF 42 is irrelevant and misleading. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts, nor does it justify NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, the contracts at issue in this proceeding. Indeed, NTSP's sole risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in

NTSP's lone risk contract. (CPF 55-58, 78). RPF 42 is also misleading; NTSP is paid specifically to perform these functions under its risk contract with PacifiCare (Deas, Tr. 2511-12; CPF 55-58, 78). RPF 42 is also misleading in that it does not account for the additional millions of dollars which NTSP generates for its physician members through the collectively-negotiated higher rates in the non-risk contracts that its physicians receive directly from health plans. (CPF 476). There is no evidence and Respondent does not even contend that these funds are dedicated for any purpose other than to augment the personal assets of NTSP's physicians, much less medical management programs.

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).

Response to Finding No. 43.:

RPF 43 is irrelevant. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts, the contracts at issue in this proceeding. Thus, RPF 43 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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)).

Response to Finding No. 44.:

RPF 44 is irrelevant. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 44 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 45.:

RPF 45 is irrelevant. NTSP's medical directors have no responsibilities in regard to NTSP's non-risk contracts, the contracts at issue in this proceeding. (Deas, Tr. 2553). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's sole risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 45 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

46. Gordian is a company that provides medical management and utilization management services to NTSP on its risk contracts. Among it 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)).

Response to Finding No. 46.:

RPF 46 is irrelevant. Gordian has no responsibilities in regard to NTSP's non-risk contracts, the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 46 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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)).

Response to Finding No. 47.:

RPF 47 is irrelevant. NTSP does not monitor physician performance in its non-risk contracts (Van Wagner, Tr. 1849-1850), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 47 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions.

Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

Furthermore, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 47 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 48.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 49.:

RPF 49 is misleading and irrelevant. RPF 49 is misleading in its use of the word "can" to the extent that it implies that NTSP actually achieves quality improvement through the monitoring of physician practice patterns. NTSP does monitor its physicians' adherence to its clinical guidelines and protocols for patients under its risk contract. (Casalino, Tr. 2840). However, the evidence as to whether NTSP actually achieves quality improvement for patients under its shared-risk contract is not reliable. (Casalino, Tr. 2827-2829). NTSP does not even

monitor its physicians' adherence to its clinical guidelines and protocols for patients under its non-risk contracts. (Casalino, Tr. 2840.)

Since RPF 49 merely suggests a theoretical proposition and at best refers to NTSP's risk contract it is irrelevant and does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. (CPF 55-58, 78).

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).

Response to Finding No. 50.:

RPF 50 is irrelevant. NTSP does not monitor physician performance in its non-risk contracts (Van Wagner, Tr. 1849-1850), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 50 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 50 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

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).

Response to Finding No. 51.:

RPF 51 is irrelevant. NTSP does not monitor physician performance or similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 51 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 51 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

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).

Response to Finding No. 52.:

RPF 52 is irrelevant. NTSP does not monitor physician performance or any similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. There is little evidence of coordination between NTSP and its primary care physicians, who do not share risk, much less evidence of monitoring as suggested in RPF 52. (Casalino, Tr. 2848-2851). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 52 does not have any bearing

on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 53.:

RPF 53 is irrelevant. NTSP does not provide such counseling or any similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. The Medical Management Committee has no responsibility for NTSP's 20 non-risk contracts. (Deas, Tr. 2550-2555). NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 53 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 53 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 54.:

RPF 54 is irrelevant. NTSP does not provide practice pattern information with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 54 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 54 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

55. Physician counseling is generally provided orally, rather than in writing, due to concerns of confidentiality and medical malpractice litigation. (Deas, Tr. 2448-49).

Response to Finding No. 55.:

RPF 55 is irrelevant. NTSP does not provide such counseling or other similar conduct with respect to its non-risk contracts and non-risk taking physicians (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 55 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In

addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 55 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 66).

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)).

Response to Finding No. 56.:

RPF 56 is irrelevant. NTSP does not utilize practice guidelines and clinical protocols or any similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 56 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

Furthermore, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 56 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*,

Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

57. NTSP has developed over one hundred protocols. (Van Wagner, Tr. 1543).

Response to Finding No. 57.:

RPF 57 is irrelevant and inaccurate. Most of these protocols were not developed by NTSP, but rather taken from textbooks and local hospitals. (CPF 425). NTSP also lacks the procedures required to monitor adherence to the protocols, rendering them ineffective as a means of improving quality. (CPF 425). Finally, RPF 57 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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)).

Response to Finding No. 58.:

RPF 58 is incomplete and irrelevant. NTSP does not utilize or monitor clinical protocols or any similar conduct with respect to its non-risk contracts. (CPF 417-429). NTSP's guidelines and protocols are also too lengthy to be effective. (CPF 425). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 58 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 59.:

RPF 59 is irrelevant. NTSP does not utilize or monitor clinical protocols or any similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. There is little evidence of coordination between NTSP and its primary care physicians, much less the "interplay" alleged in RPF 59. (Casalino, Tr. 2848-2851). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 59 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 59 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

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).

Response to Finding No. 60.:

RPF 60 is irrelevant. NTSP does not monitor compliance with guidelines and protocols or other similar conduct with respect to its non-risk contracts, a practice which is key in making guidelines work. (CPF 417-429; Casalino, Tr. 2840). NTSP's risk contract is not at

issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 60 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 60 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

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).

Response to Finding No. 61.:

RPF 61 is irrelevant. The website did not exist during the relevant time period and was not even conceived of until August of 2003. (CX0154 at 4). The existence of NTSP's website does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. In addition, RPF 61 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 62.:

RPF 62 is misleading and irrelevant. NTSP is an IPA and lacks the authority to require physicians to follow protocols. (CPF 27). In order for guidelines to be effective and to improve quality, physicians' adherence to them must be monitored, which NTSP does not do.

(CPF 425). NTSP's guidelines are also too lengthy to improve quality and to be effective. (CPF 425). Moreover, NTSP's alleged activity in this matter only relates to its lone risk-sharing contract and does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. In addition, RPF 62 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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. (Lonergan, Tr. 2721-22).

Response to Finding No. 63.:

RPF 63 is inaccurate and misleading. The sole support for RPF 63 is the testimony of one physician that cannot plausibly support the broad statement in RPF 63, much less an inference that this is standard practice at NTSP. More importantly, NTSP is an IPA and lacks the authority to require physicians to follow protocols. (CPF 27). In order for guidelines to be effective and to improve quality, physicians' adherence to them must be monitored, which NTSP does not do. (CPF 425). NTSP's guidelines are also too lengthy to be effective. (CPF 425). RPF 63 is also vague as to the relevant time period.

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).

Response to Finding No. 64.:

RPF 64 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct with respect to its non-risk contracts. (CPF 417-429). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to

conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 64 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 64 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

65. NTSP is involved in monitoring pain management, immunoglobulin patients, palliative care, and certain pharmaceuticals in risk contracts. (Van Wagner, Tr. 1568-72).

Response to Finding No. 65.:

RPF 65 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct in its non-risk contracts. (CPF 417-429). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 65 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 65 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 66.:

RPF 66 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct in its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 66 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

67. NTSP's participating physicians have referred approximately 600 patients of risk contracts to disease management programs this year. (Van Wagner, Tr. 1567-68).

Response to Finding No. 67.:

RPF 67 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 67 is supported exclusively by self-serving

testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 68.:

RPF 68 is irrelevant. The website did not exist during the relevant time period and was not even conceived of until August of 2003. (CX0154 at 4). The existence of NTSP's website does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. In addition, RPF 68 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 69.:

RPF 69 is irrelevant. The website did not exist during the relevant time period and was not even conceived of until August of 2003. (CX0154 at 4). The existence of NTSP's website does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. In addition, RPF 69 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 70.:

RPF 70 is irrelevant. The website did not exist during the relevant time period and was not even conceived until of August of 2003. (CX0154 at 4). The existence of NTSP's website does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. In addition, RPF 70 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 71.:

RPF 71 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct in its non-risk contracts. (CPF 417-429). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 71 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 71 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

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).

Response to Finding No. 72.:

RPF 72 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct with respect to its non-risk contracts. (CPF 417-429). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 72 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 72 is supported exclusively by self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding. (CPF 74).

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).

Response to Finding No. 73.:

RPF 73 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct with respect to its non-risk contracts. (CPF 417-429). NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 73 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to

participate in NTSP's lone risk contract. (CPF 55-58, 78). Moreover, the evidence cited in RPF 73 is not credible. The testimony of Van Wagner is self-serving testimony from a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66). Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 73 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

74. NTSP's information system used to track risk patient data is a good tool. (Casalino, Tr. 2805-06).

Response to Finding No. 74.: .

RPF 74 is irrelevant because it does not distinguish between shared risk and non-risk contracts. NTSP's performance for its shared-risk contract has no bearing on NTSP's price-fixing conduct with respect to its non-risk contracts which are the subject of this litigation, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 74's claim as to the value of NTSP's information system does not demonstrate that any efficiencies from its shared-risk contract "spilled over" to its non-risk contracts, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

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).

Response to Finding No. 75.:

RPF 75 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct in its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 75 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 75 is supported exclusively by self-serving testimony from Karen Van Wagner and Dr. Deas, witnesses with personal and financial interest in the outcome of this proceeding. (CPF 66, 74).

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).

Response to Finding No. 76.:

RPF 76 is irrelevant. NTSP does not perform any of the activities described above or any similar conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 76 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's

member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 76 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

77. Payors have asked NTSP to assist in interpreting and utilizing data. (Van Wagner, Tr. 1534-35).

Response to Finding No. 77.:

RPF 77 is inaccurate and misleading. By NTSP's own admission, PacifiCare is the only health plan that has made any such request, and has done so with regard to its risk contract. (Van Wagner, Tr. 1534). Moreover, RPF 77 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 78.:

RPF 78 is irrelevant. NTSP does not perform any such conduct with respect to its non-risk contracts (CPF 417-429), the contracts at issue in this proceeding. NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 78 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78). Finally, RPF 78 is supported

exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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)).

Response to Finding No. 79.:

RPF 79 is inaccurate and misleading to the extent that it states that NTSP has achieved the delivery of physician services in a high quality and cost effective manner. {[redacted]} (Grizzle, Tr. 880 *in camera (see Grizzle, Tr. 752-754)*).

In addition, RPF 79 is misleading in that the data upon which Dr. Maness relies in reaching this conclusion was compiled by PacifiCare. (Maness, Tr. 2071, 2073-2074). Quantitative analyses that address an IPA's performance for controlling costs or improving quality cannot be relied upon unless they are properly adjusted for demographic differences, such as age and sex, and "case mix," that is, the illness status of patients. (Casalino, Tr. 2827- 2828). The PacifiCare data fails to control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). No conclusions should be drawn from such data. (Casalino, Tr. 2829).

The evidence cited in support of RPF 79 is not reliable. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in

this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' testimony is entitled to little or no weight and does not support RPF 79. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 79 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 80.:

RPF 80 is misleading and irrelevant. RPF 80 says little about the success of such steps. The cited references refer to division meetings at which attendance can be extremely low and the medical management committee which has no responsibilities outside of NTSP's risk contract. (Van Wagner Tr. 1854-55; Deas, Tr. 2550-2555).

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).

Response to Finding No. 81.:

RPF 81 is inaccurate and misleading in that it confuses evidence of the potential of teamwork for controlling costs and improving quality with evidence that NTSP has actually achieved cost control and quality improvement through its teamwork. The cited testimony of Dr. Frech, Dr. Wilensky and Dr. Deas affirms that teamwork within physician organizations is "useful" and "important," not that NTSP's teamwork has realized its potential. (Frech, Tr. 1406-1407; Wilensky, Tr. 2191-2192; Deas Tr. 2469-2470). The cited testimony of Dr. Maness affirms merely that "one would expect" benefits to arise from "an IPA that values close teamwork." (Maness, Tr. 2064). Although Van Wagner, Dr. Deas and Dr. Lonergran give examples of teamwork among NTSP member physicians, none of them make a claim as to whether this teamwork has achieved measurable improvements in cost control or quality improvement (Van Wagner, Tr. 1572; Deas, Tr. 2530-2532; Lonergran, Tr. 2720-2721), nor do they possess the appropriate expertise to make such assessment. Lovelady of PacifiCare believes that teamwork is "important," but admits he has no ability to measure whether NTSP's teamwork provides any benefits. (Lovelady, Tr. 2685-2686). In truth, outside the small inner core of physicians, NTSP does not demonstrate a high degree of teamwork. (Casalino, Tr. 2854-2857).

RPF 81 is inaccurate and misleading in that it wrongly credits NTSP for teamwork that is a product of its physicians serving on the medical staffs of the same hospitals. (CX1174 (Deas, Dep. at 21)).

The evidence cited in support of RPF 81 is not reliable. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work

of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' testimony is entitled to little or no weight and does not support RPF 81.

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)).

Response to Finding 82:

RPF 82 is irrelevant because it does not distinguish between shared-risk and non-risk contracts. NTSP's performance for its shared-risk contract has no bearing on NTSP's price-fixing conduct with respect to its non-risk contracts that are at issue in this proceeding, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 82's performance claims do not demonstrate that any efficiencies from NTSP's shared-risk contract "spilled over" to its non-risk contracts, especially with respect to the nearly half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

RPF 82 is inaccurate in its assertion that NTSP's organizational capital has provided actual benefits in achieving quality improvement for patients under its shared-risk contract. NTSP has placed greater emphasis on controlling costs than on improving quality for patients under its shared-risk contract. (Casalino, Tr. 2811). NTSP's failures to fully achieve its potential for improving quality for patients under its shared-risk contract are numerous. First,

with respect to clinical guidelines and protocols, most of NTSP clinical guidelines and protocols are too lengthy to be effective in assisting practical, clinical decision-making to improve quality. (Casalino, Tr. 2838- 2839). The small number of NTSP clinical guidelines and protocols in comparison to other similar IPAs indicates that NTSP is not realizing the full potential of clinical guidelines and protocols to improve quality. (Casalino, Tr. 2838-2839). NTSP's lack of electronic medical records for its patients prevents it from implementing an effective reminder system, at the point of care, for its clinical guidelines and protocols for patients under its shared-risk contract. (Casalino, Tr. 2839- 2840). Second, with respect to patient education programs, NTSP's only patient education program is the operation of a web site. (Casalino, Tr 2844-2845). NTSP's web site was developed in early 2004. (Casalino, Tr 2847). NTSP's web site is not very effective in improving quality for patients under its shared-risk contract. (Casalino, Tr. 2847-2848). Third, with respect to coordination between primary care physicians and specialists, NTSP has not improved quality by improving this coordination for patients under its shared-risk contract. (Casalino, Tr. 2848). NTSP's board includes no primary care physicians among its voting members. (Deas, Tr. 2598). NTSP's coordination of primary care physicians and specialist physicians is hindered by the limited membership status primary care physicians hold in NTSP. (Casalino, Tr. 2848-2849, 2851-2852). NTSP's primary care council is ineffective in improving quality because it meets only 2 to 4 times per year, the attendance at its meetings averages only 6 to 10, and information about its work is not readily available to NTSP physicians. (Casalino, Tr. 2850- 2851). Fourth, with respect to teamwork among physicians, NTSP has not improved quality by enhancing teamwork among its physicians for patients under its shared-risk contract. (Casalino, Tr. 2854-2854). NTSP's goal of enhanced teamwork among its physicians is hindered by poor attendance of its physicians at divisional and general meetings. (Casalino, Tr.

2854-2855; Van Wagner, Tr. 1854-1855). NTSP's goal of enhanced teamwork among its physicians is also hindered by the lack of pediatricians, cardiologists, and obstetricians in NTSP, forcing NTSP patients needing the services of these core specialties to seek physicians outside NTSP. (Casalino, Tr. 2854-2856; Frech, Tr. 1432).

Furthermore, the evidence cited in support of RPF 82 is not reliable. Van Wagner in seemingly expert testimony inappropriately provides self-serving testimony which is entitled to no weight. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' report is entitled to little or no weight and does not support RPF 82. In addition, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 82 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Complaint Counsel does not disagree that NTSP may have created organizational capital that is beneficial in achieving cost control for patients under shared-risk contracts.

However, this is irrelevant.

83. NTSP's high-performing team generates a sense of peer morale and a resulting peer pressure that is powerful and can brings [*sic*] about changes in physician behavior. (Van Wagner, Tr. 1580-81; Wilensky, Tr. 2193-94; Deas, Tr. 2497-98; Lovelady, Tr. 2685-86).

Response to Finding 83:

RPF 83 is misleading in that it confuses the potential for peer morale and peer pressure to change physician behavior with whether NTSP has a level of peer morale and peer pressure that have actually changed physician behavior. Complaint Counsel does not disagree that peer morale and peer pressure have some potential to bring about changes in physician behavior, especially if the peer morale and peer pressure take the form of written feedback. (Casalino, Tr. 2923-2925). NTSP lacks the structural control over its member physicians to bring about changes in their behavior. (Casalino, Tr. 2799-2800). In addition, the characterization of NTSP as "high-performing" is not supported by the any of the cited evidence. In fact, NTSP has failed to initiate many different programs to improve quality that it has had the unilateral ability to initiate. (Casalino, Tr. 2869-2872).

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).

Response to Finding 84:

RPF 84 is misleading to the extent that it implies that physicians are not responsive to economic incentives. Dr. Wilensky had no evidence as to whether NTSP physicians respond to financial incentives. (Wilensky, Tr. 2198-2199). In fact, physicians do respond to financial incentives. (Frech, Tr. 1284-1285; Maness, Tr. 2037, 2077; Wilensky, Tr. 2154-2155; Casalino, Tr. 2860-2862, 2902).

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)).

Response to Finding No. 85.:

RPF 85 is inaccurate. The evidentiary support cited by Respondent lacks any evidence of any mechanism whereby NTSP's approximately 300 physicians who do not take risk generate "spill-over" efficiencies. In fact, the testimony cited includes the admission that NTSP has no management or oversight of these physicians that could plausibly generate "spillover" efficiencies for these 300 physicians. (CX1199 (Vance, Dep. at 288)). The source of testimony is Dr. Vance, who previously wrote that NTSP's coordinated threats and departicipations of its physicians were a "template" for NTSP's negotiations with health plans. (CX0256). RPF 85 is also incomplete and misleading. NTSP's alleged "business model" is vague and undefined, though Complaint Counsel agrees it would include, as described in CX1117 (cited previously by Respondent in RPF 28), the fact that NTSP members "rely on" and can direct NTSP to negotiate contracts on their behalf. NTSP's "business model" also includes collective price negotiation (CPF 125-128), collective refusals to deal (CPF 129-142), threats of and actual departicipation of its members to increase its negotiating leverage, coordination of targeted campaigns at health plans' customers to increase its negotiating leverage (CPF 129-142), and the collection and use of powers of attorney to increase its negotiating leverage. (CPF 129-142). NTSP's "business model" is designed to threaten health plans with termination to obtain higher prices. (CX0256)

As RPF 85 pertains to NTSP's claimed efficiencies, it is irrelevant because Respondent has put forth absolutely no evidence that any health plan has agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or alleged cost reductions. In fact, the

health plans uniformly rejected NTSP's efficiency claims. (CPF 399, 288). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227).

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)).

Response to Finding No. 86.:

RPF 86 is inaccurate and misleading. The cited testimony of Dr. Frech and Dr. Maness does not support the proposition that NTSP has achieved spillover benefits, but merely supports the proposition that spillover benefits are potentially available. (Frech, Tr. 1348, 1415, 1441-1442; Maness, Tr. 2069). Complaint Counsel does not disagree with this theoretical proposition, as it is consistent with the record in this case. (Casalino, Tr. 2859-2860). Dr. Wilensky agrees that spillover of cost control and quality improvement benefits is potentially achievable and connects the spillover to the employment of medical management strategies. (Wilensky, Tr. 2162-2166). Complaint Counsel does not disagree that the employment of medical management strategies, that is, organized processes, are necessary for the achievement of significant spillover benefits, as this is consistent with the record in this case. (Casalino Tr. 2864-2865). Dr. Wilensky, however, recognizes that NTSP does not employ two such programs – utilization review and clinical reminder systems – for its patients under non-risk contracts. (Wilensky, Tr. 2200-2202). Dr. Wilensky admits that she does not know whether NTSP employs other such programs – identification of patients whose care can be better managed, disease

registries, and all disease management programs, including the palliative care program – for patients under its non-risk contracts. (Wilensky, Tr. 2199-2202). Dr. Wilensky's inability to affirm the employment of processes used by NTSP for patients under its shared-risk contract for patients under its non-risk contracts is consistent with the record in this case. (Frech, Tr. 1354-1355; Casalino, Tr. 2864-2865, 2870, 2871-2872). Accordingly, Dr. Wilensky's testimony that NTSP "appears" to achieve some spillover benefits is entitled to no weight. (Wilensky, Tr. 2163).

Dr. Maness' testimony and report, cited in support of RPF 86 are not reliable. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' testimony and report are entitled to little or no weight and do not support RPF 86. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 86 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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 {[redacted]}, *in camera*).

Response to Finding 87:

RPF 87 is inaccurate in that it asserts that NTSP's medical costs are low for patients under its shared-risk contract. NTSP has a shared-risk contract with only one health plan, PacifiCare. (CX1177 (Grant, Dep. 19)). Data compiled under this contract is unreliable. Quantitative analyses which address an IPA's performance for controlling costs or improving quality cannot be relied upon unless it is properly adjusted for demographic differences, such as age and sex, and "case mix," that is, the illness status of patients. (Casalino, Tr. 2827-2828). The PacifiCare data fails to control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). No conclusions should be drawn from such data. (Casalino, Tr. 2829). {[redacted]} (Grizzle, Tr. 880, *in camera (see Grizzle, Tr. 752-754)*).

RPF 87 is inaccurate in that it asserts that spillover benefits are significant and in that it asserts that the practices which allow NTSP to maintain low medical costs in its risk contracts directly carry over to the non-risk contracts. For an IPA to achieve significant "spillover" benefits from its shared-risk patients to its non-risk patients, it would need to apply organized processes to its non-risk patients. (Casalino, Tr. 2864-2865). NTSP does not apply the organized processes it has developed for patients under its shared-risk contract to patients under

its non risk contracts, with the possible exception of distributing clinical guidelines and protocols. (Casalino, Tr. 2864-2865, 2870-2872; Frech, Tr. 1354-1355). Specifically, NTSP does not employ nurse care managers, disease management programs, unannounced site visits to physician offices, and chart review for quality measures for patients under it non-risk contracts. (Casalino, Tr. 2870-2872).

Dr. Maness' testimony and report, cited in support of RPF 87, are not reliable. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' testimony and report are entitled to little or no weight and do not support RPF 87. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 87 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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 contracts. (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)).

Response to Finding No. 88.:

RPF 88 is inaccurate and misleading in that it claims that changes in physician practice patterns are not normal. In fact, physicians do respond to financial incentives. (Frech, Tr. 1284-1285; Maness, Tr. 2037, 2077; Wilensky, Tr. 2154-2155; Casalino, Tr. 2860-2862, 2902). These responses include changes in clinical practice patterns. (Wilensky, Tr. 2154-2155; Maness, Tr. 2077; Casalino, Tr. 2860-2862).

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 [*sic*], Tr. 2277; Lovelady, Tr. 2685-88).

Response to Finding No. 89.:

RPF 89 is misleading to the extent that it implies that any alleged spillover benefits that apply to NTSP physicians who do not participate in the shared-risk contract are significant in magnitude. In fact, spillover in such cases is likely to be minimal, because NTSP physicians who do not participate in NTSP's shared-risk contract are unlikely to learn techniques under this contract to control costs and to improve quality, and, therefore, are unlikely to apply these techniques to their patients. (Casalino, Tr. 2860; Frech, Tr. 1353-1354). Dr. Maness testified that this spillover occurs, but had no measurement of the magnitude of this spillover. (Maness, Tr. 2277).

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).

Response to Finding 90:

RPF 90 is misleading to the extent that it implies that any spillover benefits that

apply to NTSP physicians who do not participate in the shared-risk contract are significant in magnitude. In fact, spillover in such cases is likely to be minimal, because NTSP physicians who do not participate in NTSP's shared-risk contract are unlikely to learn techniques under these contracts to control costs and to improve quality, and, therefore, are unlikely to apply these techniques to their patients. (Casalino, Tr. 2860; Frech, Tr. 1353-1354). Dr. Maness testified that this spillover occurs, but had no measurement of the magnitude of this spillover. (Maness, Tr. 2277).

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).

Response to Finding 91:

Complaint Counsel has no specific response.

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)).

Response to Finding No. 92.:

RPF 92 is inaccurate and misleading to the extent that it states that NTSP has achieved the delivery of physician services in a high quality and cost effective manner. [redacted] (Grizzle, Tr. 880, *in camera (see Grizzle, Tr. 752-754)*). None of NTSP's data from PacifiCare on cost control and quality improvement includes any adjustment for case mix. (Casalino, Tr 2827-2829). Quantitative analyses which address an IPA's performance for controlling costs or improving quality cannot be relied upon unless patient populations are adjusted for "case mix," that is, the illness status of patients. (Casalino, Tr. 2827-2828).

As RPF 92 pertains to NTSP's claimed efficiencies, it is irrelevant because

Respondent has put forth absolutely no evidence that any health plan that has contracted with NTSP agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or cost reductions. In fact, health plans rejected NTSP's efficiency claims. (CPF 288, 399). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227).

Furthermore, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 92 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 93.:

RPF 93 in misleading and unsupported by reliable data. Quantitative analyses which address an IPA's performance for controlling costs or improving quality cannot be relied upon unless patient populations are adjusted for "case mix," that is, the illness status of patients. (Casalino, Tr. 2827-2828).

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).

Response to Finding No. 94.:

RPF 94 is irrelevant because the cited figures do not adjust for any of the 10-25 variables, such as plan design and sex, for which Aetna adjusts in evaluating the performance of IPAs (see CPF 397). Further, the documents do not identify who or where the "other providers" are, thereby making any valid comparison impossible. Finally, because NTSP did not have a direct contract with Aetna prior to 2000, the work that NTSP would have performed on patients insured through Aetna would have been through a risk-bearing entity, MSM, not through a non-risk contract. (*E.g.*, Jagmin, Tr. 1029).

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 contracts 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*).

Response to Finding No. 95.:

RPF 95 is inaccurate and misleading. The cited evidence relies on unsupportable conclusions from inadequate data (CPF 66, 469; Casalino, Tr. 2827-2829; CPF 450, 460-462), and the self-serving testimony of Karen Van Wagner who has substantial personal and financial interest in the outcome of this litigation. (CPF 66). Maness' purported expert analysis, which was also based on the same source, was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 95 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

The evidence shows that {[redacted]

[redacted]} (Grizzle, Tr. 880, *in camera (see Grizzle, Tr. 752-754)*). Respondent's cited empirical support is wholly incapable of providing support for RPF 95. None of NTSP's data from PacifiCare, relied on by RPF 95, on cost control and quality improvement includes any adjustment for case mix. (Casalino, Tr 2827-2829). Quantitative analyses which address an IPA's performance for controlling costs or improving quality cannot be relied upon unless patient populations are adjusted for "case mix," that is, the illness status of patients. (Casalino, Tr. 2827-2828).

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 {([redacted]} and that Cigna's total PMPM was lower than PacifiCare's {[redacted]}. (Maness, Tr. 2075-76; RX 3118 (Maness Report ¶ 95), *in camera*; RX 3130, *in camera*).

Response to Finding No. 96.:

RPF 96 is inaccurate and misleading. The comparison between PacifiCare and CIGNA data does not control for demographic differences such as age, sex or case mix (illness of patients). (CPF 469; Maness, Tr. 2328-2330). Thus, it cannot reliably compare NTSP physicians' performance to the performance of other physicians. (*See* CPF 462). Further, the data, by comparing risk and non-risk performance, compares dissimilar contracts without adjusting for the difference. (*See*, Dr. Casalino testimony that "data without risk adjustment just isn't very useful, if useful at all. It can be extremely misleading." (Casalino, Tr. 2834-2836)).

The evidence cited in RPF 96 does not support the conclusion that NTSP's clinical integration has allowed it to produce cost savings in fee-for-service similar to its capitated business. In fact, NTSP is not clinically integrated for its non-risk contracts. (CPF 422). NTSP physicians who do not participate in NTSP's shared-risk contract–approximately half–are unlikely to learn and apply techniques to control costs that are developed in the risk-sharing arrangement.

(CPF 423). NTSP has no organized processes to control costs on the non-risk side. (CPF 423).

RPF 96 is irrelevant because it concerns only NTSP's risk patients. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts, the contracts at issue in this proceeding. Thus, RPF 96 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

Moreover, the evidence cited in RPF 96 does not adequately support Respondent's finding. RPF 96 relies exclusively on Dr. Maness, who is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440), and exclusive reliance on Van Wagner as a source of information make the validity of his conclusions questionable. (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' testimony and report are entitled to little or no weight in their support for RPF 96. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission

into evidence was procured by misrepresentation. Thus, as far as any part of RPF 96 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 97.:

RPF 97 is identical to RPF 36 and RPF 323. We reproduce our response here for the Court's convenience.

RPF 97 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 97 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

The evidence does not adequately support RPF 97. No one, not even PacifiCare's witness, testified with respect to its accuracy. Moreover RX3139 itself does not support RPF 97; it does not label the per member per month comparison as being a national average as RPF 97 states.

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).

Response to Finding No. 98.:

RPF 98 is identical to RPF 37 and RPF 324. We reproduce our response here for the Court's convenience.

RPF 98 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 98 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

RPF 98 is not adequately supported by the evidence. Lovelady of PacifiCare–the appropriate witness in this matter–lent no support to this finding. Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provided self-serving testimony to interpret the data. (*See* CPF 66).

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*).

Response to Finding No. 99:

RPF 99 is incomplete and misleading. The same exhibit cited in RPF 99 concludes that total cost per member per month on the PacifiCare capitation contract is equal to the national average. (RX3176). The data, by comparing risk and non-risk performance, compares dissimilar contracts without adjusting for the difference. (*See* Casalino, Tr. 2834-2836 ("[D]ata without risk adjustment just isn't very useful, if useful at all. It can be extremely misleading.")). Moreover,

the data does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834).

RPF 99 is irrelevant because NTSP's performance on the PacifiCare risk contract has no bearing on NTSP's price-fixing conduct in its non-risk contracts with health plans that are the subject of this Complaint, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 99 does not demonstrate that any efficiencies from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the nearly half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

Evidence cited in RPF 99 does not adequately support Respondent's findings. RPF 99 exclusively relies on Van Wagner's self-serving testimony, a witness with substantial financial and personal interest in the outcome of this proceeding (*See* CPF 66), while Lovelady of PacifiCare–the appropriate witness in an issue concerning PacifiCare's data–lent no support to this finding.

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).

Response to Finding No. 100.:

RPF 100 is identical to RPF 39. We reproduce our response here for the Court's convenience.

RPF 100 is vague, irrelevant and not adequately supported in evidence. RPF 100 is vague as to what HMO contracts has been included in the population cited. The cite is supported exclusively by the self-serving testimony of Van Wagner–a lay witness with substantial personal

and financial interest in the outcome of this litigation. (CPF 66). Van Wagner has no medical or economics expertise regarding the cost of treatment for different population groups. RPF 100 is also irrelevant because NTSP's risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 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).

Response to Finding No. 101.:

RPF 101 is inaccurate and misleading. The methodology used in the analyses was fundamentally flawed and inadequate to support RPF 101. (Casalino, Tr. 2827-2829). Both analyses cited by Respondent are analyses of a single practice group in each specialty. In other words, all the neurosurgeons analyzed practice together in a practice group, Southwest Neurology Associates PA, a wholly separate entity from NTSP. (RX3135; RX3136; RX3137; RX3138). This is similarly true for the opthalmology group analyzed, Opthalmology Associates, PA. (RX3168; RX3169; RX3170; RX3171). Within these discrete practice groups any number of factors, processes, or their financial and clinical integration could account for the alleged similarity in performance. Any such integration within the practice groups would be specific to

the practice group and in no way attributable to NTSP. No conclusions whatsoever can be drawn as to what role, if any, NTSP could have in affecting their practice behavior. The analysis is especially vulnerable to selection bias by Respondent. (Casalino, Tr. 2827-2828). An analysis of a specialty division would only be relevant if it were an analysis of several discrete practice groups whose only commonality is that they are in the same NTSP Division. An adequate study would have provided the risk adjustment procedure rates for all NTSP specialties or for a random sample of them. (Casalino, Tr. 2827-2829). Such a study is conspicuously absent from Respondent's findings and expert analysis. RPF 101 is also misleading by characterizing the data as demonstrating that the two practice groups performed equally "well" in both contracts. The evidence cited by Respondent provides no reference point to measure efficient utilization and therefore would equally support a conclusion that the two practice groups performed equally "poorly" under both contracts.

As RPF 101 pertains to NTSP's claimed efficiencies, it is irrelevant because Respondent has put forth absolutely no evidence that any health plan that has contracted with NTSP agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or cost reductions. In fact, health plans rejected NTSP's efficiency claims. (CPF 288, 399). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as

far as any part of RPF 101 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 102.:

RPF 102 is irrelevant because it cites to data for only one primary care physician group *within* NTSP and does not support the conclusion that NTSP as a whole is more cost efficient than other providers, particularly in its non-risk patient population. In addition, this data does not adjust for differences of the patient population. Therefore, the statistical comparison is neither valid nor reliable for the purpose for which it is offered. *(See* CPF 417-429, 462).

RPF 102 is only supported by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

103. NTSP's patient satisfaction rating for specialists exceeds that of payors as a whole operating in the Metroplex. (RX 3118 (Maness Report ¶ 98)).

Response to Finding No. 103.:

RPF 103 is irrelevant. Respondent offers no evidence and does not even contend that the health plans paid NTSP's higher rates on the basis of NTSP's own patient surveys. The uncontroverted evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227). Respondent's use of alleged patient satisfaction rating as some measure of quality of medical care is improper expert testimony and is irrelevant. The greater weight of the evidence, including expert testimony from Dr.

Casalino, demonstrates that NTSP lacks meaningful quality improvement processes, that should be fully credited on issues relating to quality of medical care. (CPF 422-429).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 104.:

RPF 104 is irrelevant. Respondent offers no evidence and does not even contend that the health plans paid NTSP's higher rates on the basis of NTSP's own patient surveys. The uncontroverted evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227). Respondent's use of patient surveys as some measure of quality of medical care is improper expert testimony and is irrelevant. The greater weight of the evidence, including expert testimony from Dr. Casalino, demonstrates that NTSP lacks meaningful quality improvement processes, that should be fully credited on issues relating to quality of medical care. (CPF 422-429).

105. NTSP has had much lower complaint rates from patients than the averages for Aetna, Cigna, PacifiCare, and United. (RX 3183).

Response to Finding No. 105.:

RPF 105 is irrelevant. Respondent offers no evidence and does not even contend that the health plans paid NTSP's higher rates on the basis of NTSP's own patient surveys. The uncontroverted evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227). Respondent's use of the alleged complaint rate as some measure of quality of medical care is improper expert testimony and is irrelevant. The greater weight of the evidence, including expert testimony from Dr. Casalino, demonstrates that NTSP lacks meaningful quality improvement processes, that should be fully credited on issues relating to quality of medical care. (CPF 422-429).

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).

Response to Finding No. 106.:

RPF 106 is incomplete and misleading. NTSP's alleged philosophy and/or "business model" is vague and undefined, though Complaint Counsel agrees it would include, as described in CX1117 (cited in RPF 28 by Respondent), the fact that NTSP members "rely on" and can direct NTSP to negotiate contracts on their behalf. NTSP's "business model" also includes collective price negotiation (CPF 125-1106), collective refusals to deal (CPF 129-142), threats of and actual deparcipation of its members to increase its negotiating leverage, coordination of targeted campaigns at health plans' customers to increase its negotiating leverage (CPF 129-142), and the collection and use of powers of attorney to increase its negotiating leverage. (CPF 129-142).

As RPF 106 pertains to NTSP's claimed efficiencies, it is irrelevant because

Respondent has put forth absolutely no evidence that health plans that have contracted with NTSP agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or cost reductions. In fact, health plans rejected NTSP's efficiency claims. (CPF 288, 399). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227).

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*).

Response to Finding No. 107.:

RFP 107 is irrelevant because it is a purely speculative supposition. If anything, RFP 117 is an admission by Respondent that it was not able to and therefore did not improve either the quality or efficiency of care for the overwhelming majority of their non-risk contracts with health plans, that are the subject of this litigation. RFP 107 is also irrelevant because Respondent has put forth no evidence that the health plans that have contracted with NTSP agreed to pay NTSP's above-market rates based on NTSP's promoted efficiencies or promised cost reductions. In fact, health plans rejected NTSP's efficiency claims. (CPF 288, 399). The evidence from these health plans is that they paid NTSP's higher prices solely to maintain an adequate network of physicians in Fort Worth in the face of NTSP's coordinated threats and collective refusals to deal. (CPF 334, 275, 226-227).

108. Many payors have not yet chosen to provide their data to NTSP. (Deas, Tr. 2434-35; Casalino, Tr. 2869, 2939).

Response to Finding No. 108.:

Complaint Counsel has no specific response.

109. {[redacted]} 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*).

Response to Finding No. 109.:

RPF 109 is irrelevant because it does not have any bearing on NTSP's actions to negotiate and fix prices paid by health plans that are the subject of this Complaint. In any event, NTSP has never been in a position to document its alleged ability to lower costs for United's patients. Moreover, NTSP is incapable of tracking utilization patterns and quality control measures for United's patients since these are fee-for-service patients for which United bears the risk and thus maintains the claims data itself. (Quirk, Tr. 256).

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)).

Response to Finding No. 110.:

RPF 110 is inaccurate and irrelevant. There is no evidence that RPF 110, even if true, applies to any relevant time period. More importantly, NTSP is an IPA and lacks the authority to require physicians to follow protocols. (CPF 27). In order for guidelines to be effective and to improve quality, physicians' adherence to them must be monitored, which NTSP does not do. (CPF 425). The greater weight of evidence shows that NTSP's guidelines are not effective. (CPF 425).

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).

Response to Finding No. 111.:

RPF 111 is irrelevant and demonstrates only that NTSP has failed to successfully

market its "business model" but has nonetheless coerced health plans to pay for alleged efficiencies that NTSP admits they do not and cannot provide. (CPF 129-142).

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).

Response to Finding No. 112.:

RPF 112 is incomplete and misleading in that Dr. Casalino testified that some medical management programs can and should be implemented without direct payment from a health plan. (Casalino, Tr. 2902-2904). Specifically, he identified the employment of nurse care managers and a disease management program for congestive heart failure as activities that an IPA can and should implement without direct payment from a health plan. (Casalino, Tr, 2902-2904).

Complaint Counsel does not disagree that implementation of some medical management activities by IPAs is not realistic without direct payment from a health plan to cover the cost of the service.

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*).

Response to Finding No. 113.:

RPF 113 is misleading in that it implies that NTSP has achieved continuity of care among its member physicians. In fact, NTSP's goal of enhanced teamwork among its physicians is hindered, first, by the lack of pediatricians, cardiologists, and obstetricians in NTSP, forcing NTSP patients needing the services of these core specialties to seek physicians outside NTSP. (Casalino, Tr. 2854-2856; Frech, Tr. 1432). Second, the record of NTSP physician participation in specific contracts is non-systematic. (RX13; Maness, Tr. 2117-2121). This lack of consistency

in contract participation creates another source of discontinuity of participating physicians. (Maness, Tr. 2121-2122).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 113 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 114.:

Complaint Counsel has no specific response.

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)).

Response to Finding No. 115.:

RPF 115 is irrelevant and demonstrates only that the NTSP organization provides no added value to health plans while obstructing their efforts to build an adequate network in Forth Worth. In fact, RPF 115 is an admission by Respondent that if its physicians are participating in a contract with a health plan through some other organization or directly, then NTSP's price-fixing is not necessary in order to get physicians to participate in NTSP's contracts. RPF 115 is also incomplete in that it fails to address the fact that many of NTSP's member

physicians practice in the same few important hospitals and must work as a "team" in the course of these duties regardless of NTSP. (CX1174) (Deas, Dep. at 21); RPF 94).

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).

Response to Finding No. 116.:

RPF 116 is misleading to the extent that it states that NTSP has a low-cost and high-quality reputation. Dr. Wilensky did not state that NTSP has a low-cost and high-quality reputation; she merely agreed that adding low-quality physicians to NTSP could harm NTSP's reputation. (Wilensky, Tr. 2171). In fact, no payor, whether health plan or employer, testified that NTSP has a low-cost or high-quality reputation. CIGNA's representative testified concerning NTSP's physicians as opposed to NTSP as an organization, and stated the NTSP physicians have a "good" reputation. (Grizzle, Tr. 719-721).

RPF 116 is misleading to the extent that it implies that NTSP has achieved efficiencies for patients under its non-risk contracts.

As to efficiencies related to cost control, NTSP's information system does not include data for patients under its non-risk contracts. (Van Wagner, Tr. 1837-1841, 1877; Deas, Tr. 2487- 2488).

NTSP cannot evaluate the performance of its physicians for patients under its non-risk contracts because it lacks data for these patients. (Van Wagner, Tr. 1849-1850). NTSP is hindered in implementing organized processes for patients under non-risk contracts because it lacks data for these patients. (Casalino, Tr. 2868-2869). NTSP receives no funding, data, or delegation to perform utilization or medical management to control costs for patients under its non-risk contracts. (Lovelady, Tr. 2674; Deas, Tr. 2515, 2552-2553). NTSP's medical

management committee does not consider patients under NTSP's non-risk contracts. (Deas, Tr. 2550-2551). NTSP does not provide feedback to physicians concerning patients under its non-risk contracts. (Lonergan, Tr. 2722-2723). NTSP's ability to identify physician outliers is limited to contracts in which NTSP is delegated to manage claims and utilization. (Van Wagner, Tr. 1506-1507). NTSP's hospital utilization management program does not apply to patients under its non-risk contracts. (Van Wagner, Tr. 1834). NTSP's medical director has no responsibility for controlling costs for patients under its non-risk contracts. (Deas, Tr. 2553).

As to efficiencies related to quality improvement, IPAs can implement some organized processes to improve quality for patients under non-risk contracts, including distributing clinical guidelines and protocols to all its physicians; employing nurse care managers to implement disease management programs; operating patient education programs; conducting site visits to its physicians' offices; and reviewing its physicians' patient charts. (Casalino, Tr. 2870-2871). NTSP has taken no collective action as an IPA, and has initiated no organized processes, to improve quality for patient under its non-risk contracts. (Casalino, Tr. 2816). NTSP receives no funding, data, or delegation to include in its disease registries patients under its non-risk contracts. (Deas, Tr. 2517-2518). NTSP provides no direct economic incentives, either rewards or penalties, to physicians for cost control or quality improvement for patients under its non-risk contracts. (Deas, Tr. 2553-2554). NTSP provides no feedback to NTSP physicians for patients under its non-risk contracts. (Deas, Tr. 2598). NTSP does not use nurse care managers for patients under its non-risk contracts. (Deas, Tr. 2514). NTSP may not distribute its clinical guidelines and protocols to its physicians who do not participate in its shared risk contracts. (Casalino, Tr. 2839). NTSP's lack of electronic medical records for its patients prevents it from implementing an effective reminder system, at the point of care, for its clinical guidelines and

protocols for patients under its non-risk contracts. (Casalino, Tr. 2839-2840). NTSP does not monitor its physicians' adherence to its clinical guidelines and protocols for patients under its non-risk contracts. (Casalino, Tr. 2840). NTSP's palliative care program does not include patients under its non-risk contracts. (Casalino, Tr. 2844). NTSP's web site is not very effective in improving quality for patients under its non-risk contracts. (Casalino, Tr. 2847- 2848). NTSP has not improved quality by improving coordination of patient care between primary care physicians and specialists for patients under its non-risk contracts. (Casalino, Tr. 2848.) NTSP has not improved quality by enhancing teamwork among its physicians for patients under its non-risk contracts. (Casalino, Tr. 2854- 2854). NTSP's medical director has no responsibility for improving quality for patients under its non-risk contracts. (Deas, Tr. 2553)

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)).

Response to Finding No. 117.:

RPF 117 is inaccurate in that it asserts that NTSP has achieved a high degree of coordination and teamwork. In fact, NTSP's goal of enhanced teamwork among its physicians is hindered, first, by the lack of pediatricians, cardiologists, and obstetricians in NTSP, forcing NTSP patients needing the services of these core specialties to seek physicians outside NTSP. (Casalino, Tr. 2854-2856; Frech, Tr. 1432). Second, the record of NTSP physician participation in specific contracts is nonsystematic. (RX13; Maness, Tr. 2117-2121). This lack of consistency in contract participation creates another source of discontinuity of participating physicians. (Maness, Tr. 2121-2122). Third, with respect to coordination between primary care physicians and specialists, NTSP has not improved quality by improving this coordination for patients under its shared risk contracts. (Casalino, Tr. 2848). NTSP's board includes no primary care physicians

among its voting members. (Deas, Tr. 2598). NTSP's coordination of primary care physicians and specialist physicians is hindered by the limited membership status primary care physicians hold in NTSP. (Casalino, Tr. 2848-2849, 2851-2852). NTSP's primary care council is ineffective in improving quality because it meets only 2 to 4 times per year; the attendance at its meetings averages only 6 to 10; and information about its work is not readily available to NTSP physicians. (Casalino, Tr. 2850- 2851). Fourth, with respect to teamwork among physicians, NTSP has not improved quality by enhancing teamwork among its physicians for patients under its shared risk contracts. (Casalino, Tr. 2854-2854). NTSP's goal of enhanced teamwork among its physicians is hindered by poor attendance by its physicians at divisional and general meetings. (Casalino, Tr. 2854-2855; Van Wagner, Tr. 1854- 1855).

RPF 117 is inaccurate in that it asserts that NTSP benefits non-risk health plans. United HealthCare, a large purchaser of healthcare services in the Fort Worth area, has been harmed in its non-risk contract by NTSP's business practices. (Quirk, Tr. 348-349). CIGNA, another large purchaser of healthcare services in the Fort Worth area, estimates that NTSP's business practices have increased its costs in its non-risk contract [redacted] (CX0814, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04);* Grizzle, Tr. 877-879, *in camera (see Grizzle, Tr. 752-754)).* Likewise, Aetna concluded that NTSP rates were not competitive, and terminated its NTSP contract, resulting in harm to Aetna in that its provider network was disrupted. (CX0640; Jagmin, Tr. 997-1002).

The evidence cited in support of RPF 117 is not reliable. Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in

this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' report is entitled to little or no weight and does not support RPF 117. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 117 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)

Response to Finding No. 118.:

RPF 118 is inaccurate and misleading in that it wrongly credits NTSP for teamwork that is a product of its physicians serving on the medical staffs of the same hospitals. (CX1174 (Deas, Dep. 21)).

RPF 118 is misleading to the extent that it implies that NTSP has actually achieved cost control and quality improvement through its teamwork. Although Van Wagner and Dr. Deas give examples of teamwork among NTSP member physicians, none of them make a claim as to

whether this teamwork has achieved measurable improvements in cost control or quality improvement. (Van Wagner, Tr. 1572; Deas, Tr. 2530-2532; Lonergran, Tr. 2720-2721). Lovelady, PacifiCare's contracting manager, believes that teamwork is "important," but admits he has no ability to measure whether NTSP's teamwork provides any benefits. (Lovelady, Tr. 2685-2686). In fact, outside the small inner core of physicians, NTSP does not demonstrate a high degree of teamwork. (Casalino, Tr. 2854-2857).

RPF 118 is contrary to the weight of the evidence on the question of whether NTSP is more effective than health plans in changing physician practice patterns. According to Aetna's Roberts, health plans and physician organizations can both be effective, and he evaded the attempt of NTSP's Counsel to agree with RPF 118. (Roberts, Tr. 554-555). Dr. Frech, Dr. Deas and Lovelady never expressed an opinion on the issue, and did not even discuss the issue on the cited pages. (Casalino, Tr. 1406-1407; Deas, Tr. 2411-13, 2480-82; Lovelady, Tr. 2685-86). Dr. Wilensky stated that physicians prefer to have physician organizations, rather than health plans, perform medical management functions, but she did not state which entity is likely to be more effective. (Wilensky, Tr. 2172-2173). Accordingly, the proposition that NTSP is more effective than health plans in changing physician practice patterns is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial financial interest in the outcome of this proceeding. (CFF 66).

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)).

Response to Finding No. 119.:

RPF 119 is incomplete and misleading. RPF 119 fails to address countervailing economic incentives that would cause physicians to remain in NTSP to participate only in non-risk contracts. The collective negotiation of non-risk contracts makes non-risk contracts artificially attractive to physicians and undermines any incentive for non-risk physicians to also participate in shared risk contracts. (Frech, Tr. 1349).

RPF 119 is misleading in that it confuses a theoretical possibility with actual fact. Dr. Maness' report merely claims that reverse spillover is "possible." (RX3118 (Maness Report ¶ 100)).

RPF 119 is incomplete and misleading in that it ignores Dr. Maness' trial testimony on reverse spillover. Dr. Maness testified that he had not studied physician movement from NTSP's non-risk panel to its shared risk panel. (Maness, Tr. 2333). He agreed that this is a subject that he could have studied. (Maness, Tr. 2334-2336). To support his conclusions on potential physician movement from NTSP's non-risk panel to its shared risk panel, he relied solely on Van Wagner. (Maness, Tr. 2333). Accordingly, the proposition that NTSP achieves beneficial spillover from its non-risk contracts to its shared risk contracts is supported ultimately by self-serving statements from Karen Van Wagner, a witness with substantial financial interest in the outcome of this proceeding. (CPF 66).

RPF 119 is incomplete and misleading in that it ignores harmful spillover from NTSP's non-risk contracts to its risk-contracts. NTSP's non-risk physicians include those who have no interest in accepting risk, but enjoy the great benefit of receiving NTSP's higher fee-for-service rates without participating in NTSP's risk contract. (CPF 78, 79; Van Wagner, Tr. 1880-83). This ability makes non-risk contracts artificially attractive to physicians, discourages

their participation in shared risk contracts, and creates inefficiency in the market. (Frech, Tr. 1349).

Finally, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 120.:

RPF 120 is wholly irrelevant and, even if true, occurred well beyond any relevant time period and well into Respondent's preparation for litigation in this matter. Furthermore, NTSP has admitted that during the relevant time period NTSP had physicians who were uninterested and unwilling to accept risk and considered having access to NTSP's higher rates without taking risk a great benefit of being a part of NTSP. (Van Wagner, Tr 1881-1884).

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).

Response to Finding No. 121.:

RPF 121 is incomplete and misleading. RPF 121 is NTSP's admission of price-fixing by collecting information on future prices from otherwise competing physicians. NTSP's effort to represent the polling as a legitimate objective cannot prevail because the greater weight of the evidence shows that the polling was just another means to share future price information by physicians and to set minimum prices by NTSP's Board. In fact NTSP's Board had set minimum prices before polling, as referenced in RPF 121-136, commencing on September 14, 2001. (CX1195 (Van Wagner, Dep. at 66-67); CX0018 at 103 (absence of PPO poll conducted prior to September 2001)). Therefore, any alleged efficiencies derived from NTSP's polling, could not be used to justify the considerable anticompetitive conduct and price-fixing conduct that occurred prior to this date, including use of "Board Minimums" and joint negotiation. (CPF 147-249; 258-287; 297-384).

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).

Response to Finding No. 122.:

RPF 122 is misleading and relies exclusively on the self-serving testimony of Karen Van Wagner who has substantial personal and financial interest in the outcome of this litigation. NTSP's "objective" in conducting the poll cannot be viewed in isolation from its overall objective to increase price evidenced by its coordination of refusals to deal and collective negotiation. (CPF 7, 129-142). RPF 122 is also irrelevant as to conduct occurring prior to the institution of NTSP's polling of both PPO and HMO prices. NTSP's polling, as referenced in RPF 121-136, did not commence until September 14, 2001. However, NTSP had established Board minimum prices prior to the institution of polling. (CX1042 (NTSP's minimum price

unchanged for 4 years prior to 2001); CX1195 (Van Wagner, Dep. at 66-67) (Annual Poll first appears in 2001); CX0018 at 103 (absence of PPO poll conducted prior to September 2001)). Therefore, any alleged efficiencies derived from NTSP's polling, could not be used to justify the considerable anticompetitive and price-fixing conduct that occurred prior to this date including use of "Board Minimums" and joint negotiation. (CPF 147-249, 258-287, 297-384).

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).

Response to Finding No. 123.:

RPF 123 is incomplete and vague. Due to Respondent's repeated efforts to alter the meaning of everyday words and terms such as "participating physicians," it should be noted that the polls were sent to all member physicians, i.e., physicians who had any agreement permitting them access to NTSP's non-risk contracts. (CX1194 (Van Wagner, Dep. at 85).

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); CX1178 (Hollander, Dep. at 27-28)).

Response to Finding No. 124.:

RPF 124 is inaccurate. NTSP expends considerable resources on contract offers that fall below NTSP's "threshold rate." NTSP negotiated to increase the price terms of health plans, orchestrated campaigns targeting health plans' customers, threatened and departicipated from health plan networks, held general membership meetings, corresponded with health plans and its member physicians, and collected signed powers of attorney. (CPF 129-142). RPF 124 is also inaccurate and misleading because there is no link between the setting of NTSP's "threshold" rates and NTSP's "risk panel." RPF 124 implies that NTSP set the "threshold" rates based on

some understanding of what was acceptable to its "risk panel." However, NTSP had no such understanding and did not differentiate the poll responses of its risk panel from its non-risk physicians. (See, Complaint Counsel's reply to RPF 128; CX1194 (Van Wagner, Dep. at 90)). Moreover, NTSP admits in RPF 270 infra, that messengering contracts is "very easy" to do.

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)).

Response to Finding No. 125.:

RPF 125 is incomplete and misleading. NTSP expends considerable resources on contract offers that fall below NTSP's "threshold rate." NTSP negotiated to increase the price terms of health plans, orchestrated campaigns targeting health plan's customers, threatened and departicipated from health plan networks, held general membership meetings, corresponded with helath plans and its member physicians, and collected signed powers of attorney. (CPF 129-142).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 125 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 126.:

RPF 126 is inaccurate and misleading. NTSP does not follow the messenger model (*e.g.* Van Wagner Tr. 1927-1928). The use of the term "messenger model" is misleading because it suggests that NTSP's actions were in compliance with the *Department of Justice and FTC Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (August 28, 1996)* ("*Health Care Statements*"), while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction to the Health Care Statements' messenger model and the antitrust laws they embody. RPF 126 does not identify the alleged costs, does not identify if those costs include other costs associated with it such as NTSP's representation of its members via powers of attorneys, nor does it state whether such costs would include NTSP's second largest line item, legal fees. (CX1195 (Van Wagner, Dep. at 137).

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)).

Response to Finding No. 127.:

RPF 127 is inaccurate and misleading. NTSP's member physicians in Fort Worth who pay the initiation fee gain access to NTSP's fee-for-service contracts. (CX1194 (Van Wagner, Dep. at 17-18; CX0311). The use of the term "messenger model" is misleading because it suggests that NTSP's actions were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction to the Health Care Statements' messenger model

and the antitrust laws they embody. To the extent that NTSP receives no benefit from the non-risk contracts, RPF 127 is an admission that NTSP's only reason to engage in such negotiations is for the benefit of its member physicians.

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).

Response to Finding No. 128.:

RPF 128 is inaccurate and misleading. NTSP does not differentiate between risk and non-risk responders to the polls. (CX1194 (Van Wagner, Dep. at 90)). In fact, the Board has no such requirement. Dr. Grant stated that the Board viewed poll results as valid regardless of response rates (CX1177 (Grant, Dep. at 53-54)), and when asked about response rates, Dr. Deas made no reference to any Board policy regarding such a requirement (CX1173 (Deas, Dep. at 23-24). NTSP polls and then tabulates the results of all NTSP members, not just risk panel members. (CX1195 (Van Wagner, Dep. at 67-68); CX0430). NTSP does not sub-calculate the poll results of the risk-sharing members in setting the Board minimum. (CX1194 (Van Wagner, Dep. At 90); CX0628; CX0432; CX0430). The alleged policy, by aggregating the results of all members, is logically inconsistent with NTSP's alleged purpose of the poll: to guarantee to health plans a critical mass of these risk-taking members (Van Wagner, Tr. 1637-1639). In addition, the alleged policy could not have existed prior to the tabulation of NTSP's first complete HMO/PPO poll results in October, 2001, before which much of NTSP's alleged anticompetitive conduct occurred. (CX0430). Finally, RPF 128 is supported exclusively by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 129.:

RPF 129 is supported by self-serving testimony from a biased witness and documents that by NTSP's own admission are unreliable and prepared for litigation. The cited evidence directly contradicts prior deposition testimony by the witness, Karen Van Wagner and a contemporaneous document. Van Wagner testified in 2002, unambiguously, that NTSP looked only for a 50% response rate from the entire membership, not just the risk panel. (CX1196 (Van Wagner Dep. at 31-32). Over a year later, in 2003, Van Wagner testified without hesitation that NTSP has never made any effort to determine any characteristic of responders to the poll "in any manner." (CX1194 (Van Wagner, Dep. at 89-90)). She was also asked directly whether NTSP had any distinction between the poll response data based on whether the responder could take risk with NTSP, and replied that no distinction is made by NTSP. She further testified, that the Board never even discussed looking at any characteristic of the physicians that responded to the poll. (CX1194 (Van Wagner, Dep. at 89-90)). In fact, a contemporaneous document, containing results presented to the Board for the 2001 poll, contains no breakout of responders for NTSP risk-sharing physicians. (CX0389; CX1194 (Van Wagner, Dep. at 184-185)). Van Wagner further testified that the same documents cited in RPF 129 are unreliable and that she would not trust the data. (CX1195 (Van Wagner, Tr. 103-104). Van Wagner also testified that the document was prepared for litigation and that NTSP had reformatted the fields before disclosing the document to Complaint Counsel. (CX1195 (Van Wagner, Tr. 91-93). Thus the evidence cited in support of RPF 129 is wholly inadequate to reach the conclusions Respondent is asserting.

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)).

Response to Finding No. 130.:

RPF 130 is unsupported and relies upon data that NTSP itself does not deem reliable or trustworthy (CX1195 (Van Wagner, Tr. 103-104). RPF 130 is also vague as to time and fails to limit the application of the procedure described to the time period of after September 2001, and after much of the anticompetitive conduct occurred. (CX1042) (NTSP's minimum unchanged for 4 years prior to 2001); CX1195 (Van Wagner Dep. at 66-67) (Annual Poll first appears in 2001); CX0018 at 103 (absence of PPO poll conducted prior to September 2001)). Therefore, any alleged efficiencies derived from NTSP's polling, could not be used to justify the considerable anticompetitive conduct that occurred prior to this date including use of "Board Minimums" and joint negotiation. (CPF 147-249, 258-287, 297-384).

131. The NTSP poll spans all specialties, and the mean, median, and mode statistics are aggregated across all specialties. (RX 3118 (Maness Report ¶ 56)).

Response to Finding No. 131.:

RPF 131 is misleading. NTSP's anesthesiologists were excluded from the first annual poll, and in turn were excluded from the tabulation of poll results. (CX0274; CX0628). After the 2001 poll results were shared with the members, a separate poll was distributed to NTSP anesthesiologists. (CX0633). NTSP anesthesiologists were also separated in the tabulation of the 2002 poll. (CX0432). In addition, RPF 131 relies solely upon the expert report of Dr. Maness. In formulating his opinion in this matter Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Karen Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further

highlighted by his reluctance to seek independent confirmation even where it was available (CPF 441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' report is entitled to little or no weight and does not support RPF 131. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 131 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 132.:

Complaint Counsel has no specific response.

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)).

Response to Finding No. 133.:

RPF 133 is misleading and incomplete. The information that is provided to NTSP member physicians is keyed to an index, RBRVS, which does communicate relative prices, and which in turn can facilitate price-fixing. An index such as RBRVS, which condenses complex pricing information (CPF 118), can aid in the formation and maintenance of price-fixing agreements (CPF 119). In addition, NTSP's polling, setting of minimum contract prices, and

related dissemination of future pricing information enable member physicians acting through and with NTSP to coordinate pricing. (*See generally* CPF 114-23; further discussion in CRF 136 *infra*). Finally, RPF 133 is supported by the self-serving testimony of Karen Van Wagner, a witness with substantial personal and economic interest in the outcome of this proceeding, and by the expert report of Dr. Maness, who relied exclusively upon Karen Van Wagner for information. (CPF 66, 439-474). Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 133 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 134.:

RPF 134 is incomplete and misleading. In the very same answer from which NTSP frames RPF 134, Dr. Frech states that the sharing of information is a double-edged sword, that, depending on the context, has the ability to help or to harm competition. (Frech, Tr. 1438). NTSP has used information to harm competition by collecting information as a first step to determine a collective price at which its competing physicians would price their services. (Frech, Tr. 1316-1318). NTSP then used this information to establish a minimum price at which its competing physicians would offer their services. (Frech, Tr. 1319-1321).

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).

Response to Finding No. 135.:

RPF 135 is technically accurate, but incomplete, misleading, and irrelevant. Professor Frech noted that the percentage of poll responders falling in any given band (*i.e.*, in any one of the alternative minimum contract price ranges used in the survey instrument) is just "an artifact of how you ask the question." (Frech, Tr. 1386). As Professor Frech explained, "it just depends on how – how broad the bands are that you allow them to vote. If you -- obviously, if you picked -- made it even more narrow, you'd get a smaller percentage. If you asked for a number, you might actually end up with absolutely hardly anybody at the median. It's just it's an artifact of how you ask the question." (Frech, Tr. 1385-1386). Moreover, NTSP has admitted that NTSP sought the poll results based on its representation to its member physicians that it would use the poll results to establish its minimum contract prices and that it would share both the aggregated poll results and the fixed contract minimums with its member physicians (RPF 121, 123, 133, 141), and it is incontrovertible that NTSP did precisely that. (CPF 108, 109, 114-121). NTSP nowhere informed its member physicians as to the percentage of members who were poll responders. (RPF 133). NTSP's actions indicate that it viewed the polled consensus price as highly probative of its member physicians' intentions by repeatedly setting the collective's minimum price at the polled average. (CPF 120, 125-126). The polling and sharing of prospective price information established a consensus price that was adopted by NTSP and that NTSP and its member physicians then used as the basis of concerted negotiation with health plans. (CPF 125-126). Respondent is disingenuous when it argues that its price-fixing consensus price was based on non-robust sampling methodologies.

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)).

Response to Finding No. 136:

RPF 136 is incomplete, misleading, and contrary to the greater weight of the evidence. NTSP's polling, setting of minimum contract prices, and sharing with its member physicians information about polled measures of central tendency (*i.e.*, mean, median, and mode) and the specific fixed minimum contract prices do not allow any one doctor to determine with certainty what any given other doctor has stated in reply to the poll. (Frech, Tr. 1437). However, NTSP's polling, setting of minimum contract prices, and related dissemination of future pricing information enable member physicians acting through and with NTSP to coordinate pricing. (*See generally* CPF 114-23). The coordinated pricing is reflected both in NTSP's negotiations with specific health plans and by the actions of member physicians in support of those negotiations. (*See, e.g.*, CPF 119, 121-22, 124 (including Maness' acknowledgment that reduction of uncertainty among competitors can facilitate collusion); *see also* CPF 125-28 and 147-416 (describing use of minimum contract prices in negotiations by the NTSP collective for and with its member physicians)). Further, these horizontal practices themselves result in higher prices. (CPF 123). Neither the cited Maness testimony nor his report contain probative evidence to the contrary. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 137 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12,

2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 137.:

RPF 137 is completely inaccurate and misleading. The Physician Participation Agreement to which physician members are signatories grants NTSP the right to receive all health plan offers and imposes on them a duty to promptly forward those offers to NTSP. Each member physician then agrees to refrain from pursuing offers from a health plan until NTSP notifies that it is permanently discontinuing negotiations with the health plan. (CPF 97-99). Recognizing that its success in obtaining supra-competitive prices for fee-for-service contracts is dependant on its ability to maintain a united front before health plans (CPF 130), NTSP has adopted various practices that strengthen adherence to its price-fixing scheme and that reduce the ability of health plans to reach agreements with NTSP physicians through other means. Those practices include the solicitation of powers of attorney giving NTSP the unfettered right to negotiate non-risk contracts on behalf of its members. NTSP is able to negotiate for members who did not sign the powers of attorney (CPF 135-138, CX0179). NTSP also cautions its physician members to avoid undermining NTSP solidarity and its pricing consensus (CPF 131, 133). NTSP provides physician members continuous updates about NTSP's progress in its negotiations with health plans in order to coordinate physician contracting behavior (CPF 134). NTSP has also orchestrated letter writing campaigns by its member physicians to employers and others seeking to undermine confidence in the adequacy of health plans' physician networks. (CPF 139). Moreover, RPF 137 is only supported by self-serving testimony from NTSP employees and

officials, including Karen Van Wagner, a witness with personal as well as financial interest in the outcome of these proceeding.

138. NTSP has no power to bind and does not bind any participating physician or physician group to a non-risk contracts. (Frech, Tr. 1363-64; Van Wagner, Tr. 1637, 1777; Deas, Tr. 2605).

Response to Finding No. 138.:

See Complaint Counsel's response to RPF 137.

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)).

Response to Finding No. 139.:

RPF 139 is inaccurate and misleading. First, NTSP's agreements with its physicians do provide for a period of exclusivity during which NTSP member physicians agree to refuse to deal with a health plan directly while the health plan is in negotiations with NTSP and *until* NTSP notifies its physicians "in writing that it [NTSP] is permanently discontinuing negotiations. Only then do NTSP's physicians "have the right" to directly contract with the health plan. (CX0311 at 10; CPF 99). This was confirmed in the testimony of Van Wagner (Van Wagner, Tr. 1857-1858) and a founding and longtime NTSP Board Member, Dr. Hollander. (CX1178) Hollander, Dep. at 9-10, 68) ("And there were various criteria like time limits that the participating physician generally agreed that they would just wait and after that time limit was expired, then they were free to negotiate on their own.")). The second sentence of RPF 139 completely contradicts its own cited support in the Physician Agreement and the cited testimony. Section 2.1 reads with great clarity that, "NTSP shall have the right to receive all Payor offers

made to NTSP or physician, except for any Payor Offer made to Physician which is solely in replacement of a contract which exists between such Payor and ***Physician*** as of the date of March 1, 1998." (CX0311 at 8). Van Wagner recited this provision at trial. (Van Wagner, Tr. 1554-55). The representation in RPF 139 that NTSP can only review offers for which NTSP has an existing contract is unsupportable and erroneous.

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).

Response to Finding No. 140.:

RPF 140 is inaccurate because NTSP's Board established minimums prior to the institution of polling. (CX1042 (Board minimums constant for four years prior to 2001); CX1194 (Van Wagner, Dep. at 86) (at earliest poll started in late 1999); CX1195 (Van Wagner, Dep. at 66-67) (Annual Poll first appears in 2001); CX0018 at 103 (absence of PPO poll conducted prior to September 2001)). Respondent does not and cannot put forth any contemporaneous documents to support RPF 140 as it pertains to the purpose of the minimum. RPF 140 is inaccurate and inconsistent with contemporaneous documents and trial testimony from NTSP that demonstrate that the minimum has not been used to "activate" a network but to disrupt and/or terminate a health plan's network. (Van Wagner Tr. 1728-1729; CX1062; CPF 369; CX0256). NTSP's use of the minimum as a strategy of threatened termination and refusals to deal *premised* on Board minimums is clearly outlined in a contemporaneous writing by NTSP's former president. (CX0256). More importantly, NTSP has misrepresented its minimums to health plans, making price demands well above the *actual* minimums. (CPF 72; CX0795 at 2, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)* {[redacted]

[redacted]}; (CX1042) (stating actual minimum was 140% Tarrant RBRVS); (CX1195 (Van Wagner, Dep. at 110-111) (NTSP's minimums always in Tarrant RBRVS)); (Haddock,Tr. 2743) (Dallas RBRVS is 5% higher than Tarrant RBRVS)). RPF 140 is also irrelevant, as it suggests the reasonableness of the price fixed by Respondent. The reasonableness of the price fixed is no defense to a charge of price-fixing. (*U.S. vs. Trans Missouri Freight Association, 166 U.S. 290 (1897)*). Moreover, neither RPF 140, nor Maness' testimony address the fact that even the setting of monopolistic prices would be consistent with the stated purpose of NTSP's minimum.

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

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)).

Response to Finding No. 141.:

RPF 141 is inaccurate. NTSP informs health plans of the minimums regardless of whether they ask (CX1196 (Van Wagner, Dep. at 62-62; Van Wagner Tr. 1776-1777; Quirk, Tr. 301), and counter-offers the health plan offer with NTSP's minimum price. (CPF 167; 126; CX0311 (NTSP authority to submit counter-offers)). RPF 141 is also misleading because some health plans have been directed by NTSP's physicians to deal with NTSP, thus making meeting NTSP's "threshold rate for NTSP's involvement" the minimum rate for its members' involvement as well. (Beatty, Tr. 452-460; Grizzle, Tr. 697-710; CX0760, admitted as verbal acts). RPF 141 is further inaccurate in that there is no limitation on "NTSP's authorization to act" (CX1170 (Blue, Dep. at 10-11); CX1177 (Grant, Dep. at 12); CX0085 at 3 (Board had discretion over minimums)). NTSP, in fact, did send out contracts below the minimums but only after the health

plan had raised its offer as a result of NTSP's anticompetitive conduct. (CPF 226-227, 250, 254; CX0256; CPF 141). The sole stated basis for the limitation of NTSP authority to send out offers is the poll itself. (CX1196 (Van Wagner, Dep. at 62). The poll states only that NTSP "utilizes these minimums when negotiating managed care contracts on behalf of its participants" with no limitation of authority granted to NTSP. (CX0387 at 1; CX0633). RPF 141 is also solely supported by Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this litigation.

RPF 141 is also vague as to time and is therefore irrelevant as it pertains to NTSP's antitcompetitive conduct prior to September 2001. Importantly, NTSP's Board established minimums prior to the institution of polling for PPO and HMO minimum rates. (CX1042 (Board minimums constant for four years prior to 2001); CX1194 (Van Wagner, Dep. at 86) (at earliest poll started in late 1999); CX1195 (Van Wagner Dep. at 66-67) (Annual Poll first appears in 2001); CX0018 at 103 (absence of PPO poll conducted prior to September 2001)).

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 contracts 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)).

Response to Finding No. 142.:

RPF 142 is inaccurate and misleading. NTSP has, with various health plans, presented counter offers to the proposed rates for non-risk contracts. (CPF 278, 328-329, 179).

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).

Response to Finding No. 143.:

RPF 143 is inaccurate and misleading. The record of this case is replete with direct

evidence of NTSP negotiating on behalf of its member physicians. NTSP has repeatedly solicited and obtained powers of attorney from its members in order to gain the right to negotiate non-risk contracts, including rates, on behalf of those members. (CPF 135). NTSP has negotiated rates on non-risk contracts with United (CPF 167, 179), CIGNA (CPF 278), and Aetna (CPF 320, 328, 329).

144. When NTSP uses the terms "negotiate" or "negotiation" relating to a non-risk contracts, 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).

Response to Finding No. 144.:

RPF 144 is an entirely self-serving, uncredible, and over-broad generalization of over 100,000 pages of documented material. RPF 144's sole supporting witness is biased by her substantial personal and financial interest in this matter, whose testimony has been directly contradicted by two contemporaneous documents (the first of which Van Wagner testified repeatedly was a typographical error) as well as live testimony (CPF 72). There is also a wealth of evidence in the record, documentary and testimonial, that NTSP does in fact negotiate the price terms of contracts. (*see, e.g.,* CPF 125-128). RPF 144 is devoid of context, contemporaneous documented support, or common sense.

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).

Response to Finding No. 145.:

RPF 145 is misleading in its use of the term "messenger" because it suggests that NTSP's acts were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices,

is in direct contradiction to the Health Care Statements' messenger model, and the antitrust laws they embody.

RPF 145 is inaccurate and misleading. NTSP does not follow the messenger model. NTSP, admittedly, does not messenger all non-risk offers from health plans made pursuant to the Health Care Statements (§9(C)). (Van Wagner, Tr. 1825-1828). NTSP repeatedly refused to present health plans' non-risk offers to its member physicians. (CPF 177-181, 327-328, 392-394, 269-270, 321, 325-326, 329-330). RPF 145 is incomplete. The Health Care Statements set parameters for antitrust behavior in health care. NTSP does not pass the Health Care Statements' test for the "key issue in any messenger model arrangement:" whether the arrangement creates or facilitates an agreement among competitors on prices. (Health Care Statements §9(C)). NTSP facilitates such anticompetitive agreement on prices. (CPF 105-128). It sets off triggers of per se illegal price-fixing including collective decision-making (CPF 108, 110, 113, 122, 138), coordination of physician responses, (CPF 108, 110, 113, 120, 121, 131, 132, 133, 135, 139), and collective negotiation (CPF 125-128). (Health Care Statements §9(C)). The Health Care Statements consider the exchange of "future" prices by competing physicians which result in agreement on the prices of health care services, to be unlawful per se. (Health Care Statements §6(B)). NTSP's polls resulted in the exchange of information for "future" prices. (Van Wagner, Tr. 1818; CPF 105-128). Non-exclusive physician network joint ventures fall within the safety zones of the Health Care Statements, but NTSP is not non-exclusive. Its right of first negotiation provision (CPF 99) in its Physician Participation Agreements "restrict the ability or willingness of a network's physicians to join other networks or contract individually with managed care plans" (*see* Health Care Statements §8(A)). Finally, NTSP has extended and broadened its right of first negotiation by collecting powers of attorneys. (CPF 135, 137-138, 146,

161, 222-224, 245, 318, 338-342, 345). NTSP's practices have routinely violated the messenger model.

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).

Response to Finding No. 146.:

RPF 146 is inaccurate and misleading. On numerous occasions, NTSP solicited specific actions with respect to fee levels from health plans (*see e.g.*, CPF 167; CPF 411; CPF 278). With regard to employers, RPF 146 is also inaccurate; NTSP threatened employers and by extension their employees, with network disruption and requested that health plans provide assistance by encouraging health plans to resolve fee disputes in NTSP's favor. (*See e.g.*, CX1041; CPF 139, 204, 216).

147. NTSP has not made any threats to payors relating to rates. (Roberts, Tr. 513-14).

Response to Finding No. 147.:

RPF 147 is inaccurate and misleading. NTSP has threatened to departicipate its physicians from health plans unless the health plans raised their rate offers, a strategy that has been effective on multiple occasions. (CPF 140-141). The evidence cited in RPF 147 is a sole incident in which NTSP did not make threats relating to rates, and does not represent NTSP's actions in other circumstances, not even with the same health plan. Indeed, the evidence demonstrates that in negotiations with CIGNA, NTSP effectively used the threat of contract termination first to ensure the inclusion of a specialist group in a contract agreement, and then to pressure CIGNA {[redacted]}. (CPF 271-272, 278, *in camera, (Order on Non-Party Cigna's Motion for In Camera Treatment, 04.23.04)*). NTSP also used the strategy with Aetna, as stated unambiguously by former NTSP President, Dr. Vance, "NTSP has been successful in negotiating decent rates from Aetna, but only after threatening to term the entire

NTSP network last year." (CX0256, CPF 383).

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)).

Response to Finding No. 148.:

RPF 148 is irrelevant, incomplete and misleading since only one of all of the health plans to whom NTSP directed its price-fixing conduct towards required the use of powers of attorney. United only knew about NTSP's collecting of powers of attorney from its member physicians after receiving copies of NTSP's internal Fax Alerts, CX1051 and 1051A, in which NTSP solicited powers of attorney and later informed its member physicians that it had collected 107 powers of attorney. (CPF 214-225). In fact, NTSP did not offer any explanation of its purpose and use of powers of attorney to United until after United had expressed antitrust concerns of NTSP's actions. (CPF 218, 230, 245). Similarly, CIGNA became aware of NTSP's agency agreements with its physicians after NTSP's member physicians referred CIGNA back to NTSP as their "contracting agent" for all negotiations. (CPF 261-263).

RPF 148 is additionally incomplete and misleading because NTSP did not use the powers of attorney it collected from its member physicians in order to comply with these health plans' requirements but instead, collected and used them to increase its negotiating leverage. (CPF 129-142).

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 contracts. (Quirk, Tr. 419; Jagmin, Tr. 1141-42; Van Wagner, Tr. 1706).

Response to Finding No. 149.:

RPF 149 is wholly inaccurate, incomplete and misleading. The testimony from Quirk to which Respondent cites does not support the contention in RPF 149 because it is Quirk's recollection of NTSP's explanations and not its actual use of these powers of attorney. NTSP's explanations for the broad authority conferred to NTSP were offered to Quirk only after NTSP received a letter from United's attorneys informing them of their serious antitrust concerns. (CPF 218, 230, 245). Similarly, CX1083, to which Respondent cites, does not support RPF 149 since it is Quirk's handwritten notes of NTSP's explanations of these powers of attorney during their meeting, but not an accurate statement of NTSP's actions. Moreover, RPF 149 is supported by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

The evidence shows that contrary to RPF 149, NTSP did, in fact, use the powers of attorney it collected from its member physicians in negotiations with United, CIGNA and Aetna regarding price. (CPF 146, 214-225, 261-264, 342-245).

Furthermore, although RPF 149 suggests that these powers of attorney were non-binding, NTSP communicated the numbers of powers of attorney it collected to its member physicians as incentive for other member physicians to grant NTSP powers of attorney. (CPF 135).

Moreover, the alleged interpretation of the above term "in any lawful manner" constitutes a legal argument and is inappropriate for the proposed findings of fact. Therefore, RPF 149 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 150.:

RPF 150 is unsupported by the evidence cited and is incomplete, misleading, and irrelevant. The evidence cited by Respondent simply indicates that the witnesses are not aware of any physicians having specific knowledge of what any other physician will do. For example, Dr. Deas' testimony is limited to his own stated lack of knowledge of the intentions of others; he was not even asked whether other physicians might have such knowledge. (Deas, Tr. 2423 ("Have you ever known what anybody else, you know, in Tarrant County, how they responded to a poll other than the members of your own corporation?")). Moreover, RPF 150 is irrelevant. No such specific knowledge is required to render NTSP and its member physicians' conduct unlawful. NTSP's polling, setting of minimum contract prices, and sharing with its member physicians information about polled measures of central tendency (*i.e.*, mean, median, and mode) and the specific fixed minimum contract prices enable member physicians acting through and with NTSP to coordinate pricing. (*See generally* CPF 114-23). The coordinated pricing is reflected both in NTSP's negotiations with specific health plans and by the actions of member physicians in support of those negotiations. (*See, e.g.*, CPF 119, 121-22, 124 (including Maness' acknowledgment that reduction of uncertainty among competitors can facilitate collusion); *see also* CPF 125-28 and 147-416 (describing use of minimum contract prices in negotiations by the NTSP collective for and with its member physicians)). Further, these horizontal practices themselves result in higher prices. (CPF 123). Neither the cited Maness testimony nor his report contain probative evidence to the contrary.

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)).

Response to Finding No. 151:

RPF 151 is technically accurate, but incomplete, misleading, and irrelevant. Professor Frech noted that the percentage of poll responders falling in any given band (*i.e.*, in any one of the alternative minimum contract price ranges used in the survey instrument) is just "an artifact of how you ask the question." (Frech, Tr. 1386). As Professor Frech explained, "it just depends on how – how broad the bands are that you allow them to vote. . . . If you asked for a number, you might actually end up with absolutely hardly anybody at the median. It's just it's an artifact of how you ask the question." (Frech, Tr. 1385-1386). Moreover, NTSP has admitted that NTSP sought the poll results based on its representation to its member physicians that it would use the poll results to establish its minimum contract prices and that it would share both the aggregated poll results and the fixed contract minimums with its member physicians (RPF 121, 123, 133, 141), and it is incontrovertible that NTSP did precisely that. (CPF 108, 109, 114-121). NTSP nowhere informed its member physicians as to the percentage of members who were poll responders, never mind the distribution of responders' price-fixing preferences. (RPF 133). NTSP's actions indicate that it viewed the polled consensus price as highly probative of its member physicians' intentions by repeatedly setting the collective's minimum price at the polled average. (CPF 120, 125-126). The polling and sharing of prospective price information established a consensus price that was adopted by NTSP and that NTSP and its member physicians then used as the basis of concerted negotiation with health plans. (CPF 125-126). It

does not avail Respondent to argue that its price-fixing consensus price was based on non-robust sampling methodologies. Further, the evidence cited by Respondent simply indicates that the persons cited are not aware of any physicians' having *specific* knowledge of what any other physician will do. For example, Dr. Deas' testimony is limited to his own stated lack of knowledge of the intentions of others; he was not even asked whether other physicians might have such knowledge. (Deas, Tr. 2423 ("Have you ever known what anybody else, you know, in Tarrant County, how they responded to a poll other than the members of your own corporation?")).

Moreover, RPF 151 is irrelevant. No such specific knowledge is required to render NTSP and its member physicians' conduct unlawful. NTSP's polling, setting of minimum contract prices, and sharing with its member physicians information about polled measures of central tendency (*i.e.*, mean, median, and mode) and the specific fixed minimum contract prices enable member physicians acting through and with NTSP to coordinate pricing. (*See generally* CPF 114-23). The coordinated pricing is reflected both in NTSP's negotiations with specific health plans and by the actions of member physicians in support of those negotiations. (*See, e.g.*, CPF 119, 121-22, 124 (including Maness' acknowledgment that reduction of uncertainty among competitors can facilitate collusion); *see also* CPF 125-28 and 147-416 (describing the use of minimum contract prices in negotiations by the NTSP collective for and with its member physicians)). Further, these horizontal practices themselves result in higher prices. (CPF 123).

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).

Response to Finding No. 152:

RPF 152 is unsupported by the evidence cited and is inaccurate, misleading, and

contrary to the greater weight of evidence. In the Van Wagner testimony cited by Respondent, she simply indicates awareness that at times NTSP member physicians contract with health plans other than through NTSP. (Van Wagner, Tr. 1564). Dr. Deas actually stated that at times he contacts NTSP to inquire about whether a health plan seeking to contract with his practice group also is talking with NTSP, and that at times he puts the proposal down and defers to NTSP. (Deas, Tr. 2404-06 (at 2406: "I may put it down and not read it and just wait and see what happens through NTSP . . .")). In the testimony cited by Respondent, Professor Frech simply states that he has no knowledge of a "doctor-to-doctor agreement not to participate" in a health plan offer, etc. Furthermore, RPF 153 is contrary to the direct testimony: NTSP member physicians have colluded with others and refused to entertain offers tendered directly by health plans. (CPF 137). Moreover, RPF 152 is irrelevant because Complaint Counsel need not establish any such "doctor-to-doctor" agreement. In fact, NTSP member physicians have colluded with others and refused to entertain offers tendered directly by health plans. NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–threats of and actual concerted departicipations from health plan networks–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 153:

RPF 153 is unsupported by the evidence cited and is inaccurate, misleading, and irrelevant. In the testimony cited by Respondent, Professor Frech simply states that he has no

knowledge of a doctor-to-doctor agreement to reject a health plan offer. (Frech, Tr. 1365). Dr. Maness simply states that he found no information that there were doctor-to-doctor agreements. (Maness, Tr. 2048). Moreover, Complaint Counsel need not establish any such "doctor-to-doctor" agreement. In fact, NTSP member physicians have colluded with others and refused to entertain offers tendered directly by health plans. NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–the grant to NTSP of first rights of negotiation and threats of and actual concerted departicipations from health plan networks, for example–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 154:

RPF 154 is unsupported by the evidence cited and is inaccurate, misleading, and irrelevant. In the testimony cited by Respondent, Professor Frech simply states that he has no knowledge of a doctor-to-doctor agreement to reject a health plan offer (see response to RPF 153); he is not asked about nor does he there address the question of any NTSP-physician agreement to reject any health plan offer. (Frech, Tr. 1365-1366). Dr. Maness simply states that he found no information that there were doctor-to-doctor agreements, and that member physicians did not necessarily adhere to their polled preferences. (Maness, Tr. 2048-2049). Nor is the cited Hollander deposition at 147, CX1178, reliable or apposite. Hollander simply asserts that it is the member physicians rather than NTSP that accept or reject health plan offers. The evidence that

NTSP does so, however, is admitted by NTSP and overwhelming. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing numerous NTSP rejections of health plan offers)). Indeed, Respondent's proposed findings are replete with claims as reasons why NTSP has and would refuse contract offers of health plans. (RPF 163-84).

Moreover, NTSP member physicians' nominal freedom of contract is not at issue here; one may be free to undermine a consensus price and yet find it preferable to forego that freedom in favor of rent-sharing. (Frech, Tr. 1326-27). In fact, NTSP member physicians have colluded through and with NTSP and refused to entertain offers tendered directly by health plans as a result of agreements between NTSP and member physicians, including both the NTSP Physician Participation Agreement and numerous powers of attorney. In addition, NTSP and its member physicians threatened to and did terminate dealings with health plans pursuant to those agreements in furtherance of their common pricing objectives. (*See, e.g.,* CPF 159-61, 188, 205-10, 214-215, 219-225, 259-64, 311-313, 319, 328-34; *see generally* CPF 97-142, and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 155:

RPF 155 is false. It is inaccurate, misleading, contrary to the greater weight of evidence, and irrelevant. In the testimony cited by Respondent, Professor Frech simply states that as he understands it NTSP does not have the ability to bind a member physician to a contract with a health plan; he is not asked about nor does he there address the question of whether any NTSP member physician has given up the right, formally or tacitly, to accept or reject a health plan offer. (Frech, Tr. 1363-1364). Dr. Maness simply agrees with Dr. Frech's testimony – Van Wagner's

testimony is to the same effect, (Van Wagner, Tr. 1637) – and adds that he found no information that a doctor had ever honored any provision in the NTSP Physician Participation Agreement that would involve the giving up of the right of independent action. (Maness, Tr. 2047-2048). Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, his conclusion about the Physician Participation Agreement appears to concede the plain meaning of that agreement: that the physicians each grant a right of first negotiation to the collective, NTSP. (*See generally* CPF 97-104). Nor is Hollander, Dep. at 147, apposite or reliable. Hollander simply asserts that it is the member physicians rather than NTSP that accept or reject health plan offers. The evidence that NTSP does so, however, is admitted by NTSP and overwhelming. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing numerous NTSP rejections of health plan offers)). Indeed, Respondent's proposed findings are replete with claims as reasons why NTSP has and would refuse contract offers of health plans. (RPF 163-84). Moreover, NTSP member physicians' nominal freedom of contract is not at issue here; one may be free to undermine a consensus price and yet find it preferable to forego that freedom in favor of rent-sharing. (Frech, Tr. 1326-1327). In fact, NTSP member physicians have colluded through and with NTSP and refused to entertain offers tendered directly by health plans as a result of agreements between NTSP and member physicians, including both the NTSP Physician Participation Agreement and numerous powers of attorney. In addition, NTSP and its member physicians threatened to and did terminate dealings with health plans pursuant to those agreements in furtherance of their common pricing objectives. (*See, e.g.,* CPF 159-61, 188, 205-10, 214-215, 219-225, 259-64, 311-313, 319, 328-34). NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly

based on that consensus, and through a variety of stratagems–threats of and actual concerted departicipations from health plan networks–enhances its collective price bargaining power. *(See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 156:

RPF 156 is false. It is unsupported by the evidence cited and is incomplete, misleading, and against the weight of evidence. In the testimony cited by Respondent, Professor Frech simply states that he has no knowledge of a member physician rejecting an offer based on a power of attorney granted to NTSP. (Frech, Tr. 1365). Dr. Maness similarly stated that he had no such knowledge. (Maness, Tr. 2049). Nor is the McCallum deposition at 48-49, CX1187, reliable or apposite. All McCallum testified to in the cited text was Van Wagner's communication to member physicians stating "NTSP members who have authorized NTSP to act as their agent in regards to Medical Clinic of North Texas should refer all calls from MCNT to the NTSP offices. Because an authorized agency agreement exists, MCNT is legally and ethically bound to initiate all contracts and in regards to proposed contractual agreements through NTSP . . . ." McCallum simply said that he personally had no such understanding and thought Van Wagner wrong. Van Wagner's statement is, however, an admission and an act itself by NTSP asserting its rights under powers of attorney granted to it by its member physicians. In fact, NTSP member physicians have colluded through and with NTSP and refused to entertain offers tendered directly by health plans as a result of agreements between NTSP and member physicians, including both the NTSP Physician Participation Agreement and numerous powers of attorney. In

addition, NTSP and its member physicians threatened to and did terminate dealings with health plans pursuant to those agreements in furtherance of their common pricing objectives. (*See, e.g.*, CPF 159-61, 188, 205-10, 214-215, 219-225, 259-64, 311-313, 319, 328-34). NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–threats of and actual concerted departicipations from health plan networks–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

157. No NTSP participating physician has refused to negotiate with a payor because of NTSP's Physician Participation Agreement. (Frech, Tr. 1368).

Response to Finding No. 157:

RPF 157 is false. It is unsupported by the evidence cited and is incomplete, misleading, and against the greater weight of evidence. In the testimony cited by Respondent, Professor Frech simply states that he has no knowledge of a member physician rejecting an offer based on the Physician Participation Agreement. Respondent has not cited to any member physician or other NTSP witness for this proposition, although it surely would have were it able to do so. More importantly, NTSP repeatedly reminded member physicians even in the absence of explicit powers of attorney to defer to NTSP during the pendency of NTSP-health plan negotiations (and even projected negotiations). (*See e.g.*, CPF 99-100, 131-34, 138, 141, 104). Thereby, NTSP's Physician Participation Agreement facilitated NTSP's fixing and coordination of member physicians' prices.

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).

Response to Finding No. 158:

This RPF is literally identical to RPF 153. For the Court's convenience we reproduce our response here.

RPF 158 is unsupported by the evidence cited and is incomplete, misleading, and irrelevant. In the testimony cited by Respondent, Professor Frech simply states that he has no knowledge of a doctor-to-doctor agreement to reject a health plan offer. (Frech, Tr. 1365). Dr. Maness simply states that he found no information that there were doctor-to-doctor agreements. (Maness, Tr. 2048). More importantly, Complaint Counsel need not establish any such "doctor-to-doctor" agreement. In fact, NTSP member physicians have colluded with others and refused to entertain offers tendered directly by health plans. NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–threats of and actual concerted departicipations from health plan networks–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 159:

RPF 159 is unsupported by the evidence cited and is inaccurate, misleading, and irrelevant. In the testimony cited by Respondent, Maness simply states that he found no indication that member physicians consulted with one another when making decisions "on a messengered contract." (Maness, Tr. 2049-50). Maness appears not to have interviewed NTSP physicians to ask about such matters as whether and with whom they consulted when responding

to NTSP polls or when making decisions about fee-for-service offers. (*See* Maness, Tr. 2123-24). Indeed, the record is devoid of any evidence that Maness spoke at all with member physicians other than a few Board members. Complaint Counsel has no comment on the accuracy of Maness' finding, other than to observe that Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Lonergan simply states that he did not discuss poll responses with other physicians or they with him. (Lonergan, Tr. 2718). Complaint Counsel has not alleged that specific physicians discussed their poll responses with other specific physicians, or that specific physicians consulted with other specific physicians when making decisions "on a messengered contract." NTSP and its member physicians effectuated their price-fixing through the act of polling, sharing of future pricing information to establish a consensus minimum contract price, collective negotiation with health plans based on that minimum contract price, and through a variety of stratagems–including concerted refusals to deal or to continue dealing–to enhance their collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). These acts generally occur prior to NTSP's "messengering" of a contract. The very point is that NTSP conditions its "messengering" on health plans' acceding to the collective's minimum contract price. Moreover, the price-fixing by NTSP and its member physicians is not dependent on direct discussions between or among physicians as to any individual physician's polled preferences. NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–threats of and actual concerted departicipations from health plan networks–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-

292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 160:

Complaint Counsel does not disagree with RPF 160; but RPF 160 is irrelevant. Any NTSP member physician who can in particular circumstances command a higher price for his or her specific services can be expected to do so (albeit after having skewed upward the polled measures of central tendency). (Frech, Tr. 1322-1323). And where circumstances preclude member physicians' achieving the consensus price, they will accept the lower market price. Frech, Tr. 1322-23. This is, in fact, evidence of actual effect of NTSP's price-fixing for and with its member physicians. (CPR 123; *see generally* CPR 114-24).

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)).

Response to Finding No. 161:

RPF 161 is unsupported by reliable evidence and is inaccurate and misleading. Maness merely observes that member physicians' prices at times deviates from their preferences as expressed in NTSP polls. The other testimony cited by Respondent is to like effect, that the respective physicians at times accepted prices other than those suggested by their polling responses. Further, Complaint Counsel has not alleged that NTSP member physicians do not deviate from their polling responses. Any NTSP member physician who can in particular circumstances command a higher price for his or her specific services can be expected to do so (albeit after having skewed upward the polled measures of central tendency). (Frech, Tr. 1322-

1323). And where circumstances preclude member physicians' achieving the consensus price, they will accept the lower market price. (Frech, Tr. 1322-1323). This is, in fact, evidence of actual effect of NTSP's price-fixing for and with its member physicians. (CPR 123; *see generally* CPR 114-124). Indeed, Dr. Deas, on whom Respondent would rely for this finding, has acknowledged that at times he contacts NTSP to inquire about whether a health plan seeking to contract with his practice group also is talking with NTSP, and that at times he puts the proposal down and defers to NTSP. (Deas, Tr. 2404-2406 (at 2406: "I may put it down and not read it and just wait and see what happens through NTSP . . .")).

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)).

Response to Finding No. 162:

Complaint Counsel neither agrees nor disagrees with Respondent's calculation of average (here meaning "mean") number of NTSP contracts in which member physicians participate; but RPF 162 is incomplete and misleading. The absence in Respondent's proposed findings of other information concerning distribution (such as median and mode) and number of lives covered renders this datum essentially meaningless. Further, limited member physician participation in NTSP contracts is consistent with NTSP price-fixing. Any NTSP member physician who can in particular circumstances command a higher price for his or her specific services can be expected to do so (albeit after having skewed upward the polled measures of central tendency). (Frech, Tr. 1322-1323). And where circumstances preclude member physicians' achieving the consensus price, they will accept the lower market price. (Frech, Tr. 1322-1323). This is, in fact, evidence of actual effect of NTSP's price-fixing for and with its

member physicians. (CPR 123; see generally CPR 114-24).

The one area where RPF 162 appears to have some meaning is in casting further discredit on Respondent's "teamwork" efficiency claims, often made through Maness. In fact, if, as RPF 162 states, the average member physician participates in only 7.47 contracts, and, as RX13 indicates, there is great variation in which member physicians participate in any given fee-for-service contract, it is evident that there is not a significant, stable core of participating physicians in which to ground the claimed "teamwork" efficiencies.

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).

Response to Finding No. 163:

RPF 163 is misleading and irrelevant. RPF 163 seeks to obscure the important legal distinction between unilateral and concerted action. Respondent's actions, for and with its physician members are concerted actions. NTSP's concerted refusals to deal or to continue dealings and threats thereof were tactical devices to enhance its collective price bargaining power; they were in furtherance of and resulted in price-fixing. NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–including concerted refusals to deal and threats thereof–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). Furthermore, NTSP presented no contemporaneous evidence that they rejected a contract because they "just did not like" someone. In fact, the evidence demonstrates, and NTSP has admitted, that NTSP has and does

refuse to deal with health plans based on price. (CPF 126; RPF 124).

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)).

Response to Finding No. 164:

Complaint Counsel neither agrees nor disagrees with RPF 164; but RPF 164 is irrelevant. NTSP had little concern about its polls being a reliable indicator of member participation, or participation of a critical core of member physicians. (*See e.g.,* Vance, Tr. 613-16 (showing Vance's lack of relevant knowledge regarding quality/use of polling data in setting of minimum contract prices); CX1178 (Hollander, Dep. at 28-30) (Hollander unaware of polling regarding specific health plan offers; stating that purpose of polling is to find "consensus" regarding contracts member physicians want, but unable to explain what NTSP deems a consensus for those purposes); CX1187 (McCallum, Dep. at 122-29) (showing a string of "don't knows" and "can't remembers" regarding quality/use of polling data in setting of minimum contract prices); *see also* CX0389 (Van Wagner, IH at 90-102; 155-56; 279-280) (NTSP made no effort to understand differences between poll responders and non-responders; no effort to segment analysis of poll responses by kind of physician practice or otherwise; never considered sources of possible biasing of poll results; never looked at how good or bad a predictor polling responses are of responder behavior in fact)). In fact, according to Respondent's own admission in RPF 162 *supra*, many of NTSP member physicians only participate in a few contracts through NTSP. Also, according to RPF 115, *supra,* regarding NTSP member physicians participating in health plan networks through other organizations, NTSP has no way of knowing how many of its member physicians actually participate in a contract. Moreover, RPF 164 is irrelevant because NTSP's concern for efficient use of its resources cannot justify horizontal price-fixing. (*See* CPF

417-429).

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)).

Response to Finding No. 165:

RPF 165 is false. It is incomplete, misleading, unsupported by probative evidence, inconsistent with the greater weight of evidence, and irrelevant. RPF 165 is supported solely by the naked assertions of Maness. It is contradicted by other portions of Maness' testimony. (*See* CPF 442 (Maness testified to need of a common "core" of member physicians, but did not know what he himself meant by "core.")). This underscores the fact that Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). As far as Maness's report is the support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

In fact, NTSP does not "rel[y] upon a 'team' approach to provide high-quality and efficient services" in the context of fee-for-service physicians and physician services. (*See* CPF 417-429). According to Respondent's own admission in RPF 162 *supra*, many of NTSP member physicians only participate in a few contracts through NTSP. Also, according to RPF 115, *supra*, regarding NTSP member physicians participating in health plan networks through other organizations, NTSP has no way of knowing how many of its member physicians actually participate in a contract Moreover, RPF 165 is irrelevant because NTSP's claimed wish to promote teamwork does not justify horizontal price-fixing. (*See* CPF 417-429).

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).

Response to Finding No. 166:

Complaint Counsel neither agrees nor disagrees with RPF 166; but it is irrelevant. NTSP's abstract concerns do not justify price-fixing. Respondent offers no probative evidence indicating that the concerns enumerated by Van Wagner in the cited testimony correspond at all, never mind meaningfully, with NTSP's price-fixing conduct, including its various threatened and actual concerted refusals to deal or to continue dealing with health plans. (*See* Van Wagner, Tr. 1657-1658; *see also* CPF 64-73 (Van Wagner's testimony was not credible and is entitled to little weight)). NTSP's expressed concerns appear largely pretextual. (*See* CPF 157-257, 258-292, and 297-394 (showing price to be true basis of NTSP actions specific health plans)). In fact, NTSP member physicians have colluded through and with NTSP and refused to entertain offers tendered directly by health plans as a result of agreements between NTSP and member physicians, including both the NTSP Physician Participation Agreement and numerous powers of attorney. In addition, NTSP and its member physicians threatened to and did terminate dealings with health plans pursuant to those agreements in furtherance of their common pricing objectives. (*See, e.g.*, CPF 159-161, 188, 205-210, 214-215, 219-225, 259-264, 311-313, 319, 328-334). NTSP, for and with its physicians, fixes prices by reaching and sharing a price consensus, collectively negotiating with health plans based on a minimum contract price explicitly based on that consensus, and through a variety of stratagems–threats of and actual concerted departicipations from health plan networks–enhances its collective price bargaining power. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 167:

RPF 167 is incomplete, misleading, and irrelevant. It is loosely and solely predicated on the testimony of Van Wagner (Van Wagner, Tr. 1647-48), whose testimony is not credible and is entitled to little weight. (CPF 64-73). NTSP's expressed concerns appear largely pretextual. The evidence is clear that NTSP's anticompetitive actions did not result from any wish to avoid contract review costs. (*See generally* CPF 157-257, 258-292, and 297-394 (showing price to be true basis of NTSP actions with specific health plans)). Moreover, RPF 167 is irrelevant because NTSP's claimed wish to avoid contract review costs does not justify horizontal price-fixing: price-fixing is not ancillary to NTSP's avoidance of contract review costs. (*See* CPF 417-429).

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).

Response to Finding No. 168:

Complaint Counsel does not disagree that health plan contracts *can be* long and complicated. The balance of RPF 168 is incomplete and misleading, and the entirety of RPF 168 is irrelevant. Professor Frech, cited by Respondent as a source for RPF 168, in fact does not discuss legal or practical pitfalls IPAs face in contracting with health plans. (Frech, Tr. 1376). Dr. Wilensky simply indicates without more her understanding that NTSP undertakes a review of several contract elements. (Wilensky, Tr. 2160). Lonergan merely refers, without specificity, to potential pitfalls of which he, especially as someone without legal training, would have to be wary. In fact, what RPF 168 calls pitfalls often may more accurately be described as terms of contract that NTSP wishes to negotiate for and on behalf of its member physicians. (CPF 269,

273). Van Wagner does describe a number of elements of contract review that NTSP undertakes (Van Wagner, Tr. 1648-1650). However, Complaint Counsel need not and does not contend that NTSP provides no value to its member physicians. Rather, RPF 168 is irrelevant because NTSP's provision to its member physicians of contract review services does not justify horizontal price-fixing: price-fixing is not ancillary to NTSP's provision of contract review services to its member physicians. (*See* CPF 417-429).

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).

Response to Finding No. 169:

RPF 169 is incomplete, misleading, and irrelevant. Complaint Counsel does not disagree that compensation methodologies can be complex. We are unable to discern what Respondent means by referring to compensation methodologies as "potentially risky." If by that Respondent means in the absence of collective action physicians may take lower prices than they can obtain through collective action, that risk is the desired outcome of competition. (*See* CPF 28-31). If by that Respondent means simply that an inadequately described compensation methodology may yield unpleasant surprises to member physicians, we do not disagree. Nor do we contend that an IPA generally must avoid negotiating for clear and complete description of compensation methodologies, or from alerting member physicians to an unresolved lack of clarity. Doing so does not require the collective negotiation of the substance of the compensation methodology–the prices to be paid. Accordingly, RPF 169 is irrelevant because concern about unclear compensation methodologies cannot justify horizontal price-fixing: horizontal price-fixing is not ancillary to NTSP's ability to clarify or caution member physicians about unclear

compensation methodologies. (*See* CPF 417-429).

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).

Response to Finding No. 170:

RPF 170 is a mix of legal argument/conclusion, recounting of Van Wagner's well-rehearsed but nevertheless naked assertions, and irrelevant sidebars. It is both misleading and irrelevant. The assertion that NTSP may refuse to deal to avoid being a party to an unlawful contract is legal argument/conclusion, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Such conduct simply is not at issue here. Neither the testimony cited by Counsel for Respondent in RPF 170 nor any other evidence of which Complaint Counsel is aware suggest that any of the NTSP conduct here under review was occasioned by or even related to concerns about participation in unlawful contracts. Further, that contention is irrelevant. NTSP and its member physicians' price-fixing was wholly unrelated to the avoidance of unlawful contracts. Respondent has not identified nor is Complaint Counsel aware of any evidence to the contrary. There is, however, overwhelming evidence that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

The list of supposed legal issues in RPF 170 have nothing whatsoever to do with the horizontal price-fixing established by Complaint Counsel. They are a parade of hypothetical concerns–most of which do not relate to lawfulness of contracts at all–for which Van Wagner is the sole support. (Van Wagner, Tr. 1656-1657 (relating to requirements that network physicians comply with health plans' quality and utilization management programs and to evenhandedness of contract termination provisions), 1661-1662 (relating to terms of hold harmless clauses; extent of malpractice coverage), 1667 (relating to the creditworthiness of the health plan or other payor), 1679-80 (relating to avoidance of "gag clauses")). Only three of the listed items appear to relate, however remotely, to issues of contract lawfulness: the avoidance of unlawful sex discrimination (Van Wagner, Tr. 1659-1660); the fraudulent distribution of "discount cards" by fly-by-night networks (Van Wagner, Tr. 1664-1665); and the inclusion in health plan contracts of "all products clauses" (Van Wagner, Tr. 1667-1668). Van Wagner's single example regarding sex discrimination appears to involve a good faith dispute as to application of Texas law to an existing agreement. (Van Wagner, Tr. 1660). Her concern about fraudulent distribution of "discount cards" by fly-by-night networks appears to be purely hypothetical and plainly has no application to the substantial health plans whose representatives have testified in this suit. (*See* Van Wagner, Tr. 1664-1665). And her reference to an "all products clauses" appears to have initially involved solely NTSP's preference, not unlawfulness of the clauses, and a later regulatory action by Texas to limit the use of those clauses. (Van Wagner, Tr. 1667-1668; *see also* CPF 64-73 (Van Wagner's testimony was not credible and is entitled to little weight)).

Not one of these matters is plausibly related to the horizontal price-fixing conduct here established. Insofar as government agencies have involved themselves in any of these issues, it underscores the fact that an NTSP-orchestrated horizontal refusal to deal or to continue dealing

is not necessary to the accomplishment of any public policy objectives. Rather, the entire list of supposed legal concerns contained in RPF 170 is invoked to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of the evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). RPF 170 is irrelevant because NTSP's concern about avoidance of unlawful contract terms cannot justify horizontal price-fixing: NTSP's price-fixing and related conduct was not and is not ancillary to the avoidance of unlawful contract terms.

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).

Response to Finding No. 171:

RPF 171 is a misleading mix of legal argument/conclusion and irrelevancy, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Complaint Counsel expresses no opinion as to the circumstances under which an IPA generally may refuse to deal with a health plan based on honestly held and material quality-of-care concerns. But, neither the testimony cited by Counsel for Respondent in RPF 171 nor any other evidence of which Complaint Counsel is aware suggest that any of the NTSP conduct here under review was occasioned by or even related to concerns about health plan quality of care. (*See* Frech, Tr. 1405-1406; Van Wagner, Tr. 1679-1680; Deas, Tr. 2413-2414). Rather, the articulated concern about health plan quality of care contained in RPF 171 is invoked to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did

achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). RPF 171 is irrelevant because NTSP concern about health plans providing inadequate quality of care cannot justify horizontal price-fixing: NTSP's price-fixing and related conduct was not and is not ancillary to the avoidance of health plans providing inadequate quality of care.

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).

Response to Finding No. 172:

RPF 172 is a misleading mix of legal argument/conclusion and irrelevancy, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Moreover, Complaint Counsel is unable to understand what is meant by the phrase "legally risky to NTSP from a financial, administrative, . . . viewpoint." The Grizzle testimony cited by Counsel for Respondent simply does not support RPF 172. (*See* Grizzle, Tr. 770-771). The Van Wagner testimony indicates little more than that NTSP has financial and administrative terms that it prefers and seeks to negotiate, and that in some instances it has been able to affect state regulation relating to those preferences. (*See* Van Wagner, Tr. 1651, 1676-1679). Not one of the items referred to by Van Wagner is plausibly related to the horizontal price-fixing conduct here established. Insofar as the agencies of government have involved themselves in any of these issues, it underscores the fact that an NTSP-orchestrated horizontal refusal to deal or to continue dealing is not necessary to the accomplishment of any public policy objectives. Rather, RPF 172 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of

evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). RPF 172 is irrelevant because NTSP concern about situations that are "legally risky to NTSP from a financial, administrative, or standard-of-care standpoint" cannot justify horizontal price-fixing: NTSP's price-fixing and related conduct was not and is not ancillary to the avoidance of situations that are "legally risky to NTSP from a financial, administrative, or standard-of-care standpoint."

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)).

Response to Finding No. 173:

RPF 173 is a misleading mix of legal argument/conclusion and irrelevancy, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Further, the evidence cited by Counsel for Respondent in support of RPF 173 simply indicates that sometimes health plans may be or become insolvent and bankrupt. Complaint Counsel does not contend that where an IPA is at honest and material risk of non-payment, as where it is offered capitation by a health plan, it may not refuse to accept that risk. Nor does Complaint Counsel contend that an IPA may not advise its member physicians, whether operating in a risk-sharing or non-risk environment, of the IPA's honestly held and material concerns regarding health plans' and other payors' financial soundness, and individual member physicians (and integrated physician groups) unilaterally may refuse to deal based on that caution. NTSP's horizontal price-fixing and related conduct with respect to

fee-for-service medical services is wholly unnecessary to the effectuation of those ends.

Moreover, neither the evidence cited by NTSP nor other evidence of which Complaint Counsel is aware suggest that concerns about health plan financial soundness motivated NTSP's price-fixing and related conduct established here. Rather, RPF 173 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). RPF 173 is irrelevant because NTSP concern regarding health plans' or other payors' financial soundness cannot justify horizontal price-fixing: NTSP's price-fixing and related conduct was not and is not ancillary to the protection of NTSP or the cautioning of its member physicians about payor financial unsoundness.

174. NTSP may refuse to deal to avoid involvement with health plans 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).

Response to Finding No. 174.:

RPF 174 is a misleading mix of legal argument/conclusion and irrelevancy, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Further, Complaint Counsel does not contend that an IPA *qua* the IPA may not refuse to deal with health plans or other payors that are in breach of or have a history of breaching contract obligations owed the IPA (as opposed to its member physicians). Nor does Complaint Counsel contend that an IPA may not advise its member physicians, whether operating in a risk-sharing or non-risk environment, of accurate and true facts

concerning health plans' and other payors' financial soundness, and individual member physicians (and integrated physician groups) unilaterally may refuse to deal based on that caution. NTSP's horizontal price-fixing and related conduct with respect to fee-for-service medical services is wholly unnecessary to the effectuation of those ends.

Moreover, neither the evidence cited by NTSP nor other evidence of which Complaint Counsel is aware suggest that concerns about health plan financial soundness motivated NTSP's price-fixing and related conduct established here. Rather, RPF 173 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). RPF 174 is irrelevant because NTSP concern regarding health plans' or other payors' financial soundness cannot justify horizontal price-fixing: NTSP's price-fixing and related conduct was not and is not ancillary to the protection of NTSP or the cautioning of its member physicians about payor financial unsoundness.

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).

Response to Finding No. 175:

RPF 175 is a misleading mix of legal argument/conclusion and irrelevancy, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Further, the evidence cited by Counsel for Respondent in support of RPF 175 is a hodgepodge of information relating to: criminal financial misconduct by an MSM officer, *e.g.*, RX1805; Department of Insurance fines imposed on substantially the entire complement of Texas health plans due to their inability to timely comply with then recently adopted regulations, RX3103; governmental inquiries into the effects of "all products clauses," *e.g.*, CX0057; an assurance of voluntary compliance ("AVC") relating to claims that its provider agreements was "approved" by Texas officials, RX1301, and a notice of breach (not a finding resulting from any contested proceeding) of that AVC, RX339; an NTSP Fax Alert disclosing that NTSP had procured the Texas Department of Insurance's ("TDI") interest in the adequacy of the Aetna/MSM provider network (which later was found to satisfy TDI regulatory requirements, Roberts, Tr. 531), CX0586; and even information regarding the Department of Justice's investigation of a health plan merger, RX451. (Please note as well that Van Wagner, Tr. 1673, although not so-identified by Respondent in RPF 175, was not admitted for the truth of the matter asserted. (Van Wagner, Tr. 1673-1674). Similarly, the questions at Van Wagner, Tr. 1772-73, although not so-identified by Respondent in RPF 175, were asked solely in connection with NTSP's "state of mind.")

The remarkable breadth of events cited by Respondent as evidencing deceit and other conduct condemned by government officials is indicative of the insubstantiality of RPF 175. The phrase "deceit and other conduct condemned by government officials," as used by Respondent, is so plastic as to be devoid of meaning. Complaint Counsel does not contend that

where an IPA itself may be at material financial risk, as where it is offered capitation by a health plan, it may not refuse to accept that risk. Nor does Complaint Counsel contend that an IPA may not advise its member physicians, whether operating in a risk-sharing or non-risk environment, of accurate and true facts regarding the "character" of health plans and other payors, and individual member physicians (and integrated physician groups) unilaterally may refuse to deal based on that information. NTSP's horizontal price-fixing and related conduct with respect to fee-for-service medical services is wholly unnecessary to the effectuation of those ends.

Moreover, neither the evidence cited by NTSP nor other evidence of which Complaint Counsel is aware suggest that concerns about the "character" of health plans motivated NTSP's price-fixing and related conduct established here. Rather, RPF 175 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). RPF 175 is irrelevant because NTSP concern regarding the "character" of health plans or other payors cannot justify horizontal price-fixing: NTSP's price-fixing and related conduct was not and is not ancillary to the protection of NTSP from or the cautioning of its member physicians about health plans of ill repute.

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).

Response to Finding No. 176:

Complaint Counsel neither agrees nor disagrees.

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)).

Response to Finding No. 177:

RPF 177 is a legal argument/conclusion, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Further, RPF 177 is wrong. Concerted horizontal actions may not be used to substitute the collective's notion of price equity for the "judgment" of the market operating on supply/demand principles. The evidence cited by Respondent's Counsel does not support RPF 177, rather it indicates that some health plans would prefer to offer prices that vary depending on supply and demand for specific types of physician, and that NTSP prefers otherwise.

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).

Response to Finding No. 178:

RPF 178 is a legal argument/conclusion, is irrelevant, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Complaint Counsel takes no position on whether in general an IPA may refuse to deal except with health plans that provide requested medical management data. Further, RPF 178 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to any NTSP policy to refuse to deal with health plans and other payors that decline to provide NTSP with medical management data. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing

agreements in operation against specific health plans)).

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).

Response to Finding No. 179:

RPF 179 is a legal argument/conclusion that is irrelevant, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Complaint Counsel takes no position on whether in general an IPA may refuse to deal except with health plans that provide clear delegations of medical management functions to it. RPF 179 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to any NTSP policy to refuse to deal with health plans and other payors that decline to delegate medical management functions to NTSP. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 180:

RPF 180 is a legal argument/conclusion, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Further, RPF 180 is wrong. Concerted horizontal actions may not be used to substitute, in whole or in part, the collective's judgments regarding price for the "judgments" of the market

operating on supply/demand principles. The evidence cited by Respondent does not support RPF 180, rather it consists only of Van Wagner's statement that at times some NTSP member physicians have had access to higher prices from the same health plan.

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*).

Response to Finding No. 181:

RPF 181 is a legal argument/conclusion that is irrelevant, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Complaint Counsel takes no position on whether in general an IPA may refuse to deal on a fee-for-service basis with a health plan with which it is seeking a risk contract. The evidence cited by Respondent does not support RPF 181, rather it indicates only that at times negotiations with health plans may involve both risk and non-risk proposals. RPF 181 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to any NTSP policy to refuse to deal with health plans other than on a risk-sharing basis. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

182. NTSP may refuse to deal if a payor is undermining a NTSP risk contract. (Quirk, Tr. 365).

Response to Finding No. 182:

RPF 182 is a legal argument/conclusion that is irrelevant, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order

on Post Trial Briefs. Complaint Counsel takes no position on whether in general an IPA may refuse to deal with a health plan that also competes directly or indirectly with it. (Quirk, Tr. 365). Counsel for Respondent's sole support for RPF 182, is wholly inapposite. RPF 182 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to any such refusal to deal with health plans that also compete with NTSP. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 183:

RPF 183 mixes legal and factual conclusions. Complaint Counsel neither agrees nor disagrees with a legal argument/conclusion that in general an IPA may communicate with others about healthcare issues. Insofar as RPF 183 asserts that "NTSP has the right to . . . ," it is legal argument/conclusion and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. In addition, we must note that Respondent misrepresents Complaint Counsel's stipulation at Tr. 1148-1150. Further, Respondent cites that stipulation for its claims of NTSP "rights," seeking to obscure the important

legal distinction between unilateral and concerted action. The stipulation actually states: "We're not contesting *the right of a physician* to complain or to notify patients about its compensation arrangements . . . ." (emphasis added.) Here, we deal with concerted action. Many of NTSP's communications with others were in furtherance of a price-fixing scheme and should be deemed as such. (*See* CPF 131, 133, 139, 141; *see also* CPF 157-257, 297-394 (showing such communications as part of price-fixing efforts against United and Aetna, respectively)).

184. NTSP may speak out to prevent payor deception or violations of the law. (Van Wagner, Tr. 1462, 1651-53, 1772).

Response to Finding No. 184:

RPF 184 is a legal argument/conclusion, and is inappropriate for findings of fact. Complaint Counsel submits that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. Further, RPF 184 is irrelevant. Complaint Counsel neither agrees nor disagrees with a legal conclusion that in general an IPA may speak out to prevent health plan violations of law. RPF 184 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to any such "speak[ing] out." Rather, RPF 184 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 185.:

RPF 185 is irrelevant because, subsequent to the investigation, NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any investigation of Aetna. (CPF 379-90). Indeed, NTSP initiated the discussions for a non-risk contract with Aetna (*e.g.*, Jagmin, Tr. 1030), and there is no evidence that this merger investigation ever dissuaded NTSP from negotiating or contracting with Aetna. Further, the alleged prior extrinsic acts of a health plan should have no weight. *See* Fed. R. Evid. 608(b). Specifically RPF 185 should be disregarded since the merger discussed is in a different market, and more importantly, the consent agreement is not an admission of liability. Finally, any action by antitrust regulators regarding merger activity by any health plan has no bearing on the price-fixing charges detailed in the Complaint.

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)).

Response to Finding No. 186.:

RPF 186 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by Aetna, nor does RPF 186 justify such conduct. The assertion of a breach constitutes a legal conclusion and is inappropriate for the proposed findings of fact. Therefore, RPF 332 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 187.:

RPF 187 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any of Aetna's conduct regarding MSM. *(E.g.*, CPF 379-390; Deas, Tr. 2589-2590). Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Further, RPF 187 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by Aetna, nor does RPF 187 justify such conduct. (*E.g.*, CPF 379-390; Deas, Tr. 2589-2590).

188. MSM's chief operating officer was convicted of fraud, money laundering, and tax evasion. (RX 1805; RX 3101).

Response to Finding No. 188.:

RPF 188 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 188 justify such conduct.

Moreover, the indictment and the conviction took place after NTSP jointly negotiated prices with Aetna and, by fixing prices, increased the prices paid to its members physicians.

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).

Response to Finding No. 189.:

RPF 189 is irrelevant because, subsequent to the investigation, NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any investigation of Aetna. *(E.g.*, CPF 379-90). Indeed, NTSP initiated the discussions for a non-risk contract with Aetna (*e.g.*, Jagmin, Tr. 1030), and there is no evidence that this investigation ever dissuaded NTSP from negotiating or contracting with Aetna. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Finally, any action

by regulators regarding all-product requirements of health plans has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint.

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).

Response to Finding No. 190.:

RPF 190 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of the AVC or any issue involving the AVC. (CPF 379-390). Moreover, RPF 190 is misleading because NTSP initiated discussions with Aetna, and completed the price negotiations, prior to the issuance of the AVC, thereby further demonstrating that the allegations in RPF 190 did not influence NTSP's behavior regarding the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Finally, RPF 190 is also misleading because it states that RX339 "disciplined" Dr. Jagmin, when in fact, the letter imposes no sanctions on Dr. Jagmin whatsoever so long as Dr. Jagmin remedied an issue regarding AVC compliance. (RX339 at 4-5).

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)).

Response to Finding No. 191.:

RPF 190 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any investigation of Aetna. *(E.g.*, CPF 379-390). Any issue regarding the adequacy of any health plan's network has no

bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint.

Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Finally, any fear by Aetna of network inadequacy arose due to concerns that NTSP could prevent Aetna from contracting NTSP's member physicians. (Jagmin, Tr. 1178).

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).

Response to Finding No. 192.:

Complaint Counsel neither agrees nor disagrees with RPF 192. RPF 192 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to its communications with the Texas Department of Insurance. Rather, RPF 192 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. *(See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 193:

Complaint Counsel neither agrees nor disagrees with RPF 193. RPF 193 is irrelevant because NTSP's price-fixing as established by Complaint Counsel is unrelated to the regulatory or enforcement actions of government organs. Rather, RPF 193 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of the evidence is that NTSP's concerted actions were intended to and did achieve higher

prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 194.:

RPF 194 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any complaints about Aetna's contracting practices. (*E.g.*, CPF 379-390). Any issue regarding Aetna's contracting practices has no bearing on the price-fixing charges detailed in the Complaint. Further, these allegations should be given little or no weight because, during the year 2002, NTSP was trying to pressure Aetna into paying NTSP member physicians supra-competitive rates. (*E.g.*, CPF 408-411).

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)).

Response to Finding No. 195.:

Complaint Counsel does not disagree with RPF 195. RPF 195 is, however, irrelevant because NTSP's price-fixing was not and is not ancillary to any such providing information about the meaning of contract terms or background on the contracting process.

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)).

Response to Finding No. 196.:

Complaint Counsel does not disagree with RPF 196. RPF 196 is, however,

irrelevant because NTSP's price-fixing was not and is not ancillary to providing member physicians with information about whether NTSP is exploring a health plan offer, or whether member physicians need to do anything to avail or exclude themselves from participation in that arrangement. Rather, RPF 196 is intended to camouflage recent, and provide cover for future, horizontal price-fixing. The overwhelming weight of the evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 197.:

RPF 197 is false and irrelevant. Professor Frech stated that "NTSP's actions reduces competition and likely increases prices and/or reduces output in the market for medical services, physician services in the Fort Worth area of Tarrant County." (Frech, Tr. 1280-81; *See also* Frech, Tr. 1452-53; *See also* Maness, Tr. 2217 (acknowledging that Frech posited a Fort Worth geographic market)). RPF 197 is irrelevant because defining the specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established.

198. Complaint Counsel's expert, Dr. Frech, has not calculated any concentration ratios or performed any concentration analysis. (Frech, Tr. 1394).

Response to Finding No. 198:

RPF 198 is incomplete, misleading, and irrelevant. Professor Frech did not compute HHIs or four or eight firm concentration ratios. He did, however, take account of concentration in his analysis. (*See e.g.*, Frech, Tr. 1298-1302 (discussion of concentration of NTSP physicians as percentage of Tarrant County physicians in similar areas of specialization); Frech, Tr. 1303-1305 (discussion of concentration of NTSP physicians as percentage of admitters to critical Fort Worth hospitals)). Moreover, RPF 198 is irrelevant because the calculation of concentration ratios and related analysis is not necessary where, as here, the *per se* rule is applicable, or where, again as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

199. Complaint Counsel's expert, Dr. Frech, has not performed any entry analysis. (Frech, Tr. 1394).

Response to Finding No. 199:

RPF 199 is incomplete, misleading, and irrelevant. Professor Frech did not explicitly analyze entry conditions, but he implicitly found that entry had not defeated collusive price increases. (Frech, Tr. 1280-1281 ("NTSP's actions reduces [sic] competition and likely increases prices and/or reduces output in the market for medical services, physician services in the Fort Worth area of Tarrant County.")). RPF 199 is irrelevant because assessing conditions of entry is not necessary: (1) where, as here, the per se rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

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)).

Response to Finding No. 200.:

Complaint Counsel neither agrees nor disagrees with RPF 200, but it is irrelevant. The overwhelming weight of the evidence is that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 201.:

RPF 201 is incomplete and misleading. Respondent rests its assertion that patient switching from one to another geographic area would be easy solely on Maness. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

The overwhelming weight of evidence is that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90).

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)).

Response to Finding No. 202.:

RPF 202 is incomplete and misleading. The overwhelming weight of evidence is that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90).

Maness' purported expert analysis, cited in RPF 202, was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint

Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 202 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 203.:

RPF 203 is incomplete and misleading. The overwhelming weight of evidence is that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 203 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 204.:

RPF 204 is false. Professor Frech did not testify that the Mid Cities unites Fort

Worth and Dallas in a single market. While acknowledging that any large intermediate population will "tend in [the] direction" of tying the larger area together, Professor Frech made clear that given the facts as he found them, and as testified to by the health plan witnesses, in fact the Mid Cities did not mediate a single Fort Worth-Mid Cities-Dallas market. (Frech, Tr. 1452; *see also* Frech, Tr. 1280-81 (NTSP's actions reduce competition and likely increase prices and/or reduce output in the Fort Worth area)).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

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)).

Response to Finding No. 205.:

RPF 205 is incomplete and misleading. The Aetna-Prudential matter was a settlement of a challenge to a merger of two insurers. The product markets involved were health plan products and the purchase, not, as here, the sale, of physician services. In addition, the settlement in no way stands for the proposition that there were not smaller included markets (or submarkets depending on nomenclature). We ask your Honor to take judicial notice of these facts, and to that end have attached the Revised Competitive Impact Statement filed with the Court in that matter. Further, the overwhelming weight of evidence is that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90).

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)

Response to Finding No. 206.:

Complaint Counsel neither agrees nor disagrees with RPF 206; but it is irrelevant. The overwhelming weight of evidence is that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90).

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)).

Response to Finding No. 207.:

RPF 207 is wrong and misleading. It is misleading to the extent that it implies that Complaint Counsel must establish the specific metes and bounds of a market in this suit. That is incorrect. Defining the specific metes and bounds of markets is not necessary where, as here, the *per se* rule is applicable, or where, again as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)). Moreover, the overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-90). Further, Maness did not actually use the DOJ/FTC Merger Guidelines, as represented by Maness and Respondent's Counsel. (Maness, Tr. 2224-27; *See also* CPF 81-90, 444). Finally, Maness purported expert analysis–the only support for this RPF–was wholly lacking in analytical rigor, biased, unreliable,

and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 207 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 208.:

RPF 208 is wrong and misleading. It is misleading to the extent that it implies that Complaint Counsel must establish the specific metes and bounds of a market in this suit. That is incorrect. Defining the specific metes and bounds of markets is not necessary where, as here, the *per se* rule is applicable, or where, again as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)). Moreover, the overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth specialists to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See* generally CPF 81-90). Maness' purported expert analysis–the sole support to this RPF–was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 208 is solely supported by Maness' report, we submit that part of this

finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 209.:

RPF 209 is incomplete, misleading, and irrelevant. Far and away the majority of NTSP physicians of all kinds are in the Fort Worth area. (*See* CPF 91-96). Moreover, RPF 209 is irrelevant because the question before this Court is "is there any area in which NTSP's anticompetitive concerted actions have caused harm." Even were NTSP's member physicians located throughout Texas, that would not be probative of NTSP's ability to cause competitive harm in any given smaller region. Abundant evidence establishes that NTSP can cause, and has caused, such harm in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 97-142, 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 210.:

RPF 210 is incomplete, misleading, and irrelevant. Far and away the majority of NTSP physicians of all kinds are in the Fort Worth area. (*See* CPF 91-96). Moreover, RPF 210 is irrelevant because the question before this Court is "is there any area in which NTSP's anticompetitive concerted actions have caused harm." Even were NTSP's member physicians located throughout Texas, that would not be probative of NTSP's ability to cause competitive harm in any given smaller region. Abundant evidence establishes that NTSP can cause, and has caused, such harm in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 97-142 and 157-257,

258-292, and 297-394 (showing agreements in operation against specific health plans)).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

211. Physicians in any county in and around the Metroplex are eligible to join NTSP if invited by the Board. (Van Wagner, Tr. 1472).

Response to Finding No. 211.:

RPF 211 is incomplete, misleading, and irrelevant. Far and away the majority of NTSP physicians of all kinds are in the Fort Worth area. (*See* CPF 91-96). Moreover, RPF 211 is irrelevant because the question before this Court is "is there any area in which NTSP's anticompetitive concerted actions have caused harm." Even were NTSP's member physicians located throughout Texas, that would not be probative of NTSP's ability to cause competitive harm in any given smaller region. Abundant evidence establishes that NTSP can cause, and has caused, such harm in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 97-142 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 212.:

RPF 212 is irrelevant because the question before this Court is "is there any area in

which NTSP's anticompetitive concerted actions have caused harm." Even were a non-trivial number of member physicians' patients drawn from throughout Texas, that would not be probative of NTSP's ability to cause competitive harm in any given smaller region. Abundant evidence establishes that NTSP can cause, and has caused, such harm in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 97-142 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 213.:

RPF 213 is misleading and irrelevant. The cited support from Van Wagner refers only to offices outside of downtown Fort Worth, and the other cited testimony refers only to a single practice group. Van Wagner states that NTSP member physicians maintain offices in both "downtown Fort Worth" and "surrounding areas". (Van Wagner, Tr. 1470). Even if many NTSP member physicians had multiple offices located throughout Texas, that would not be probative of NTSP's ability to cause competitive harm in any given smaller region. Abundant evidence establishes that NTSP can cause, and has caused, such harm in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 214.:

RPF 214 is incomplete, misleading, and irrelevant. Health plan witness testimony,

among other things, firmly establishes that patients and their proxies (employers, for example) will not switch from Fort Worth specialists to specialists located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 214 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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 is 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)).

Response to Finding No. 215.:

RPF 215 is false. Counsel for Respondent's argument using U.S. News and World Report's list of Best Hospitals, is logically fallacious. It no more argues for the inclusion of Dallas in a relevant market with Fort Worth than would the inclusion on the list of Houston, or for that matter Washington, D.C.

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's

citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 215 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 216.:

RPF 216 is incomplete and misleading. The tendency acknowledged by Frech is limited by Frech's immediately subsequent observation that the research literature indicates that hospitals have narrow, not multi-county, primary draw areas. (Frech, Tr. 1430). The overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See generally* CPF 81-96).

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)).

Response to Finding No. 217.:

RPF 217 is incomplete, misleading, and irrelevant. The Dartmouth Atlas of Health Care was not intended to define antitrust markets. The Atlas looks only at a few highly advanced procedures in cardiology and neurosurgery to define *hospital* service areas and referral regions, neither of which is at issue here (Maness, Tr. 2131), and there is no record evidence that hospital service areas and referral regions and physician services markets are coextensive or nearly so.

Moreover, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Thus, as far as any part of RPF 217 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 218.:

Complaint Counsel does not disagree, but RPF 218 is irrelevant. The Dartmouth Atlas of Health Care was not intended to and does not define antitrust markets. The Atlas looks only at a few highly advanced procedures in cardiology and neurosurgery to define *hospital* service areas and referral regions, neither of which is at issue here (Maness, Tr. 2131), and there is no record evidence that hospital service areas and referral regions and physician services markets are coextensive or nearly so.

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 219.:

Complaint Counsel does not disagree, but RPF 219 is irrelevant. The Dartmouth Atlas of Health Care was not intended to and does not define antitrust markets. The Atlas looks only at a few highly advanced procedures in cardiology and neurosurgery to define *hospital* service areas and referral regions ("HRRs"), neither of which is at issue here (Maness, Tr. 2131), and there is no record evidence that hospital service areas and referral regions and physician services markets are coextensive or nearly so.

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 220.:

RPF 220 is incomplete, misleading, and irrelevant. The Dartmouth Atlas of Health Care was not intended to and does not define antitrust markets. The Atlas looks only at a few highly advanced procedures in cardiology and neurosurgery to define *hospital* service areas and referral regions ("HRRs"), neither of which is at issue here (Maness, Tr. 2131), and there is no record evidence that hospital service areas and referral regions and physician services markets are

coextensive or nearly so.

Moreover, Counsel for Respondent and Maness' use of "and/or" in the statement that patients from each [hospital service area as defined by the Atlas based on a few highly advanced procedures in cardiology and neurosurgery] specifically receive care from providers in either Dallas *and/or* Tarrant County," conveys no useful information and is meaningless, much as it would be meaningless to state that "all patients from Tarrant County and Houston, or even Washington, D.C., hospitals receive care in either Houston, or Washington, *and/or* Tarrant County." Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Thus, as far as any part of RPF 220 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 221.:

Complaint Counsel does not disagree, but RPF 221 is irrelevant. This case is not about hospital markets (Maness, Tr. 2131), and there is no record evidence that hospital markets

and physician services markets are coextensive or nearly so.

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, 1488-1489).

Response to Finding No. 222.:

Complaint Counsel neither agrees nor disagrees, but RPF 222 is irrelevant. This case is not about hospital markets (Maness, Tr. 2131), and there is no record evidence that hospital markets and physician services markets are coextensive or nearly so.

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).

Response to Finding No. 223.:

Complaint Counsel does not disagree, but RPF 223 is irrelevant. Fort Worth employers' need for an substantial cadre of Fort Worth area physicians results from their location and that of large numbers of their employees in Fort Worth. (CPF 81-90). Logically, the fact that some Fort Worth employees and their dependents live outside of Fort Worth may mean that health plans serving them may need substantial physician panels outside of Fort Worth, but it does not mean that the need for substantial Fort Worth physician panels to serve Fort Worth employers, employees, and dependents is reduced. The overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 224.:

Complaint Counsel does not disagree, but RPF 224 is irrelevant. Fort Worth employers' need for a substantial cadre of Fort Worth area physicians results from their location and that of large numbers of their employees in Fort Worth. (CPF 81-90). Logically, the fact that some Fort Worth employees and their dependents live outside of Fort Worth may mean that health plans serving them may need substantial physician panels outside of Fort Worth, but it does not mean that the need for substantial Fort Worth physician panels to serve Fort Worth employers, employees, and dependents is reduced. The overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 225.:

Complaint Counsel does not disagree, but RPF 225 is irrelevant. Fort Worth employers' need for a substantial cadre of Fort Worth area physicians results from their location and that of large numbers of their employees in Fort Worth. (CPF 81-90). Logically, the fact that some Fort Worth employees and their dependents live outside of Fort Worth may mean that health plans serving them may need substantial physician panels outside of Fort Worth, but it does not mean that the need for substantial Fort Worth physician panels to serve Fort Worth employers,

employees, and dependents is reduced. The overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area. (*See* CPF 81-96; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 226.:

Insofar as RPF 226 seeks to equate a health plan's administrative service area with an antitrust relevant geographic market, RPF 226 is wrong. Health plan representatives testified that the metroplex or some other area larger that Fort Worth was used by the health plan for administrative purposes (*see e.g.*, (Quirk Tr. 235-236), but expressly denied substitutability of physicians throughout that area. (*See* CPF 81-96; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans). The very fact that Respondent's Counsel relies solely on Maness for RPF 226, despite the fact that representatives of several health plans took the stand in this suit, is remarkable. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Thus, as far as any part of RPF 226 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 227.:

RPF 227 is incomplete, misleading, and irrelevant. RPF 227 refers to cross-county use of a single index, the Dallas RBRVS. However, any index, including the Dallas RBRVS, can be used to yield various numbers by modifying the percentage multiplier applied to the index. Assuming RPF 227 to be true, the use by some health plans of the Dallas RBRVS index for all of their North Texas physicians does not imply that those physicians receive the same prices. For example, a health plan might pay Dallas County physicians 135% of Dallas RBRVS while paying Tarrant County physicians 125% of RBRVS. Counsel for Respondent makes no claim in RPF 227 that the same index *and* multiplier often are used across Dallas and Tarrant Counties.

228. United HealthCare's service area for North Texas is the Metroplex. (Quirk, Tr. 236-37).

Response to Finding No. 228.:

Insofar as RPF 228 seeks to equate a United HealthCare's administrative service area with an antitrust relevant geographic market, RPF 228 is wrong. Quirk testified that the metroplex or some other area larger that Fort Worth was used by the health plan for administrative purposes (*see e.g.,* Quirk Tr. 235-36), but expressly denied substitutability of physicians throughout that area. (*See* Quirk, Tr. 276-77, 280-82; *see also* CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 229.:

Insofar as RPF 229 seeks to equate a United HealthCare's administrative service area with an antitrust relevant geographic market, RPF 229 is wrong. Roberts testified that

Aetna's service area for North Texas stretched all the way to the Louisiana border, Roberts, Tr. 459, surely not a description of an antitrust market for physician services. And his colleague Dr. Jagmin expressly denied substitutability of physicians throughout the metroplex. (*See* Jagmin, Tr. 1103-1107; *see also* CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

230. Cigna's service area covers the Metroplex and includes 12-14 counties. (Grizzle, Tr. 759).

Response to Finding No. 230.:

Insofar as RPF 230 seeks to equate CIGNA's administrative service area with an antitrust relevant geographic market, RPF 230 is wrong. In fact, {[redacted]} (*See* Grizzle, Tr. 917-918, *in camera (see Grizzle, Tr. 752-754)*; *see also* CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

231. PacifiCare considers Dallas and Tarrant Counties as one market. (Lovelady, Tr. 2623).

Response to Finding No. 231.:

Insofar as RPF 231 seeks to equate PacifiCare's administrative service area with an antitrust relevant geographic market, RPF 231 is wrong. In fact, Lovelady specifically indicated that NTSP member physicians "are essential" for PacifiCare to be able to market its products in Fort Worth and that even a plan with Arlington (suburban Tarrant County) physicians could not be substituted for its Fort Worth physician panel, except at a discounted price. (Lovelady, Tr. 2679; *see also* Lovelady, Tr. 2680; CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 232.:

Insofar as RPF 232 seeks to equate PacifiCare's administrative service area with an antitrust relevant geographic market, RPF 232 is wrong. In fact, Lovelady specifically indicated that NTSP member physicians "are essential" for PacifiCare to be able to market its products in Fort Worth and that even a plan with Arlington (suburban Tarrant County) physicians could not be substituted for its Fort Worth physician panel, except at a discounted price. (Lovelady, Tr. 2679; *see also* Lovelady, Tr. 2680; CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 233.:

Insofar as RPF 233 seeks to equate Texas Department of Insurance ("TDI") health plan adequacy regulations with antitrust relevant geographic markets, RPF 233 is wrong. TDI regulations are intended to prevent inadequacy of medical care, not to respond to consumer preferences. (*See, e.g.*, Quirk, Tr. 274-275; Roberts, Tr. 531-535; Maness, Tr. 2221-2222). Health plan products that merely met TDI standards would not be marketable products because consumers demand extensive localized physician participation in networks. (*See, e.g.*, Quirk, Tr. 274-275; Grizzle, Tr. 917-918 *in camera (see Grizzle, Tr. 752-754)*, Jagmin, Tr. 1103-1107, and Lovelady, Tr. 2679; *see also* CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 220 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 234.:

Insofar as RPF 234 seeks to equate federal health plan adequacy regulations with antitrust relevant geographic markets because federal regulation is similar to Texas Department of Insurance ("TDI") health plan adequacy regulations, RPF 234 is wrong. TDI regulations are intended to prevent inadequacy of medical care, not to respond to consumer preferences. (*See, e.g.,* Quirk, Tr. 274-275; Roberts, Tr. 531-535; Maness, Tr. 2221-2222). Health plan products that merely met TDI standards would not be marketable products because consumers demand extensive localized physician participation in networks. (*See, e.g.*, Quirk, Tr. 274-275; Grizzle, Tr. 917-918, *in camera (see Grizzle, Tr. 752-754)*; Jagmin, Tr. 1103-1107; Lovelady, Tr. 2679; *see also* CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans).

235. Payors consider federal and state regulations when establishing networks. (Lovelady, Tr. 2628-2630).

Response to Finding No. 235.:

Insofar as RPF 235 seeks to equate federal and Texas Department of Insurance

health plan adequacy regulations with antitrust relevant geographic markets, RPF 235 is wrong. Such regulations are intended to prevent inadequacy of medical care, not to respond to consumer preferences. (*See, e.g.*, Quirk, Tr. 274-275; Roberts, Tr. 531-535; Maness, Tr. 2221-2222). Health plan products that merely met such standards would not be marketable products because consumers demand extensive localized physician participation in networks. (*See, e.g.*, Quirk, Tr. 274-275; Grizzle, Tr. 917-918 *in camera (see Grizzle, Tr. 752-754)*; Jagmin, Tr. 1103-1107; Lovelady, Tr. 2679; *see also* CPF 81-96 and 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans).

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).

Response to Finding No. 236.:

RPF 236 is unsupported, incomplete, and misleading. Counsel for Respondent's evidentiary citation for RPF 236 refers only to Professor Frech's statement that *he* did not do a detailed market analysis and explicitly posit relevant markets, as such. (Frech, Tr. 1393-1394, 1424-1425). Respondent's Counsel offers no support for the statement that *Complaint Counsel* has not posited relevant markets. Given that, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Further, RPF 236 appears intended to suggest that Complaint Counsel was obliged to detail the metes and bounds of relevant markets here. That is wrong. Defining the specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have

been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

Moreover, the overwhelming weight of evidence establishes that patients and their proxies (employers, for example) will not switch from Fort Worth physicians to physicians located elsewhere in sufficient numbers to defeat a small but significant non-transitory price increase in the Fort Worth area whether physicians are taken as a class or as practitioners in primary care and in each separate area of certified specialization are separately considered. (*See, e.g.*, Quirk, Tr. 279-282). Accordingly, this Court has ample evidence to find relevant product markets consisting, for example, of all physicians or of practitioners of primary care and in each separate area of certified specialization. (*See generally* CPF 81-90; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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)).

Response to Finding No. 237.:

RPF 237 is incomplete and misleading. Many NTSP physicians were and are, except to the extent that competition has been impaired by NTSP, in competition with one another.

CX0524 indicates, for example, a NTSP member physician roster as of January 18, 2001, indicates that NTSP member physicians on that date comprised of at least four anesthesia practices, at least three cardio-vascular disease practices, at least four cardio-thoracic surgical practices, at least seven dermatology practices, at least four endocrinology practices, at least a dozen ENT practices, at least two gastroenterology practices, at least three infectious disease practices, more than a dozen general surgery practices, at least four general vascular surgery

practices, at least three hematology/oncology practices, at least three nephrology practices, at least six neurology practices, more than a dozen opthalmology practices, more than a dozen orthopedics practices, at least nine plastic surgery practices, at least five pulmonology practices, and numerous primary care practitioners, among other competing practices. (*See also* Frech, Tr. 1301-1302).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 238 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 238.:

Complaint Counsel does not disagree with the particular and sole example contained in RPF 238.

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)).

Response to Finding No. 239.:

Complaint Counsel agrees with RPF 239.

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).

Response to Finding No. 240.:

RPF 240 is incomplete and misleading. CPT code overlaps do not establish that the practitioners reporting those codes are in the same product market. In fact, in his report at paragraph 20, Maness states: "It is likely that [the] relevant product markets in this case [are] delineated roughly by the individual areas of medicine that NTSP doctors practice." (RX3118; *see also* Frech, Tr. 1425). Maness notes that various authorities have concluded that: primary care practitioners and specialists are not in the same market; gastroenterologists constitute a market; and that physician market are defined by specialties. (RX3118 (see paragraphs 19-20 and accompanying notes)). The only exceptions Maness posits are family practitioners, internists, OB/GYNs, pediatricians, and ENTs, all of which he concludes may be in a single product market. (RX3118 (see paragraphs 19-20 and accompanying notes)). Were that true, it would not affect the result here at all. As RPF 239 indicates, health plans must include a broad range of specialties in a network if they are to have marketable products. (*See also* Quirk, Tr. 279-282).

Moreover, RPF 240 appears intended to suggest that Complaint Counsel was obliged to detail the metes and bounds of relevant markets here. That is wrong. Defining the specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

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).

Response to Finding No. 241.:

RPF 241 is incomplete and misleading. Some medical care performed by ENTs can be provided by family practitioners or pediatricians. That fact does not indicate whether the substitutability of family practitioners and pediatricians is such that substitution from one to the other would defeat a small but significant non-transitory price increase.

Moreover, RPF 241 appears intended to suggest that Complaint Counsel was obliged to detail the metes and bounds of relevant markets here. That is wrong. Defining the specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 241 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 242.:

RPF 242 is incomplete and misleading. Some medical care performed by OB/GYNs, pediatricians, pulmonologists, cardiologists, and others can be performed by primary

care practioners. That fact does not suggest that the substitutability of primary care practitioners and each or all of these specialties is such that substitution from one to others would defeat a small but significant non-transitory price increase. In fact, the notion that substitutability would yield a market including pulmonologists and cardiologists with primary care practitioners is largely debunked by Maness himself. In his report at paragraph 20, Maness states: "It is likely that [the] relevant product markets in this case [are] delineated roughly by the individual areas of medicine that NTSP doctors practice." (RX3118). Maness notes that various authorities have concluded that: primary care practitioners and specialists are not in the same market; gastroenterologists constitute a market; and that physician markets are defined by specialties. (RX3118 (see paragraphs 19-20 and accompanying notes)). The principal exceptions Maness posits are family practitioners, internists, OB/GYNs, pediatricians, and ENTs, all of which he concludes may be in a single product market (RX3118 (see paragraphs 19-20 and accompanying notes)).

Were it true that OB/GYNs, pediatricians, pulmonologists, cardiologists, and even others were in a single relevant market with primary care practitioners, it would not affect the result here at all. As RPF 239 indicates, health plans must include a broad range of specialties in a network if they are to have marketable products. (*See also* Quirk, Tr. 279-282).

Moreover, RPF 242 appears intended to suggest that Complaint Counsel was obliged to detail the metes and bounds of relevant markets here. That is wrong. Defining the specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating

actual price effects resulting from price-fixing against specific health plans)).

243. Some medical procedures performed by gastroenterologists can be performed by PCPs or colorectal surgeons. (Deas, Tr. 2396; Lonergan, Tr. 2701).

Response to Finding No. 243.:

RPF 243 is incomplete and misleading. Some medical care performed by gastroenterologists can be performed by colo-rectal surgeons or primary care practioners. That fact does not suggest that the substitutability of family practitioners and each or all of these specialties is such that substitution from one to others would defeat a small but significant non-transitory price increase. In fact, the notion that substitutability would yield a market including gastroenterologists, colo-rectal surgeons, and primary care practitioners is largely debunked by Maness himself. In his report at paragraph 20, Maness states: "It is likely that [the] relevant product markets in this case [are] delineated roughly by the individual areas of medicine that NTSP doctors practice." (RX3118). Maness notes that various authorities have concluded that: primary care practitioners and specialists are not in the same market; gastroenterologists constitute a market; and that physician market are defined by specialties. (RX3118 (see paragraphs 19-20 and accompanying notes)). The only principal exceptions Maness posits are family practitioners, internists, OB/GYNs, pediatricians, and ENTs, all of which he concludes may be in a single product market. (RX3118 (see paragraphs 19-20 and accompanying notes)).

Were it true that gastrolenterologists, colo-rectal surgeons, and primary care practitioners were in a single product market, it would not affect the result here at all. As RPF 239 indicates, health plans must include a broad range of specialties in a network if they are to have marketable products. (*See also* Quirk, Tr. 279-282).

Moreover, RPF 243 appears intended to suggest that Complaint Counsel was obliged to detail the metes and bounds of relevant markets here. That is wrong. Defining the

specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

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)).

Response to Finding No. 244.:

RPF 244 is incomplete and misleading. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 244 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Moreover, RPF 244 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual

price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

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)).

Response to Finding No. 245.:

RPF 245 is incomplete, misleading, and irrelevant. Both NTSP's shares of specialists and shares of primary care physicians and specialists within Fort Worth would be significantly greater than the Tarrant County shares presented by Respondent's Counsel. (*See* Frech, Tr. 1297-1301).

Moreover, RPF 245 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

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).

Response to Finding No. 246.:

RPF 246 is incomplete, misleading, and irrelevant. NTSP's shares of health plan physician networks within Fort Worth would be significantly greater than the Tarrant County shares presented by Respondent's Counsel. (*See* Frech, Tr. 1297-1301).

Moreover, RPF 246 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

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).

Response to Finding No. 247.:

RPF 247 is incomplete, misleading, and irrelevant. NTSP's share of health plan physician networks within Fort Worth would be significantly greater than the Tarrant County share presented by Respondent's Counsel. (*See* Frech, Tr. 1297-1301).

Moreover, RPF 247 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

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)).

Response to Finding No. 248.:

RPF 248 is incomplete, misleading, and irrelevant. NTSP's shares of physicians practicing in several specialties within Tarrant County exceed 30%. Frech, Tr. 1299 (*e.g.*, pulmonologists, 80%; urologists, 68.6%; cardiovascular disease specialists, 58.8%) . NTSP's shares within the Fort Worth area would have been more meaningful and higher still. (Frech, Tr. 1300-1301).

Moreover, RPF 248 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual

price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 248 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 249.:

RPF 249 is incomplete, misleading, and irrelevant. NTSP's shares of physicians practicing in several specialties within Tarrant County exceed 30%. Frech, Tr. 1299. NTSP's share of Tarrant County: pulmonologists is 80%; urologists, 68.6%; cardiovascular disease specialists, 58.8%). (Frech, Tr. 1299). In addition, NTSP's shares of nephrologists, hematologists/oncologists, colo-rectal surgeons, and endocrinologists all equal or exceed 50%. (Maness, Tr. 2020-2021; RX3127 (calculation of percentages); and RX306 (Texas Board of Medical Examiners data for Tarrant County)). NTSP's shares of these specialties within the Fort Worth area would have been more meaningful and higher still. (Frech, Tr. 1300-1301).

Moreover, RPF 249 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

Finally, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 249 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 250.:

RPF 250 is wrong, incomplete, misleading, and irrelevant. NTSP's share of urologists practicing in Tarrant County is 80%, its share of urologists is 68.6%, and of

cardiovascular disease specialists, 58.8%. (Frech, Tr. 1299). NTSP's shares of these specialties within the Fort Worth area would have been more meaningful and higher still. (Frech, Tr. 1300-1301). In addition, NTSP's shares of Fort Worth nephrologists, hematologists/oncologists, colo-rectal surgeons, and endocrinologists likely would have significantly exceeded 50%. (*See* Maness, Tr. 2020-2021; RX3127 (calculation of percentages); RX306 (Texas Board of Medical Examiners data for Tarrant County); Frech, Tr. 1300-1301).

Moreover, RPF 250 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

Finally, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs,

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)).

Response to Finding No. 251.:

RPF 251 is not supported by probative evidence, and is irrelevant. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Moreover, RPF 251 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

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)).

Response to Finding No. 252.:

RPF 252 is a mix of legal and factual conclusions, wrong, incomplete, misleading, and irrelevant. Although Maness is confused about what nephrologists do and what portion of end stage renal disease care is paid for by the federal government–compare Maness, Tr. 2025-2026 with his report at paragraph 36, RX3118–he nevertheless opines that the fact that the federal government pays for a sizable portion of end stage renal disease care renders concern for competition among nephrologists unimportant. That is a legal conclusion (and a horribly wrong one at that), and we submit that this portion of RPF 252 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

RPF 252 seeks to obscure the fact that 17 of the 18 nephrologists practicing in Tarrant County are NTSP member physicians. Maness' conclusion that health plans account for only a small percentage of nephrologists' income appears, given the lack of support cited by Maness and his ignorance of what nephrologists do, to be purely speculative at best. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the

sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 253.:

RPF 253 is incomplete, misleading, and unsupported by probative evidence. Diagnosis and treatment code overlaps do not establish that the practitioners reporting those codes are in the same product market. In fact, in his report at paragraph 20, Maness states: "It is likely that [the] relevant product markets in this case [are] delineated roughly by the individual areas of medicine that NTSP doctors practice." (RX3118; *see also* Frech, Tr. 1425). Maness notes that various authorities have concluded that: primary care practitioners and specialists are not in the same market; gastroenterologists constitute a market; and that physician markets are defined by specialties. (RX3118 (see paragraphs 19-20 and accompanying notes)). As RPF 239 indicates, health plans must include a broad range of specialties in a network if they are to have marketable products. (*See also* Quirk 279-282).

Moreover, even were it true, for example, as RPF 253 proposes, that colo-rectal surgeons, gastroenterologists, and primary care physicians were, by dint of overlapping practice of colonoscopy, thrown together in a single product market, it would not affect the result here. As RPF 239 indicates, health plans must include a broad range of specialties in a network if they are to have marketable products. (*See also* Quirk 279-282). But the very statement of the

proposition, which is based solely on Maness, strains credulity. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, because Maness' report is the sole support offered by Respondent's Counsel for this finding, we submit that this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Finally, RPF 253 appears intended to suggest that Complaint Counsel was obliged to detail the metes and bounds of relevant markets here. That is wrong. Defining the specific metes and bounds of markets is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. (*See* CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

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)).

Response to Finding No. 254.:

RPF 254 is wrong, incomplete, misleading, and unsupported by probative evidence. Maness' conclusions do not follow from his premises, and his premises lack evidentiary support in any event. Maness' purported expert analysis was wholly lacking in

analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 254 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

In fact, the presence of physician groups within NTSP decidedly alters the competitive landscape by reducing the effective number of market participants thereby increasing the ease with which pricing consensuses can be formed and maintained and reducing the risk of cheating by cartel participants. (Frech, Tr. 1301-1302).

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 in not high. (Maness, Tr. 2034-35).

Response to Finding No. 255.:

RPF 255 is incomplete, misleading, unsupported by probative evidence, and contrary to the greater weight of evidence. RPF 255 is based on Maness, who here ignores the fact that most NTSP member physicians do not practice in "advanced specialties" with respect to which the need for Fort Worth coverage is mitigated. (*See, e.g.*, Quirk, Tr. 280-282). Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

Moreover, it is clear that health plans seeking to serve Fort Worth customers must have significant numbers of NTSP member physicians. (*See* CPF 81-104; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)).

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).

Response to Finding No. 256.:

RPF 256 is wrong, incomplete, misleading, unsupported by probative evidence, and irrelevant. Maness' conclusion that "NTSP's market share must be reduced" does not follow from his premise. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 256 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

Complaint Counsel neither agrees nor disagrees with Respondent's calculation of average (here meaning "mean") number of NTSP contracts in which member physicians participate; but RPF 256 is irrelevant. The absence in Respondent's proposed findings of other information concerning distribution (such as median and mode) and number of lives covered renders this datum essentially meaningless. Further, limited member physician participation in NTSP contracts is consistent with NTSP price-fixing. Any NTSP member physician who can in particular circumstances command a higher price for his or her specific services can be expected to do so (albeit after having skewed upward the polled measures of central tendency). (Frech, Tr. 1322-1323). And where circumstances preclude member physicians' achieving the consensus price, they will accept the lower market price. (Frech, Tr. 1322-1323). This is, in fact, evidence

of actual effect of NTSP's price-fixing for and with its member physicians. (CCRF 123; and *see generally* CCRF 114-124).

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)).

Response to Finding No. 257.:

RPF 257 is vague, misleading, and irrelevant. Complaint Counsel is unable to discern to what "calculations" of Professor Frech RPF 257 refers. Even assuming, however, that Maness is correct as to "the average physician[s] participation" in NTSP contracts and in the conclusion that NTSP-related revenues are not a large portion of most member physicians' incomes, RPF 257 is irrelevant. Nevertheless it is clear that NTSP member physicians have colluded through and with NTSP to fix the prices paid by health plans and other payors for the services of NTSP member physicians, and that in several instances NTSP's concerted actions accomplished that goal. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). That the fixed prices may have related to only a relatively small portion of the participating physicians' incomes is irrelevant.

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).

Response to Finding No. 258.:

RPF 259 is incomplete, misleading, and irrelevant. Inaccuracies in the Texas Board of Medical Examiners' database may result in under- or over-weighting of NTSP member physicians.

Moreover, RPF 259 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power, as through the determination of market shares. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power, for example through the calculation of market shares.

Finally, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

259. The services provided by hospitals are considered primary, secondary, tertiary, or quarternary services. Quarternary 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).

Response to Finding No. 259.:

Complaint Counsel neither agrees nor disagrees with RPF 259.

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 quarternary 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).

Response to Finding No. 260.:

RPF 260 is incomplete, misleading, and irrelevant. To be marketable to Fort Worth employers, a health plan must have Harris Methodist Hospital within its network. (CPF 92). In addition to Harris Methodist Hospital, health plans must have the major admitters to provide effective access to that hospital. (CPF 93). NTSP member physicians represent the vast majority of admissions to Harris Methodist Hospital in many specialties. (CPF 94).

Moreover, RPF 260 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292,

and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power.

261. Complaint Counsel's own expert states that one should not put too much emphasis on market share alone. (Frech, Tr. 1436).

Response to Finding No. 261.:

Complaint Counsel agrees with RPF 261. In fact, market share is irrelevant: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established (CPF 157-257, 258-292, and 297-394 (demonstrating actual price effects resulting from price-fixing against specific health plans)).

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).

Response to Finding No. 262.:

RPF 262 is wrong, incomplete, misleading, unsupported by probative evidence, and irrelevant. Maness' conclusion that there are low barriers to and ease of entry typifies Maness' lack of analytical rigor and bias, as a result of which his analyses are unreliable and unworthy of weight. (CPF 436-475). Maness based his conclusion principally on his determination that there was a net inflow of physicians in Tarrant County of 13.5% over the four year period 1999-2004. (Maness, Tr. 2036-2037). But he did not compare net physician inflow with net population inflow over that same period. (Maness, Tr. 2250-2251). Hence, he could not know whether entry was or was not adequate to keep pace with demand. Further, he had no idea how long his inflow physicians contemplated entry before entering, or whether they were, by and large, succeeding economically post entry, or what scale of entry would be necessary to defeat a

small but significant nontransitory price increase. (Maness, Tr. 2250-2251). He did no analysis at all specific to Fort Worth. (Maness, Tr. 2250-2251). Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

Moreover, RPF 262 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power or its durability. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power.

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).

Response to Finding No. 263.:

RPF 263 is incomplete, misleading, and irrelevant. Maness reported that he was aware that according to some academic literature and commentators there are low mobility barriers for physicians. (Maness, Tr. 2036-2037). Appreciable physician mobility does not necessarily imply that economic rents earned by physicians inevitably will be competed rapidly away. In fact, Maness made no assertions whatever regarding the empirical relationship, or lack thereof, between the two.

Moreover, whether or not rents would be competed rapidly away is itself irrelevant in evaluating price-fixing. The law does not give a pass to price-fixers if they can demonstrate that

their unlawful gains will be short-lived. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians, for however long and in whatever amount. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). Finally, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

264. In Tarrant County, it is not difficult to come into the community and start a new practice. (Deas, Tr. 2398).

Response to Finding No. 264.:

RPF 264 is incomplete, misleading, unsupported by probative evidence, and irrelevant. RPF 264 is based solely on the testimony of Dr. Deas. As President and Chairman of the Board of Directors of NTSP, Dr. Deas is intimately bound up with the price-fixing established by Complaint Counsel. (CPF 74). Dr. Deas' testimony in this regard is not credible and should be accorded no weight. Under cross-examination Dr. Deas acknowledged that to enter a new area successfully a specialist must establish referral relationships with primary care physicians, and that that process could take years. (Deas, Tr. 2582-2584). Moreover, insofar as RPF 264 might be taken as implying a ready source of recruits, Dr. Deas direct testimony indicates that it should not be so taken. When asked about hospital recruiting of physicians, Dr. Deas indicated that that largely involved hospitalists and personnel to cover trauma and ER. (Deas, Tr. 2428). Indeed, Dr. Deas testified that his gastoenterology practice had been in a constant state of recruitment since 1997 because "recruiting is extremely difficult, [and there is a] shortage of individuals to fill all the slots." (Deas, Tr. 2425). Given, then, the lack of a probative basis for RPF 264, we submit that RPF 264 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 265.:

RPF 265 is incomplete, misleading, and irrelevant. Maness determined that there was a net inflow of physicians in Tarrant County of 13.5% over the four year period 1999-2004. (Maness, Tr. 2036-2037). But he did not compare net physician inflow with net population inflow over that same period. (Maness, Tr. 2250-2251). Hence, he could not know whether entry was or was not adequate to keep pace with demand. Further, he had no idea how long on average his inflow physicians had contemplated entry before entering, whether they were for the most part succeeding economically, or what scale of entry would be necessary to defeat a small but significant nontransitory price increase. (Maness, Tr. 2250-2251). He did no analysis at all specific to Fort Worth. (Maness, Tr. 2250-2251).

Moreover, RPF 265 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power or its durability. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power.

Finally, Maness' purported expert analysis was wholly lacking in analytical rigor,

biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 265 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 266.:

RPF 266 is incomplete, misleading, and irrelevant. In important part, it is based on the testimony of Dr. Deas. As President and Chairman of the Board of Directors of NTSP, Dr. Deas is intimately bound up with the price-fixing established by Complaint Counsel. (CPF 74). Dr. Deas' testimony in this regard is not credible and should be accorded no weight. Under cross-examination Dr. Deas acknowledged that to enter a new area successfully a specialist must establish referral relationships with primary care physicians, and that that process could take years. (Deas, Tr. 2582-84). Moreover, insofar as RPF 264 might be taken as implying a ready source of recruits, Deas' direct testimony indicates that it should not be so taken. When asked about hospital recruiting of physicians, Dr. Deas indicated that that largely involved hospitalists and personnel to cover trauma and ER. (Deas, Tr. 2428). Indeed, Dr. Deas testified that his gastoenterology practice had been in a constant state of recruitment since 1997 because "recruiting is extremely difficult, [and there is a] shortage of individuals to fill all the slots." (Deas, Tr. 2425).

Lovelady adds only that PacifiCare has recruited physicians to North Texas. (Lovelady, Tr. 2635). The questions of "how often," "how many," "how challenging," etc. were never asked or answered. Nor did Lovelady know about whether other health plans engaged in similar efforts. (Lovelady, Tr. 2636).

Maness made numerous assertions that various stakeholders recruit physicians to the area (Maness, Tr. 2037), but he talked to none of those stakeholders–made no effort to talk to any of those stakeholders. (Maness, Tr. 2125-2130, 2321-2322). Instead, he relied on the general wisdom and the self-serving assertions of Van Wagner, NTSP's Executive Director and the principal actor in the price-fixing established by Complaint Counsel (CPF 66, 441).

Moreover, RPF 266 appears intended to suggest that Complaint Counsel was obliged to estimate NTSP's market power or its durability. That is wrong. Estimation of market power is not necessary: (1) where, as here, the *per se* rule is applicable; (2) where, as here, concerted action is "inherently suspect" and no cognizable, plausible, and valid efficiency defense is established; and in every event, (3) where, as here, actual price effects have been established. The overwhelming weight of evidence is that NTSP's concerted actions were intended to and did achieve higher prices for its member physicians. (*See generally* CPF 97-142; *see also* CPF 157-257, 258-292, and 297-394 (showing agreements in operation against specific health plans)). This proof, among other things, obviates the need for any estimation of market power.

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).

Response to Finding No. 267.:

RPF 267 is inaccurate and misleading. NTSP has adopted various practices to restrain its physicians' ability to act independently. For example, the Physician Participation Agreement between NTSP and its participating physicians grants NTSP the right to receive all payor offers and imposes on the physicians a duty to promptly forward those offers to NTSP. CPF 98. Moreover, by providing its poll results to member physicians, NTSP effectively informs them as to the potential reward for deferring direct negotiations with health plans while seeking to negotiate collectively through NTSP. NTSP also has repeatedly collected powers of attorney to foreclose any avenue of direct contracting with its physicians. (CPF 135-138, 146; CPF 121; Jagmin, Tr. 1178-1179). NTSP's threatened departicipations have also made direct contracting efforts risky for health plans who fear that direct contracting efforts would further incite NTSP, or its physicians under powers of attorney or agency agreements, to refuse to deal with health plans. (Grizzle, Tr. 750-751).

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)).

Response to Finding No. 268.:

Complaint Counsel neither agrees nor disagrees with RPF 268, which is, however, irrelevant to the issues in the case. The evidence from health plans competing in Fort Worth, including Respondent's own witness, is that NTSP's physicians must be included in a health plan's network to do business in Fort Worth. (CPF 91; Lovelady, Tr. 2679). The evidence from

many of these health plans is that their attempts to secure these physicians, directly or otherwise, has been repeatedly frustrated by the anticompetitive conduct of NTSP. (*See generally*, CPF 129-149.) The existence of other IPAs in the "Metroplex" has no bearing on NTSP's price-fixing conduct in its non-risk contracts which are the subject of this litigation, nor does it provide any justification for such conduct. (*See* CPF 418).

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

Response to Finding 269:

Complaint Counsel neither agrees nor disagrees with RPF 269, which is, however, irrelevant to the issues in the case. Moreover, NTSP has at various times solicited and obtained powers of attorney from its members, giving NTSP the unfettered right to negotiate non-risk contracts on behalf of those members. (CPF 135).

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).

Response to Finding No. 270.:

RPF 270 is irrelevant to the issues of this case. Moreover, RPF 270 begs the issues raised by Complaint Counsel that NTSP has explicitly recognized that a threat to NTSP's accomplishment of its aims was "the ability of payors to do end runs around the organization," (CPF 130), and that NTSP is aware that it can increase its collective bargaining power by encouraging physicians to avoid entering into direct contracts with health plans (CPF 134), and that it has been successful in doing so (CPF 135).

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)).

Response to Finding No. 271.:

RPF 271 is irrelevant. In fact, the evidence shows that NTSP's collective price-fixing and related acts and practices have effectively raised prices and/or reduced output of physician services in the Fort Worth area of Tarrant County. (CPF 142).

Even when NTSP enters into non-risk contracts with a health plan, many NTSP member physicians contract with these same health plans outside of NTSP. (CX1187 (McCallum, Dep. at 136-37); RX3118 (Maness Report ¶ 42)).

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).

Response to Finding No. 272.:

RPF 272 is technically accurate, but misleading because NTSP's powers of attorney with its participating physicians constrained Aetna's ability to sign direct contracts for a substantial period of time, and lead Aetna to capitulate to NTSP price demand in late 2000. (*E.g.*, CPF 135; Jagmin, Tr. 1178).

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).

Response to Finding No. 273.:

RPF 273 is incomplete and misleading. After NTSP jointly terminated its member physicians' participation in United in July 2001, United tried to approach the terminated physicians directly. However, only a few accepted the offer, which contained the same

reimbursement rates as they had received under the HTPN-United agreement prior to the termination by NTSP. (CPF 220). Even after a higher rate was extended to the NTSP physicians whose contracts had been terminated, more than ten physicians' groups failed to respond to United's offer at this higher rate, notwithstanding the fact that it was higher than rates they had prior to their termination by NTSP. Some of those groups responded that they rejected United's offer for a direct contract because NTSP was negotiating on their behalf. (CPF 228-229). Moreover, some of the evidence cited in support of RPF 273 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

274. PacifiCare has direct contracts with NTSP participating physicians. (Lovelady, Tr. 2652).

Response to Finding No. 274.:

RPF 274 is incomplete. NTSP physicians who contract directly with PacifiCare do so by overcoming pressure from NTSP to forgo such contracting methods. (*See* CPF 133-134). Also, Lovelady "believe[ed]" PacifiCare contracted independently with NTSP physicians, but had no sense of how many direct contracts there were. (Lovelady, Tr. 2652). Lovelady's belief may have been influenced by "political issues" or "community ties" that NTSP has and PacifiCare exploits. (Lovelady, Tr. 2658, 2681-2682 (acknowledging that NTSP has lobbied on PacifiCare's behalf); Van Wagner, Tr.1727-1732 (discussing why NTSP lobbied the City of Ft. Worth to renew a risk contract with PacifiCare instead of switching to United)).

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)).

Response to Finding No. 275.:

RPF 275 is irrelevant. Moreover, NTSP's Physician Participation Agreement with

its member physicians grants NTSP a right of first negotiation with health plans, with the physicians agreeing that they will refrain from pursuing offers from a health plan until notified by NTSP that it is permanently discontinuing negotiations with the health plan. (CPF 99). Accordingly, the Physician Participation Agreement hinders health plans in efforts to assemble a marketable Fort Worth area physician network without submitting to the collective bargaining of NTSP. (CPF 103).

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).

Response to Finding No. 276.:

Complaint Counsel does not disagree with RPF 276 regarding GANT's direct contract with CIGNA. RPF 276, however, is incomplete and misleading. Grizzle of CIGNA testified unambiguously that NTSP's contract rates with CIGNA are significantly higher on average than CIGNA's standard rates in Fort Worth. (NTSP's rates were 15 to 20 percent higher than "CIGNA's other reimbursement rates in the Ft. Worth area.") (Grizzle Tr. 715-716; Grizzle Tr. 723-724). The existence of a single CIGNA contract at a rate higher than NTSP's rate does not change the fact that NTSP's contract rates with CIGNA was 15 to 20 percent above the standard physician rates in Fort Worth.

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).

Response to Finding No. 277.:

RPF 277 is inaccurate. The evidence shows that health plans must have NTSP

physicians to serve Fort Worth clients (CPF 91), and NTSP's Physician Participation Agreement hinders health plans in efforts to assemble a marketable Fort Worth area physician network without submitting to the collective bargaining of NTSP. (CPF 103).

278. Payors' networks are adequate by regulatory standards and company standards without a contract with NTSP. (Quirk, Tr. 289-90, 359; Roberts, Tr. 532).

Response to Finding No. 278.:

RPF 278 is partially inaccurate and thus misleading, as well as irrelevant. The evidence demonstrates a distinction between regulatory requirements and marketplace realities i.e., the difference between regulatory standards and the health plans' standards regarding adequacy and health plans' ability to market their network. (Quirk, Tr. 274-275). The evidence shows that health plans must have NTSP physicians to serve Fort Worth clients. (CPF 91; Lovelady, Tr. 2679 (NTSP physicians are "essential" to a Forth Worth network and their absence can result in coverage gaps across several specialties)). The evidence also demonstrates that NTSP's Physician Participation Agreement, powers of attorney and other anticompetitive conduct hinders health plans in efforts to assemble a marketable Fort Worth area physician network without submitting to the collective bargaining of NTSP. (CPF 103, 135-138, 146).

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)).

Response to Finding No. 279.:

Complaint Counsel does not dispute sentences one and two of RPF 279. Sentence three of RPF 279 is technically accurate but misleading because it refers only to TDI's definition of "inadequacy," and therefore does not account for the potential market impact of not having

physicians in a network. (*E.g.*, CPF 140).

280. Aetna was not particularly concerned with NTSP from a medical standpoint. (Jagmin, Tr. 1123).

Response to Finding No. 280.:

RPF 280 is technically accurate but incomplete because Aetna was concerned about NTSP in other respects, such as marketing. (Jagmin, Tr. 1123). Aetna was also concerned about NTSP's ability to extract supracompetitive rates through collective negotiation. (*E.g.*, CPF 140).

281. Cigna requires that two specialists of each type be located within 20 miles of the majority of its membership in Fort Worth. {[redacted]} (RX 2887.012, *in camera*; RX 3118 (Maness Report ¶ 41)).

Response to Finding No. 281.:

RPF 281 is incorrect and misleading. According to Rick Grizzle, the September 2000 analysis demonstrated that CIGNA would have had several coverage gaps if NTSP terminated its contract with CIGNA. (Grizzle, Tr. 719, 720, 921, *in camera* (*see Grizzle, Tr. 752-754*), 731, 757, 922, *in camera* (*see Grizzle, Tr. 752-754*) {[redacted]}; Grizzle, Tr. 921, *in camera* (*see Grizzle, Tr. 752-754*). In fact, Mr. Grizzle testified directly that CIGNA could not put together an adequate physician network in Fort Worth without having access to NTSP physicians. (Grizzle, Tr. 720 (Question: "Could you have put together an adequate network of physicians without NTSP's doctors?" Answer: "Not and sell in Ft. Worth")). Respondent's expert is confusing Mr. Grizzle's testimony (and the CIGNA analysis) because he did testify that,

{[redacted]}

(Grizzle, Tr. 920-921, *in camera (see Grizzle, Tr. 752-754)*, CX0779, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*). Mr. Grizzle is in a better position to evaluate CIGNA's physician network needs than Dr. Maness, who submitted purported expert analysis that was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475).

282. United did not need NTSP in its network. (CX 1034 (United correspondence stating NTSP "not critical" to network)).

Response to Finding No. 282.:

RPF 282 is incomplete and misleading. United had contracts with approximately two-thirds of the NTSP physicians, either directly or through other organizations, such as Health Texas Provider Network ("HTPN"). Therefore, United concluded that there was no need to enter into an agreement *with NTSP* as a contracting entity for the remainder of its physicians. (CPF 174). United did not conclude, however, that it did not need NTSP's physicians in its network. Moreover, CX1034, to which Respondent cites in support of RPF 282, represents United's position prior to NTSP terminating 108 of its physicians from United's network, since the document was written before the termination.

283. NTSP has never had a direct contract with Blue Cross. (Van Wagner, Tr. 1720).

Response to Finding No. 283.:

RPF 283 is irrelevant; also, NTSP has had access to Blue Cross contracts through its Health Texas relationship. (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)).

Response to Finding No. 284.:

RPF 284 is inaccurate and misleading. In fact, NTSP has cautioned its physicians to avoid undermining NTSP solidarity and its pricing consensus. (CPF 131).

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).

Response to Finding No. 285.:

RPF 285 is inaccurate and misleading. In fact, NTSP has at various times solicited and obtained powers of attorney from its members, giving NTSP the unfettered right to negotiate non-risk contracts on behalf of those members. (CPF 135).

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).

Response to Finding No. 286.:

RPF 286 is inaccurate and misleading. NTSP has adopted various practices to restrain its physicians' ability to act independently. For example, the Physician Participation Agreement grants NTSP the right to receive all payor offers and imposes on the physicians a duty to promptly forward those offers to NTSP. (CPF 98). Moreover, by providing its poll results to member physicians, NTSP effectively informs them as to the potential reward for deferring direct negotiations with health plans while seeking to negotiate collectively through NTSP. (CPF 121).

Finally, Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's

citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 287 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 287.:

Complaint Counsel neither agrees nor disagrees with RPF 287 as far as RPF 287 refers to NTSP's members' affiliation with other IPAs. As it pertains to NTSP's non-exclusivity in general, RPF 287 is false and misleading. NTSP's agreements with its physicians do provide for a period of exclusivity during which NTSP member physicians agree to refuse to deal with a health plan directly while the health plan is in negotiations with NTSP and *until* NTSP notifies its physicians "in writing that it [NTSP] is permanently discontinuing negotiations. Only then do NTSP's physicians "have the right" to directly contract with the health plan. (CX0311 at 10; CPF 99). This was confirmed in the testimony of Van Wagner (Van Wagner, Tr. 1857-1858) and a founding and longtime NTSP Board Member, Dr. Hollander. (CX1178) Hollander, Dep. 9-10, 68) ("And there were various criteria like time limits that the participating physician generally agreed that they would just wait and after that time limit was expired, then they were free to negotiate on their own.")).

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).

Response to Finding No. 288.:

RPF 288 is inaccurate and misleading in that NTSP attempted to influence its physicians, who were also HTPN members, regarding the reimbursement rates under an United-HTPN contract. (CPF 176).

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).

Response to Finding No. 289.:

RPF 289 is inaccurate and misleading. NTSP's powers of attorney and agency agreements were meant to prevent health plans from going around NTSP and its consensus price by approaching member physicians directly. (CPF 136). There is ample evidence that NTSP member physicians repeatedly turned away health plan offers and directed health plans to deal with NTSP. (CPF 134, 262, 340). A power of attorney, by its very nature, grants authority to accept contracts, and NTSP's own documents make it sufficiently clear that NTSP would need to suspend its powers of attorney before its physicians could contract outside of NTSP. (CX1079). RPF 289 is also incomplete because NTSP's physician members, especially those who have signed a power of attorney, have no incentive to accept an offer lower than NTSP's minimum price (Frech, Tr. 1327), rendering RPF 289 irrelevant, given that NTSP's minimums were set above direct contracting rates. (CPF 112). The physicians' incentive is to hold out in solidarity and this is precisely what the powers of attorney are intended to accomplish, and did accomplish. (Frech, Tr. 1327; CPF 132, 99, 134, 262, 340).

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).

Response to Finding No. 290.:

Complaint Counsel does not disagree; however, RPF 290 is irrelevant because the results of any such analyses could in no way justify price-fixing. Moreover, NTSP through its own admissions, in its documents as well as ample testimony from health plans demonstrate that NTSP achieved supra-competitive rates. (*See, e.g.*, CPF 79, 266, 381, 132).

291. NTSP's rates and rates offered to NTSP are not above market rates. (Quirk, Tr. 297-98 (offering NTSP market standard)).

Response to Finding No. 291.:

RPF 291 is inaccurate and misleading, as it is unsupported by the evidence cited by Respondent. Quirk did not testify that NTSP's rates are not above market, only that United offered what it believed to be the market standard for the Fort Worth area. (Quirk, Tr. 297-98).

292. Payors' standard rates are not necessarily the market rate, especially for IPAs. (Frech, Tr. 1439-40; Van Wagner, Tr. 1805-06). For example, {[redacted]} (Grizzle, Tr. 958, *in camera*).

Response to Finding No. 292.:

Complaint Counsel has no specific response; however, RPF 292 is irrelevant because, even if true, such a fact could in no way justify price-fixing. Moreover, NTSP through its own admissions in its documents as well as ample testimony from health plans demonstrate that NTSP achieved supra-competitive rates (*see, e.g.*, CPF 79, 266, 381, 132), and that NTSP's physicians through NTSP, and its anticompetitive conduct collectively obtained higher rates than they would be able to achieve individually. (CPF 7, 130, 131).

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). {[redacted]

[redacted]} (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).

Response to Finding No. 293.:

Complaint Counsel neither agrees nor disagrees with RPF 293, which is, however, irrelevant to the issues in the case.

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).

Response to Finding No. 294.:

RPF 294 is inaccurate and misleading. In fact, the evidence shows that NTSP's collective price-fixing and related acts and practices have effectively raised prices and/or reduced output of physician services in the Fort Worth area of Tarrant County. (CPF 142). Grizzle of CIGNA testified unambiguously that NTSP's contract rates with CIGNA have been significantly higher on average than Cigna's standard rates in Fort Worth. (NTSP's rates were 15 to 20 percent higher than "CIGNA's other reimbursement rates in the Ft. Worth area.") (Grizzle Tr. 715-716; Grizzle Tr. 723-724)). NTSP had acknowledged that it is able to obtain higher prices than its individual members could achieve on their own. (CPF 7). The existence of a single CIGNA contract at a rate higher than NTSP's rate does not change the fact that NTSP's contract rates with CIGNA were 15 to 20 percent above the standard physician rates in Fort Worth. A single practice group may draw higher prices for any number of reasons ranging from reputation and quality, to scarcity of intra-speciality competition or the particular needs of the health plan.

Moreover, NTSP has worked to discourage such direct contracts which might jeopardize its members' solidarity (CX0550 ("short term advantage and perceived best interest

are always controversial and potentially divisive, weakening the strength that our numbers provide."); CX0904 ("THE NTSP BOARD STRONGLY URGES ITS MEMBERS TO AVOID SIGNING INDIVIDUAL CONTRACTS IN ANY SETTING WHICH WILL PLACE THEM AT ODDS WITH OTHER MEMBERS OF THE ORGANIZATION.") (emphasis in original)) Gastroenterology of North Texas, the example given, was also a signatory to an NTSP power of attorney in another context. (Deas, Tr. 2575-2576, CX1006).

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)).

Response to Finding No. 295.:

Complaint Counsel neither agrees nor disagrees with RPF 295. However, and more importantly, RPF 295 fails to address the pertinent issues raised by Complaint Counsel that NTSP has explicitly recognized that a threat to NTSP's accomplishment of its aims was "the ability of payors to do end runs around the organization," (CPF 130), and that NTSP is aware that it can increase its collective bargaining power by encouraging physicians to avoid entering into direct contracts with health plans, (CPF 134), and that it has been successful in doing so (CPF 135).

296. Some physicians will accept only rates higher than NTSP's rates. (Frech, Tr. 1372).

Response to Finding No. 296.:

RPF 296 is irrelevant and misleading. The fact that some physicians will accept higher rates than NTSP's rates has no bearing on NTSP's price-fixing, resulting in higher rates for *the rest* of the physicians whose market rates are lower and who otherwise would accept market rates. As Dr. Jagmin of Aetna eloquently explained in his testimony, NTSP's price-fixing activity

resulted in overpaying some physicians, while the physicians who were paid at higher rates, due to their unique reputation, quality, scarcity of intra-speciality competition or the particular needs of the health plan, continued to be paid at the higher rates. (Jagmin, Tr. 1031-1032). Moreover, the evidence shows that NTSP's demand for an "across the board" rate, the same rate for all its member physicians, did not allow health plans to compensate unique and more expensive specialties, but only increased the rates for other specialties, thus resulting in overpaying the other physicians, and driving the unique physicians out of the network where they continued to be paid at *their appropriate* higher market rate. (*See, e.g.*, Jagmin, Tr. 1031-1032; CX0791 at 1; CX0904 at 2). Thus NTSP's anticompetitive conduct did in fact raise rates. (CPF 7, 412, 284, 334, 323). Dr. Frech explained the effect of NTSP's poll-derived rates prior to the cited testimony. In the context of the poll, Dr. Frech explained that, "[I]f you set a minimum, the physicians who would have been willing to take a lower price are perfectly happy to go up to the minimum so will tend to raise the price for the low -- physicians at the low end. At the high end, you have some physicians who are only willing to accept a high price, but they don't have to accept the minimum because it's a minimum, it's not mandatory, so it's not going to the high-priced physicians. So setting a minimum will tend to raise the price for the low-priced physicians and have no effect on the high-priced physicians. So you would expect the average price to rise merely from setting a minimum." (Frech, Tr. 1322-1323).

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).

Response to Finding No. 297.:

RPF 297 is irrelevant to the issues in this case. Moreover, price information

sharing reduces each physician's uncertainty as to the conduct of its competitors, enhances solidarity among the membership, and increases the likelihood of collusion. (CPF 122).

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)).

Response to Finding No. 298.:

RPF 298 is irrelevant as far as it pertains to contracting through an IPA in a lawful way, without engaging in anticompetitive joint negotiations and price-fixing between otherwise competing physicians. Complaint Counsel does not deny that contracting through an IPA could be lawful and could potentially reduce cost of contracting, (*see e.g.*, Health Care Statements) however, the evidence shows that NTSP in fact engaged in unlawful price-fixing by collecting of powers of attorney, sharing information on future prices, and setting prices.

Also, RPF 298 is incomplete and misleading in that it reports only one effect of health plans negotiating with IPAs rather than with individual physicians. In fact, collective negotiations by competing NTSP physicians reduces competition and harms consumers through higher prices. (Frech, Tr. 1280-1281, 1321-1322). The principle that collective price setting by sellers results in higher prices which harm consumers is fundamental to economics and fully applies to the market for physician services. (Frech. Tr. 1305-1307). In fact, one health plan in the Fort Worth area, CIGNA, estimates that NTSP's business practices have increased its costs {[redacted]} (CX0814, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04;* Grizzle, Tr. 877-879, *in camera (See Grizzle, Tr. 752-754)).*

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).

Response to Finding No. 299.:

Complaint Counsel has no specific response to the general proposition made in RPF 299. However, RPF 299 is generally irrelevant, and misleading to the extent that it implies NTSP physicians offer higher quality. In fact, NTSP has claimed higher quality but, in the opinion of Aetna, has not been able to present valid evidence to support such a claim. (Roberts, Tr. 497-505).

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*).

Response to Finding No. 300.:

Complaint Counsel has no specific response to the general proposition made in RPF 300. However, RFP 300 is incomplete and misleading to the extent that it implies NTSP physicians achieve efficiencies. In fact, NTSP has claimed efficiencies but, in the opinion of Aetna, has not been able to present valid evidence to support such a claim. (Roberts, Tr. 497-505).

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).

Response to Finding No. 301.:

RPF 301 is incomplete and misleading. Although higher rates may reflect efficiencies such as the ability to control costs and to improve quality, higher rates may also reflect anticompetitive price-fixing or collusion, which is the cause of NTSP's higher rates. (Frech, Tr. 1305-1317; Van Wagner, Tr. 1883).

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).

Response to Finding No. 302.:

RPF 302 is incomplete and misleading in that it fails to state that quality must also be considered in the context of measuring costs. In some cases, quality improvement requires increased utilization, and, consequently, higher overall costs. (Casalino, Tr. 2828-2809, 2902-2903).

RPF 302 is irrelevant to the extent it addresses health care costs generally, and not the specific conduct or costs of NTSP. Without regard to general national trends, NTSP harmed consumers by increasing physician reimbursement and fees, not utilization. CIGNA, a large purchaser of healthcare services in the Fort Worth area, estimates that NTSP's higher prices which resulted from its collective price negotiations have increased CIGNA's costs {[redacted]} (CX0814, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04);*Grizzle, Tr. 877-879, *in camera (see Grizzle, Tr. 752-754)).*

303. Complaint Counsel's expert admits total medical expense is an important criterion in determining the cost to payors. (Frech, Tr. 1408-09).

Response to Finding No. 303.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 304.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 305.:

This RPF is literally identical to RPF 26. For the Court's convenience we reproduce our response here.

RPF 305 is vague and misleading because the term "NTSP business model" is not defined.

RPF 305 is irrelevant because it does not distinguish between its shared risk and non-risk contracts. NTSP's performance for shared risk contract has no bearing on NTSP's price-fixing conduct in its non-risk contracts which are the subject of this litigation, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 26's performance claims do not demonstrate that any efficiencies from its shared risk contracts "spilled over" to its non-risk contracts, especially with respect to the nearly half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

RPF 305 is misleading in that it implies that NTSP is fully at risk for its facility and pharmacy costs under its shared risk contracts. NTSP has a shared risk contract with only one health plan, PacifiCare. (CX1177 (Grant, Dep. 19)). Under its HMO contracts with PacifiCare, some pharmacy costs are excluded from the risk shared with NTSP. (Lovelady, Tr. 2639). Under these contracts, hospital costs are excluded from the risk shared with NTSP. (Deas, Tr. 2489; Casalino, Tr. 2903).

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).

Response to Finding No. 306.:

RPF 306 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its non-risk contracts which are the subject of this litigation, nor does it provide any justification for such conduct. (*See* CPF 418).

307. Other appropriate outcome measures are the quality and value of the care received. (Maness, Tr. 2060-62).

Response to Finding No. 307.:

RPF 307 is vague and misleading. The finding does not specify on its own terms, or from the preceding proposed finding, what "other" appropriate outcome measures are being referenced.

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).

Response to Finding No. 308.:

RPF 308 is incomplete and misleading in that it fails to state that quality must also be considered in the context of measuring costs. In some cases, quality improvement requires increased utilization, and, consequently, higher overall costs. (Casalino, Tr. 2828-2809, 2902-2903).

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).

Response to Finding No. 309.:

RPF 309 is misleading. The data in the cited exhibits is compiled by PacifiCare. (RX1708; RX1710; RX3177; RX3178). Quantitative analyses which address an IPA's performance for controlling costs or improving quality cannot be relied upon unless it is properly adjusted for demographic differences, such as age and sex, and "case mix," that is, the illness status of patients. (Casalino, Tr. 2827- 2828). The PacifiCare data fails to control for any

demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). No conclusions should be drawn from such data. (Casalino, Tr. 2829).

310. Complaint Counsel's expert did not study total medical expense or overall costs in this case. (Frech, Tr. 1416, 1422).

Response to Finding No. 310.:

Complaint Counsel has no specific response.

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311. NTSP has current risk and non-risk contracts with PacifiCare. (Lovelady, Tr. 2665, 2668).

Response to Finding No. 311.:

RPF 311 is incomplete. About half of NTSP members participate in risk-sharing contracts while substantially all participate in fee-for-service contracts. (CPF 78). The risk contract with PacifiCare covers only 32,000 lives of NTSP's total of 660,000. (CX0616 at 2; CX0265 *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 06.29.04)*).

312. NTSP is PacifiCare's "top performer in the Metroplex" for both risk and non-risk contracts. (Lovelady, Tr. 2657-2659, 2665, 2668).

Response to Finding No. 312.:

RPF 312 is inaccurate and misleading. Lovelady only characterized NTSP as the top performer in a qualified "overall context." (Lovelady, Tr. 2665). This "context" is given the definition of neither the risk contract nor the fee-for-service contract independent of each other, but instead both "on an overall basis." (Lovelady, Tr. 2665, 2668).

RPF 312 is incomplete and does not adequately support Respondent's finding. Lovelady's assessment of NTSP's value may be influenced by "political issues" or "community

ties" that NTSP has. As Lovelady testified, PacifiCare "use[s] those and find[s] those to be valuable." (Lovelady, Tr. 2658, 2681-2682 (acknowledging that NTSP has lobbied on PacifiCare's behalf); Van Wagner, Tr.1727-1732 (discussing why NTSP lobbied the City of Fort Worth to renew a risk contract with PacifiCare instead of switching to United)).

313. PacifiCare considers NTSP a "valuable contracting partner." (Lovelady, Tr. 2657-2658).

Response to Finding No. 313.:

RPF 313 is incomplete. As Lovelady continued to testify in the same sentence, PacifiCare considers NTSP valuable "from a number of different arenas" including "political issues" and "community ties." (Lovelady, Tr. 2657-2658). Lovelady did not attribute any value to NTSP's quality of care. (Lovelady, Tr. 2657-2658).

Lovelady's assessment of NTSP's value may be influenced by the "political issues" or "community ties" arenas. PacifiCare "use[s] those and find[s] those to be valuable." (Lovelady, Tr. 2658, 2681-2682 (acknowledging that NTSP has lobbied on PacifiCare's behalf); Van Wagner, Tr.1727-1732 (discussing why NTSP lobbied the City of Fort Worth to renew a risk contract with PacifiCare instead of switching to United)).

314. PacifiCare considers NTSP's performance on the risk contract "positive and favorable." (Lovelady, Tr. 2659).

Response to Finding No. 314.:

RPF 314 is irrelevant because NTSP's performance on the PacifiCare risk contract has no bearing on NTSP's price-fixing conduct in its non-risk contracts with health plans that are the subject of this Complaint, nor does it provide any justification for such conduct. (*See* CPF 418). The risk contract with PacifiCare covers only 32,000 lives of NTSP's total of 660,000. (CX0616 at 2; CX0265 *in camera (Order on Non-Party CIGNA's Motion for In Camera*

Treatment, 06.29.04)). Moreover, RPF 314 does not demonstrate that any efficiencies from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

315. In risk contracts, PacifiCare relies on NTSP to perform medical management functions. (Lovelady, Tr. 2657-58).

Response to Finding No. 315.:

RPF 315 is incomplete and misleading. PacifiCare did not delegate disease management programs to NTSP in any sense except participation. (Lovelady, Tr. 2671; Casalino, Tr. 2810). Within risk contracts, PacifiCare retained two of the three types of quality-improving processes, only delegating utilization management. (Casalino, Tr. 2808-2809; *see* Lovelady, Tr. 2671). NTSP did not operate its own disease management programs under the capitated risk contract with PacifiCare. (Casalino, Tr. 2809-2810).

RPF 315 is irrelevant because NTSP's functions on the PacifiCare risk contract have no bearing on NTSP's price-fixing conduct in its non-risk contracts with health plans that are the subject of this Complaint, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 314 does not demonstrate that any efficiencies from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the nearly half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

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).

Response to Finding No. 316.:

RPF 316 is incomplete and misleading. The PacifiCare data does not reliably compare NTSP's performance to the performance of other physicians. (*See* CPF 462). It does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834).

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).

Response to Finding No. 317:

RPF 317 is incomplete and misleading. The PacifiCare data does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). Thus, it cannot reliably compare NTSP's performance to the performance of other physicians. (*See* CPF 462).

The data also fails to distinguish between risk and non-risk performance. Casalino testified that "data without risk adjustment just isn't very useful, if useful at all. It can be extremely misleading." (Casalino, Tr. 2834-2836). PacifiCare does not track per member per month costs for NTSP's non-risk PPO patients (Lovelady, Tr. 2678) and does not run any utilization reports under the non-risk PPO contract with NTSP (Lovelady, Tr. 2677).

RPF 317 is not adequately supported. Van Wagner's cited testimony makes no mention of "good results" or "better performance." (Van Wagner, Tr. 1614). Lovelady's cited testimony limits the comparatively good results to inpatient days per thousand, which is only a "driver of cost in general." (Lovelady, Tr. 2664). RX1719, RX1846, RX3153, and RX3154

present raw data and do not make the finding of "good results," which regardless is an economically insignificant term.

RPF 317 is irrelevant because it does not distinguish between risk and non-risk contracts. The PacifiCare performance data for the risk contract has no bearing on NTSP's price-fixing conduct in its non-risk contracts with health plans that are the subject of this Complaint, nor does it provide any justification for such conduct. (*See* CPF 418). Moreover, RPF 317's conflated data does not demonstrate that any efficiencies from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

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).

Response to Finding No. 318:

RPF 318 is identical to RPF 31, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 318 is inaccurate and misleading. The PacifiCare data does not control for any demographic differences such as age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). Thus, it cannot reliably compare NTSP's performance to the performance of other physicians. (*See* CPF 462).

RPF 318 is misleading because it fails to distinguish between risk and non-risk performance. Dr. Casalino testified, "data without risk adjustment just isn't very useful, if useful at all. It can be extremely misleading." (Casalino, Tr. 2834-2836). Indeed, PacifiCare does not

track per member per month costs for NTSP's non-risk PPO patients (Lovelady, Tr. 2678), and does not run any utilization reports under the non-risk PPO contract with NTSP (Lovelady, Tr. 2677). In fact, Maness' report states that RPF 31 relates only to NTSP's risk contract with PacifiCare. Hence RPF 318 is irrelevant because NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 318 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract with PacifiCare covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

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).

Response to Finding No. 319:

RPF 319 is identical to RPF 32, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 319 is inaccurate and misleading because it makes no distinction between risk and non-risk contracts and also does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (*See* CCRF 31). To the extent that the data is derived from the risk contract, RPF 319 is also irrelevant because it has no bearing on NTSP's price-fixing in non-risk contracts. (*See* CCRF 31). Furthermore, Dr. Casalino testified that for rates of medical procedures in particular,

the PacifiCare data lacks case mix adjustment and suffers from potential selection bias. (Casalino, Tr. 2827-2828). Dr. Casalino determined that no conclusions should be drawn from that data. (Casalino, Tr. 2829).

Moreover, the evidence cited in RPF 319 does not adequately support Respondent's finding: RX1719, RX1846, RX3153, RX3154 and RX3223 are nearly five hundred pages of raw data and Van Wagner inappropriately provides self-serving testimony to interpret the PacifiCare data. (*See* CPF 66). Moreover, Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding concerning PacifiCare's own data. Dr. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 319 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron* Co., Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 320:

RPF 320 is identical to RPF 33, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 320 is inaccurate and misleading because it makes no distinction between risk and non-risk contracts and also does not control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct

contracts. (*See* CCRF 31). To the extent that the data is derived from the risk contract, RPF 320 is also irrelevant because NTSP's activity under its sole risk contract has no bearing on NTSP's price-fixing activity in non-risk contracts, nor does it justify it. (*See* CCRF 31). RPF 320 does not demonstrate that any alleged efficiencies or quality from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423).

Moreover, the evidence cited in RPF 320 does not adequately support Respondent's finding: RX1719, RX1846, RX3153, RX3154 and RX3223 are nearly five hundred pages of raw data and Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding concerning PacifiCare's own data. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 320 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 321:

RPF 321 is identical to RPF 34, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 321 is irrelevant, inaccurate and misleading. RPF 321 is irrelevant because

the hospital utilization data only include data for PacifiCare's risk contract, and it does not include data for PacifiCare's non-risk contracts, or any of NTSP's other 20 non-risk contracts. (Lovelady, Tr. 2677). Thus, RPF 321 has no bearing on NTSP's price-fixing in non-risk contracts (*See* CCRF 31). RPF 321 does not demonstrate that any alleged efficiencies from the PacifiCare risk contract functions spilled over to NTSP's non-risk contracts with other health plans, especially with respect to the about half of NTSP physicians who did not share risk through NTSP at all. (*See* CPF 423). Thus, RPF 321 is misleading in making no distinction between risk and non-risk contracts and failing to control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (*See* CCRF 31).

The evidence cited in RPF 321 does not adequately support Respondent's finding. RX1719, cited in RPF 321, does not support the finding that NTSP has below average hospitalization rates. In fact, on its face RX1719 actually demonstrates that NTSP's hospitalization rates are above average for Medicare-eligible risk patients. (Van Wagner, Tr. 1719). Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provides self-serving testimony to interpret such data. (*See* CPF 66). Dr. Maness is not an expert regarding organizational capital or physician organizations; it is neither appropriate nor credible for him to testify as an expert in these areas. (CPF 436). In formulating his opinion in this matter, Dr. Maness often failed to apply the care and rigor that should characterize the work of an expert economist. (CPF 439). Specifically, Dr. Maness' limited document review (CPF 440) and exclusive reliance on Van Wagner as a source of information make the validity of his conclusions questionable (CPF 439-474). This is further highlighted by his reluctance to seek independent confirmation even where it was available (CPF

441), and by his unwillingness to modify his opinions upon learning additional information (CPF 438). For these reasons, and for the additional reasons discussed in CPF 437, 470-471, Dr. Maness' report is entitled to little or no weight in its support for RPF 321. Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 321 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 322:

RPF 322 is identical to RPF 35, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 322 is irrelevant, inaccurate and misleading. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 322 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

The evidence, including the expert testimony of Dr. Casalino, demonstrates that

for rates of medical procedures in particular, the PacifiCare data lacks case mix adjustment and suffers from potential selection bias. (Casalino, Tr. 2827-2828). Dr. Casalino determined that no conclusions should be drawn from that data. (Casalino, Tr. 2829). The PacifiCare data fails to control for any demographic differences like age, sex, or case mix (illness of patients) when comparing NTSP enrollees to enrollees in other IPAs or direct contracts. (Lovelady, Tr. 2676-2677; Casalino, Tr. 2833-2834). Thus, it cannot reliably compare NTSP's performance to the performance of other physicians. (*See* CPF 462). Moreover, Dr. Casalino testified that procedure rates do not correlate to total cost of care for patients because the same procedure can vary widely in cost for various reasons. (Casalino, Tr. 2827-2829).

RPF 322 is incomplete. Even if NTSP does keep total costs of patient care down on its risk contracts, such cost-cutting measures do not necessarily indicate better quality of care. (Casalino, Tr. 2808). Specifically, Casalino found NTSP lacking in processes to ensure that patients get needed procedures in a reasonable amount of time (Casalino, Tr. 2808-2809).

The evidence cited in RPF 322 does not adequately support Respondent's findings. Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding concerning PacifiCare's own data. Maness' purported expert analysis was wholly lacking in analytical rigor, biased, unreliable, and unworthy of weight. (CPF 436-475). Moreover, Counsel for Respondent's citations to Maness' report, RX3118, should be disregarded per Complaint Counsel's motion of June 25, 2004, because its admission into evidence was procured by misrepresentation. Thus, as far as any part of RPF 322 is solely supported by Maness' report, we submit that part of this finding should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 323:

RPF 323 is identical to RPF 36 and RPF 97, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 323 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 323 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

The evidence does not adequately support RPF 323. No one, not even PacifiCare's witness, testified with respect to its accuracy. Moreover RX3139 itself does not support RPF 323; it does not label the per member per month comparison as being a national average as RPF 323 states.

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).

Response to Finding No. 324:

RPF 324 is identical to RPF 37 and RPF 98, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 324 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated

by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 324 does not have any bearing on NTSP's actions to negotiate and fix prices with respect to its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

RPF 324 is not adequately supported by the evidence. Lovelady of PacifiCare–the appropriate witness in this matter–lent no support to this finding. Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provided self-serving testimony to interpret the data. *(See* CPF 66).

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*).

Response to Finding No. 325:

RPF 325 is identical to RPF 38, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 325 is irrelevant. NTSP's sole risk contract is not at issue in this proceeding and there is no reliable evidence upon which to conclude that any alleged efficiencies generated by NTSP's risk contract have any impact on NTSP's non-risk contracts. Thus, RPF 325 does not have any bearing on NTSP's actions to negotiate and fix prices in its non-risk contracts, nor does it justify those actions. Indeed, NTSP's risk contract covers only approximately 32,000 lives, while NTSP's non-risk contracts cover more than 600,000. In addition, only about half of NTSP's member physicians are even allowed to participate in NTSP's lone risk contract. (CPF 55-58, 78).

RPF 325 is not adequately supported by the evidence. Lovelady of PacifiCare–the appropriate witness on this issue–lent no support to this finding. Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provided self-serving testimony to interpret the data. *(See* CPF 66).

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).

Response to Finding No. 326:

RPF 326 is not adequately supported. PacifiCare's witness, Lovelady, lent no support to this finding. Van Wagner, a witness with substantial financial and personal interest in the outcome of this proceeding, inappropriately provided self-serving testimony to interpret the data. (*See* CPF 66). Respondent laid no foundation to show that Van Wagner knows what PacifiCare does with this data. In addition, NTSP did not use data to operate disease management programs for the capitated or fee-for-service contracts. (Casalino, Tr. 2809-2810).

RPF 326 does not support the conclusion that NTSP was more proficient with the data than PacifiCare. Even Van Wagner did not assert this, nor did she state that NTSP provided greater understanding of the medical management data to PacifiCare. (Van Wagner, Tr. 1534).

327. PacifiCare believes spillover occurs from NTSP's risk contract performance to NTSP's non-risk contract performance. (Lovelady, Tr. 2659-61, 2685-88).

Response to Finding No. 327:

RPF 327 is incomplete and misleading. Lovelady testified that he had not seen evidence that physicians "shift gears depending on how they're compensated." (Lovelady, Tr. 2660-2661). The evidence indeed supports the notion of spillover "in the individual physician's mind," from risk contract to non-risk contract behavior for a single physician with both types of

contracts. (Casalino, Tr. 2859). However, only about half of NTSP physicians participate in any risk contracts and only those physicians can receive spillover benefits from the risk side of their practice. (CPF 78; CPF 417). The risk contract with PacifiCare covers only 32,000 lives of NTSP's total of 660,000. (CX0616 at 2; CX0265 *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 06.29.04)*). Furthermore, there is no credible evidence to support NTSP's efforts for cost control and quality improvement, or that any alleged efforts are effective, or for the amount of spillover and teamwork. (Casalino, Tr. 2816; *see* CPF 422, 423).

Even under the risk contract with PacifiCare, NTSP does not operate its own disease management program. (Casalino, Tr. 2809-2810). Furthermore, if NTSP in the future tried to implement organized processes on the non-risk side to improve quality, it would have large difficulties because, for the most part, NTSP does not have claims data on the non-risk side. (Casalino, Tr. 2869; CPF 424).

Lovelady did not dispute this limited effect: though he believed some valuable relationship-related factors spilled over to the fee-for-service contract from the capitated contract, Lovelady never assigned a positive overall view to the non-risk contract with NTSP standing alone. (*See* Lovelady, Tr. 2657-2659; 2665; 2668).

RPF 327 does not support the conclusion that price-fixing is necessary for any efficiencies that do spill over from the risk panel to the fee-for service panel. (*See* CPF 418).

Additionally, Lovelady's assessment of NTSP's value may be influenced by "political issues" or "community ties" that NTSP has. PacifiCare "use[s] those and find[s] those to be valuable." (Lovelady, Tr. 2658, 2681-2682 (acknowledging that NTSP has lobbied on PacifiCare's behalf); Van Wagner, Tr.1727-1732 (discussing why NTSP lobbied the City of Ft. Worth to renew a risk contract with PacifiCare instead of switching to United)).

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

Response to Finding No. 328:

RPF 328 is incomplete and misleading. Lovelady testified that he had not seen evidence that physicians "shift gears depending on how they're compensated." (Lovelady, Tr. 2660-2661). The evidence indeed supports the notion of spillover "in the individual physician's mind," from risk contract to non-risk contract behavior for a single physician with both types of contracts. (Casalino, Tr. 2859). However, only about half of NTSP physicians participate in any risk contracts and only those physicians can receive spillover benefits from the risk side of their practice. (CPF 78; CPF 417). The risk contract with PacifiCare covers only 32,000 lives of NTSP's total of 660,000. (CX0616 at 2; CX0265 *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 06.29.04)*). Also, Lovelady admitted that he lacked knowledge of how NTSP's performance ranked compared to others. (Lovelady, Tr. 2673).

Also, Lovelady's assessment of NTSP's value may be influenced by "political issues" or "community ties" that NTSP has. PacifiCare "use[s] those and find[s] those to be valuable." (Lovelady, Tr. 2658, 2681-2682 (acknowledging that NTSP has lobbied on PacifiCare's behalf); Van Wagner, Tr.1727-1732 (discussing why NTSP lobbied the City of Ft. Worth to renew a risk contract with PacifiCare instead of switching to United)).

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).

Response to Finding No. 329.:

RPF 329 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by Aetna, nor does RPF 329 justify such conduct. Further, the

time period involved, 1994, is long before the conduct at issue in this case.

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

Response to Finding No. 330.:

RPF 330 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by Aetna, nor does RPF 330 justify such conduct. Further, the time period involved, 1994, is long before the conduct at issue in this case.

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).

Response to Finding No. 331.:

Complaint Counsel does not disagree with the first sentence of RPF 331. The second sentence of RPF 331 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 331 justify such conduct.

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).

Response to Finding No. 332.:

RPF 332 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 332 justify such conduct. Further, the time period involved, 1997, is long before the conduct at issue in this case.

Moreover, the assertion of a breach constitutes a legal conclusion and is inappropriate for the proposed findings of fact. Therefore, RPF 332 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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).

Response to Finding No. 333.:

RPF 333 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 333 justify such conduct. Further, the time period involved is long before the conduct at issue in this case.

Moreover, the assertion of a breach constitutes a legal conclusion and is inappropriate for the proposed findings of fact. Therefore, RPF 333 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 334.:

RPF 334 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 334 justify such conduct. Further, the time period involved is long before the conduct at issue in this case.

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

Response to Finding No. 335.:

RPF 335 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 335 justify such conduct. Further, the time period involved is long before the conduct at issue in this case.

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).

Response to Finding No. 336.:

Complaint Counsel does not disagree that an example of a tied offer is a contract that, among other provisions, requires acceptance of both capitation and non-capitation obligations. The second sentence of RPF 336 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

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).

Response to Finding No. 337.:

RPF 337 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 337 justify such conduct. Further, the time period involved is long before the conduct at issue in this case. Finally, RPF 337 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

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).

Response to Finding No. 338.:

RPF 338 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 338 justify such conduct. Further, the time period involved is long before the conduct at issue in this case. Finally, RPF 338 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

339. NTSP was appointed by its participating physicians to represent them in the breach of contract dispute with HMS. (Van Wagner, Tr. 1681).

Response to Finding No. 339.:

RPF 339 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 339 justify such conduct.

Moreover, RPF 339 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

Finally, the assertion of a breach constitutes a legal conclusion and is inappropriate for the proposed findings of fact. Therefore, RPF 339 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

340. In 1999, during the time the contract was being breached, HMS became Medical Select Management (MSM). (RX 832).

Response to Finding No. 340.:

RPF 340 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 340 justify such conduct. Further, RPF 340 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

Finally, the assertion of a breach constitutes a legal conclusion and is inappropriate for the proposed findings of fact. Therefore, RPF 340 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

341. The contracts between the physicians and HMS were assigned to MSM. (RX 832).

Response to Finding No. 341.:

RPF 341 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 341 justify such conduct. Further, RPF 341 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

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).

Response to Finding No. 342.:

RPF 342 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 342 justify such conduct. Further, RPF 342 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

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)).

Response to Finding No. 343.:

RPF 343 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 343 justify such conduct. Further, RPF 343 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

344. MSM continued to breach the contract after the lawsuit was filed by continuing not to pay claims. (Van Wagner, Tr. 1692).

Response to Finding No. 344.:

RPF 344 is irrelevant because it does not have any bearing on NTSP's actions in

negotiating and fixing prices paid by health plans, nor does RPF 344 justify such conduct.

Further, RPF 344 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

Finally, the assertion of a breach constitutes a legal conclusion and is inappropriate for the proposed findings of fact. Therefore, RPF 344 should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

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)).

Response to Finding No. 345.:

RPF 345 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 345 justify such conduct. Further, RPF 345 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 346.:

RPF 346 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 346 justify such conduct. Further, RPF 346 is irrelevant because the only contracts at issue in this case are NTSP's non-risk

contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 347.:

The first sentence of RPF 347 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does the first sentence of RPF 347 justify such conduct. Further, the first sentence of RPF 347 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. The second sentence of RPF 347 is misleading, because NTSP used the powers of attorney for other purposes, such as preventing Aetna from signing direct contracts with NTSP member physicians. (Jagmin, Tr. 1178-1179).

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).

Response to Finding No. 348.:

RPF 348 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 348 justify such conduct. Further, RPF 348 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

349. Aetna represented to NTSP that MSM was solvent and able to fulfill its obligations. (Jagmin, Tr. 1172-73).

Response to Finding No. 349.:

The cited testimony does not support RPF 349. Instead, the cited pages indicate that Aetna told NTSP that it would investigate any specific examples of payment problems. In any case, RPF 349 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 349 justify such conduct. Further, RPF 349 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

350. In July of 2001, the Texas Department of Insurance placed MSM under supervision. (RX 3102).

Response to Finding No. 350.:

RPF 350 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 350 justify such conduct. Further, RPF 350 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

351. One week after MSM was placed under TDI supervision, MSM filed for bankruptcy. (Grizzle, Tr. 959-60, *in camera*; RX 1556).

Response to Finding No. 351.:

RPF 351 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 351 justify such conduct. Further, RPF 351 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 352.:

RPF 352 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 352 justify such conduct. Further, RPF 352 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 353.:

RPF 353 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 353 justify such conduct. Further, RPF 353 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 354.:

RPF 354 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans, nor does RPF 354 justify such conduct. Further, RPF 354 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Finally, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 355.:

RPF 355 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by health plans. Further, RPF 355 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts.

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).

Response to Finding No. 356.:

RPF 356 is identical to RPF 185, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 356 is irrelevant because, subsequent to the investigation, NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any investigation of Aetna. (CPF 379-390). Indeed, NTSP initiated the discussions for a non-risk contracts with Aetna (*e.g.*, Jagmin, Tr. 1030), and there is no evidence that this merger investigation ever dissuaded NTSP from negotiating or contracting with Aetna. Further, the alleged prior extrinsic acts of a health plan should have no weight. *See* Fed. R. Evid. 608(b). Specifically RPF 356 should be disregarded since the merger discussed is in a different market, and more importantly, the consent agreement is not an admission of liability. Finally, any action by antitrust regulators regarding merger activity by any health plan has no bearing on the price-fixing charges detailed in the Complaint.

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).

Response to Finding No. 357.:

RPF 357 is identical to RPF 189, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 357 is irrelevant because, subsequent to the investigation, NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any investigation of Aetna. *(E.g.*, CPF 379-90). Indeed, NTSP initiated the discussions for a non-risk contract with Aetna *(e.g.*, Jagmin, Tr. 1030), and there is no evidence that this investigation ever dissuaded NTSP from negotiating or contracting with Aetna. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Finally, any action by regulators regarding all-product requirements of health plans has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint.

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).

Response to Finding No. 358.:

RPF 358 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of the Assurance of Voluntary Compliance or any issue involving it. (*E.g.*, CPF 379-390). Moreover, RPF 358 is misleading because NTSP initiated discussions with Aetna, and completed the price negotiations, prior to the issuance of the Assurance of Voluntary Compliance, thereby further demonstrating that the allegations in RPF 358 did not influence NTSP's behavior regarding the price-fixing charges

detailed in the complaint. Moreover, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 359.:

RPF 359 is identical to the second sentence of RPF 190, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 359 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of the AVC or any issue involving the AVC. (CPF 379-390). Moreover, RPF 359 is misleading because NTSP initiated discussions with Aetna, and completed the price negotiations, prior to the issuance of the AVC, thereby further demonstrating that the allegations in RPF 359 did not influence NTSP's behavior regarding the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Finally, RPF 359 is also misleading because it states that RX339 "disciplined" Dr. Jagmin, when in fact, the letter imposes no sanctions on Dr. Jagmin whatsoever so long as Dr. Jagmin remedied an issue regarding AVC compliance. (RX339 at 4-5).

360. NTSP was notified of the Assurance of Voluntary Compliance with Aetna and Jagmin's disciplinary notice. (CX 103).

Response to Finding No. 360.:

RPF 360 is identical the last sentence of RPF 190, and our response is the same. For the Court's convenience, we reproduce our response here.

RPF 360 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of the AVC or any issue involving

the AVC. (CPF 379-390). Moreover, RPF 360 is misleading because NTSP initiated discussions with Aetna, and completed the price negotiations, prior to the issuance of the AVC, thereby further demonstrating that the allegations in RPF 360 did not influence NTSP's behavior regarding the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). Finally, RPF 360 is also misleading because it states that RX339 "disciplined" Dr. Jagmin, when in fact, the letter imposes no sanctions on Dr. Jagmin whatsoever so long as Dr. Jagmin remedied an issue regarding AVC compliance. (RX339 at 4-5).

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).

Response to Finding No. 361.:

RPF 361 is irrelevant because the only contracts at issue in this case are NTSP's non-risk contracts, and NTSP's price-fixing regarding those non-risk contracts. Further, RPF 361 is misleading and incomplete, because the data issue was only one of the reasons why the risk negotiations broke down. (Jagmin, Tr. 1132).

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).

Response to Finding No. 362.:

RPF 362 is inaccurate. Prior to November 2000 discussions were ongoing for both risk and non-risk contracts. (CX0942 (Fax Alert of August 7, 2000 to NTSP member physicians. "As previously reported, NTSP has started negotiations with Aetna in regards to a risk and non-risk contract.") Dr. Jagmin's testimony, cited in RPF 362 is not to the contrary. Complaint Counsel agrees that as of November 2000, the negotiations between NTSP and Aetna were only

regarded a non-risk contract.

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).

Response to Finding No. 363.:

Complaint Counsel agrees that NTSP demanded the same rates for all of its member physicians, even though such a rate schedule could result in some specialties getting overcompensated. *(See* CPF 330-331).

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).

Response to Finding No. 364.:

RPF 364 is irrelevant because it does not have any bearing on NTSP's actions in negotiating and fixing prices paid by Aetna, nor does RPF 364 justify such conduct. Further, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 365.:

The first two sentences of RPF 365 are irrelevant because they do not have any bearing on NTSP's actions in negotiating and fixing prices paid by Aetna, nor do the first two sentences of RPF 365 justify such conduct. Further, the alleged prior extrinsic acts of third-parties should have little or no weight. *See* Fed. R. Evid. 608(b). Regarding the third sentence of RPF 365, Complaint Counsel agrees that Aetna capitulated to NTSP's contractual demands after NTSP

orchestrated a campaign of pressure on Aetna and threatened to "term the entire NTSP network." (*See* CPF 363-381).

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).

Response to Finding No. 366.:

RPF 366 is inaccurate and misleading in that Aetna's risk contract with MSM differed substantially from its non-risk, fee-for-service contract with NTSP, thereby invalidating any superficial comparison of the rates under the contracts. (*See* Jagmin, Tr. 1152-1153). In fact, the rates in the 2000 Aetna-NTSP non-risk contract were higher than rates from other IPAs providing similar services. (CPF 381).

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).

Response to Finding No. 367.:

RPF 367 is inaccurate, misleading, and irrelevant because Aetna did not require that NTSP obtain powers of attorney from its physician members regarding Aetna's *direct* contracting efforts between Aetna and NTSP's member physicians. (CPF 340-345). Moreover, as Dr. Jagmin of Aetna testified, the purpose of the individual provider addendums was to protect patients and guarantee that they would continue to receive care in case the IPA went bankrupt or ceased to exist. Thus the specific attorney-in-fact terminology contained in the provider addendum has no bearing on NTSP's price-fixing at issue here, and Respondent's attempt to confuse the individual provider addendums with the powers of attorney collected by NTSP that were used to negotiate on behalf of the members and to fix prices, should not prevail. (Jagmin, Tr. 1054-1055).

368. NTSP requested that Aetna's individual provider addendum be "amended to recognize the messenger model for non-risk products." (CX 567).

Response to Finding No. 368.:

RPF 368 is not supported by the cited authority, as CX 567 is a letter from Dr. Vance to Dr. Cavazos, chairman of MSM's board, not anyone at Aetna.

369. Aetna terminated its contract with NTSP in 2001. (Roberts, Tr. 489; Van Wagner, Tr. 1713; CX 504).

Response to Finding No. 369.:

Complaint Counsel does not disagree with RPF 369.

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).

Response to Finding No. 370.:

RPF 370 is incomplete and misleading. The first sentence is technically accurate but ignores a substantial series of events that occurred between the termination and the direct contracting efforts. (*See* CPF 386-416). These events include NTSP's rejection of a higher rate for some specialties solely because the reimbursement methodology would not apply to all of NTSP's physicians. (CPF 408). The second sentence is technically accurate for the year 2001, although it is misleading for the year 2000, during which NTSP's powers of attorney precluded Aetna from contracting directly with NTSP's physician members. (*See* CPF 340-345).

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).

Response to Finding No. 371.:

The first sentence of RPF 371 is irrelevant and incomplete, in that Aetna was not

interested in delegating medical management and utilization management functions to NTSP. (Roberts, Tr. 486-487). The second sentence is incomplete, in that the limited information NTSP provided to Aetna derived from its risk contract with one health plan, PacifiCare, and NTSP did not provide the underlying data. (CPF 401).

372. Aetna would like to receive more proposals like NTSP's proposal that incorporate utilization management. (Roberts, Tr. 558).

Response to Finding No. 372.:

RPF 372 is irrelevant, in that Aetna was not interested in delegating medical management and utilization management functions to NTSP. (Roberts, Tr. 486-487). Further, NTSP's proposal is also irrelevant in that it does not relate to or justify NTSP's price-fixing conduct.

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).

Response to Finding No. 373.:

RPF 373 is inaccurate and misleading. In evaluating NTSP's efficiency claims, Aetna used the best data that was available to it. (CPF 406). Moreover, NTSP never tried to cure the gaps in the data. (CPF 402).

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)).

Response to Finding No. 374.:

RPF 374 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any admonishment letters to

Aetna. (*E.g.*, CPF 379-390). Any issue regarding alleged prompt pay violations, noncompliance with contracts, and predatory pricing concerns has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 375.:

RPF 375 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any admonishment letters to Aetna. (*E.g.*, CPF 379-390). Any issue regarding compliance with state law has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b). In any event, the cited testimony does not support RPF 375. Van Wagner's testimony says nothing about an "intensified" review of contracts. Instead, after being prompted three times, she testified only that NTSP would "hold firm" in asking payors to comply with TDI's regulations. (Van Wagner, Tr. 1772-1773).

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).

Response to Finding No. 376.:

RPF 376 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any admonishment letters to Aetna. (*E.g.*, CPF 379-390). Any issue regarding prompt payment or clean claims has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. In

particular, by November 2001, NTSP had already engaged in almost all of the price-fixing conduct that is the subject of the Complaint. (*See* CPF 293-408). Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

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).

Response to Finding No. 377.:

Complaint Counsel does not disagree with the first sentence of RPF 377. The second sentence is misleading, in that it suggests that NTSP was somehow prevented from agreeing to the proposal, when in fact NTSP's Board evaluated the proposal and chose not to distribute it to NTSP's physicians. (*See* CPF 412-413).

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).

Response to Finding No. 378.:

RPF 378 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any complaints about Aetna's contracting practices. (*E.g.*, CPF 379-390). Any issue regarding Aetna's contracting practices has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. In particular, NTSP had already engaged in almost all of the price-fixing conduct that is the subject of the Complaint by 2002. (*See* CPF 293-416). Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

379. In April of 2002, NTSP received notice of a Senate Special Committee Hearing on prompt payment. (RX 1152).

Response to Finding No. 379.:

RPF 379 is irrelevant because NTSP actively sought to enter into, jointly negotiated, and did enter into a contract with Aetna irrespective of any complaints about prompt payment. (*E.g.*, CPF 379-390). Any issue regarding Aetna's prompt payment has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. RPF 379 is further irrelevant because nothing in RPF 379 suggests that Aetna has ever had prompt payment issues with NTSP. Finally, the alleged extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

380. There is no current contract between NTSP and Aetna. (Roberts, Tr. 549; Van Wagner, Tr. 1718-19).

Response to Finding No. 380.:

Complaint Counsel does not disagree with RPF 380.

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).

Response to Finding No. 381.:

RPF 381 is incomplete and misleading. The purpose of NTSP's arrangement with HTPN was to allow NTSP's member physicians to gain access to fee-for-service contracts at Dallas rates that were more favorable compared to Tarrant County rates. (CX1010, 1011). The agreement with HTPN enabled NTSP to terminate all of its member physicians without even consulting them. NTSP later exercised this option by terminating 108 of its member physicians' HTPN-United contracts without consultation. (CPF 205-206). In addition, Respondent's use of the term "eligible physicians" is vague and unclear in this context.

382. One of the contracts made available to NTSP's participating physicians through HTPN was a United contract. (Van Wagner, Tr. 1726-27).

Response to Finding No. 382.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 383.:

RPF 383 is inaccurate, incomplete and misleading. Contrary to Respondent's claim, NTSP **did** act on United's first direct proposal in 1998 by attempting to renegotiate United's offered rates for its HMO and PPO services. (CX1012: NTSP reporting to membership that "we made a counter proposal which United will respond to in January [1999];" CPF 167).

In fact, NTSP attempted again in 2001 to obtain a direct contract with United. However, at this time, United refused again to capitulate to NTSP's rate demands for above-standard rates in its HMO and even higher rates for its PPO services. (CPF 177-181; *see also* CX1023 and 1024). Consequently, NTSP rejected United's offer but without consulting its membership. (CPF 181). NTSP then continued to actively pursue a direct contract with United at rates at or above its Board-established minimums, adopting an aggressive strategy of applying collective pressure on United until United succumbed to its demands. (CPF 182-225). As Complaint Counsel has pointed out in its proposed findings, NTSP threatened United's network adequacy, including through threats of termination to United's clients, and eventually terminated its member physicians' contracts with United through another entity. (*See* CX1042; CPF 182, 206-210 (regarding the actual termination), 221, 225; CX1053). In addition, NTSP collected powers of attorney from its physician members to gain additional bargaining leverage with United. (CPF

214-225). These various attempts at forcing United's hand to agree to a direct contract at NTSP's demanded rates are direct evidence of NTSP's actions on United's initial direct proposal. (CX0211 at 3 ("NTSP has identified United Health Care as a re-negotiation target since the first of the year. They are quietly and quickly becoming a giant in the Fort Worth area...NTSP representatives...put the City on Notice that they may have a significantly different network on October 1").

Eventually, as a result of NTSP's activities in the marketplace it was successful in exerting a higher offer from United which was only then accepted by NTSP. (CPF 226-257).

Additionally, some of the evidence cited in support of RPF 383 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 384.:

Complaint Counsel has no specific response.

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).

Response to Finding No. 385.:

RPF 385 is inaccurate in its claim that United had "planned to replace PacifiCare's risk contract with NTSP" and misuses the testimony from Mosley to which it cites. United was not even aware of NTSP being a risk provider for the City's employees. (Quirk, Tr. 363-365). It

was the City of Fort Worth, not United, which decided to shift the risk from its former PacifiCare contract to itself by becoming self-insured. (Mosley, Tr. 206-207).

Moreover, Respondent's claim is irrelevant to NTSP's price-fixing conduct that is the subject of this Complaint nor does it provide any justification for such conduct. Also, NTSP's discussions with United and activities in pursuit of a direct contract with United were wholly based on NTSP's concern regarding the level of reimbursement it demanded. (CX1042 (NTSP and United were in agreement as to basic fundamental language terms but "far apart in agreeing to a market reimbursement fee schedule."); CPF 182-225).

Moreover, some of the evidence cited in support of RPF 385 is self-serving testimony from Karen Van Wagner, a witness with substantial financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 386.:

RPF 386 is inaccurate, incomplete and highly misleading. NTSP has no right under antitrust laws to jointly terminate its member physicians' participation in a health plan, regardless of the issue of whether it has a contractual right to terminate its own contract with HTPN. This termination was executed by NTSP as an attempt to prevent United from having NTSP member physicians in its network at prices other than at what that NTSP had demanded. The termination of the HTPN-NTSP arrangement for United's products was part of NTSP's strategy to cause United to capitulate to its fee demands. (CPF 192-194, 213, 221). This termination, in conjunction with other actions that NTSP took in the marketplace, successfully forced United to increase its offer to NTSP's member physicians. (CPF 209, 217, 226, 228-229,

250).

NTSP's termination affected 108 physicians of the 400 physicians participating in United at the time. (CPF 201, 206).

Moreover, some of the evidence cited in support of RPF 386 is self-serving testimony from Karen Van Wagner, a witness with substantial financial interest in the outcome of this proceeding. (CPF 66).

387. United told physicians that termination of the HTPN contracts with NTSP was "the result of a mutual decision." (CX 1068).

Response to Finding No. 387.:

RPF 387 is incomplete, misleading and completely mischaracterizes the text of the cited document. United used the phrase "mutual decision" to present a more "positive light of the relationship between the three parties." (Beaty, Tr. 453-454). In fact, until the termination, United was not even aware of NTSP's ability to pull out its member physicians who participated in United through HTPN. (CPF 212). Moreover, it was NTSP who decided to terminate its physician members' HTPN contracts with United for the purpose of threatening United. (*See* CX1042 ("the NTSP Board has authorized termination [of] the United Health Care contract. However, notice has not yet been sent to United as NTSP must attempt one last strategy"); CPF 194, 205, 213, 221). Interestingly, Respondent contradicts its own proposed finding, RPF 273, in which Respondent admits that it was NTSP who terminated the contract with United.

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)).

Response to Finding No. 388.:

RPF 388 is overly broad, incomplete and misleading. United already had two-thirds of the NTSP's member physicians under contract through other IPAs and direct contracts.

Therefore, from a medical standpoint, United had no need for a group contract with the remainder of NTSP's member physicians. In fact, the correspondence Respondent cites to was written prior to United becoming aware of NTSP's arrangement with HTPN which was not until after the termination itself. (CPF 212). The loss of a significant number of the NTSP member physicians who were affected by NTSP's termination caused a great deal of concern to United. (CPF 209). The potential loss of additional physicians as a result of NTSP's solicitation of powers of attorney, which included a termination clause, created a threat to the adequacy of the United network at which point United was forced to agree to a direct contract with NTSP at a substantially higher rate than United's original offer. (Quirk, Tr. 347-349, 361).

Furthermore, RPF 388 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United.

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).

Response to Finding No. 389.:

RPF 389 is inaccurate and misleading. NTSP's communication with the City of Fort Worth centered almost exclusively on NTSP's concerns about its physicians' reimbursement fees. (CPF 181-182, 185-188; *see* also CX1031 (Letter from NTSP to Mayor Barr)). In fact, NTSP's communication with the City of Fort Worth was part of its strategy of encouraging its members to convince the City's decision makers that United's prices were inadequate in order to obtain a direct contract at NTSP's demanded rates. (CPF 184-203).

Moreover, any concerns that NTSP expressed about United's utilization management are irrelevant because they cannot explain NTSP's refusal to deal with United. NTSP rejected the United offer even before the Board learned that United was negotiating with

the City of Fort Worth to provide health coverage to city employees. (CPF 182). More importantly, any network inadequacy that was discussed was due to NTSP's threats to departicipate from United if its price demands were not met by United. *(See* CX1042; CPF 192-210).

Additionally, some of the evidence cited in support of RPF 386 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (CPF 66).

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).

Response to Finding No. 390.:

RPF 390 is misleading and incomplete. NTSP's "concerns" about United's alleged network inadequacy to which Respondent refers to was the direct result of NTSP's actions in the marketplace, such as the termination of its physician members' HTPN-United contracts, the possibility of further termination by NTSP pursuant to the powers of attorney it was holding, and additional termination by individual NTSP member physicians who were exposed to NTSP's unfavorable communications concerning the United offer. Moreover, NTSP's express purpose of this termination was to increase its bargaining power with United in its attempt to obtain a direct contract at its demanded rates. (*See* CX1042; CPF 192-210).

Moreover, some of the evidence cited in support of RPF 386 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 391.:

RPF 391 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United. Moreover, the primary topic of NTSP's discussions with the City of Fort Worth was NTSP's concern regarding its physicians' reimbursement rates and obtaining higher rates from its negotiations with United. (CPF 184-203). Furthermore, the citation to Mosley's transcript does not support the proposition in RPF 391.

392. NTSP never asked the City to take any action with respect to fee levels. (Mosley, Tr. 195).

Response to Finding No. 392.:

RPF 392 is extremely misleading and incomplete. NTSP encouraged its member physicians to write letters to the City of Fort Worth for the express purpose of requesting the City's assistance in NTSP's negotiations with United regarding rates. (*See* CX1042 (Fax Alert from NTSP to its members instructing them to write letters to the City regarding NTSP's price negotiations with United: "Additionally, we recommend that you request of the Mayor and City Council members that they immediately assist in resolving our negotiations with United Health Care"); CX1029 at 11, 1029 at 13, 1029 at 15, 1029 at 16, 1031, 1037 (Letters from NTSP members requesting City's assistance in NTSP's negotiations with United), 1075); s*ee also* CPF 185-189, 192, 195-198, 203, 225, 239, 257).

NTSP's member physicians responded accordingly, sending letters to City officials complaining about United's "significantly below market" reimbursement levels and stating that unless "this contractual issue is resolved" there was a "likelihood that NTSP members will no longer be available to city employees." (CPF 188).

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).

Response to Finding No. 393.:

RPF 393 is inaccurate because NTSP based its predictions of the City's increasing overall healthcare costs on the City's own decision to be self-insured, a decision that was made independent of United. (*See* CX1069, CX1075; Mosley, Tr. 206-207). Furthermore, any network inadequacy that was discussed was a direct result of NTSP's termination of its 108 member physicians from United's network because its price demands were not met by United. (*See* CX1042; CPF 192-210).

Additionally, RPF 393 is misleading because NTSP's request for higher rates from United, the City's healthcare provider (CPF 185-189, 192, 195-198, 203, 225, 237-239, 257), contradicts NTSP's "concerns" regarding the City's increasing costs. An increase in physicians' costs would translate into an increase in overall healthcare costs for the City since it was self-funded at the time. Consequently, the City's increased costs would have been passed on to the City's employees in the form of increased premiums. (Mosley Tr. 122, CPF 476-478).

Moreover, RPF 393 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United. Furthermore, some of the evidence cited in support of RPF 393 is self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 394.:

RPF 394 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United. In fact NTSP's demand for higher prices from United and its departicipation from United's network was expected to cause an increase in the City's expenditure and enhance the City's cost overruns. Consequently, the increased costs would have been passed on to the City's employees in the form of increased premiums. (Mosley Tr. 122, CPF 476-478). Similarly, as Respondent admits, an increase in out of network payments significantly increases the costs for the City. (Van Wagner, Tr. 1731-1732).

395. To deal with United's cost overruns, the City had to discontinue its HMO programs and raise co-pays. (Mosley, Tr. 224-25).

Response to Finding No. 395.:

RPF 395 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United. In fact NTSP's demand for higher prices from United and its departicipation from United's network was expected to cause an increase in the City's expenditure and enhance the City's cost overruns. Consequently, the increased costs would have been passed on to the City's employees in the form of increased premiums. (Mosley Tr. 122, CPF 476-478). Similarly, as Respondent admits, an increase in out of network payments significantly increases the costs for the City. (Van Wagner, Tr. 1731-1732).

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).

Response to Finding No. 396.:

RPF 396 is inaccurate because NTSP collected powers of attorney to be used in its negotiations with United from its membership - approximately 600 in number - in general and not only from the 108 member physicians who were contracted with United through HTPN. (*See* CX1062; CX1066; CX1118 (List of NTSP terminated member physicians previously contracted

with United through HTPN); CX0499 (List of NTSP member physicians who submitted powers of attorney to NTSP)).

Additionally, RPF 396 is incomplete and misleading because NTSP's collection of the 107 powers of attorney Respondent references was part of NTSP's aggressive strategy of applying collective pressure on United in order to obtain a direct group contract at the prices NTSP demanded. (*See* CX1065 ("NTSP will continue to pursue a direct contract with United Healthcare [*sic*] that meets or exceeds the fee schedule minimums set by the NTSP membership"); CPF 223, 225). In fact, these powers of attorney gave NTSP the right to negotiate price on behalf of the designating member physicians. (CX1065 at 3, CPF 214-218). Also, when United tried to directly contract with the terminated NTSP physicians and offered higher rates than those under their former HTPN-United arrangement, some of these physicians refused the offer, instead referring United back to NTSP as their contracting agent. (CPF 228-229).

Moreover, some of the evidence cited in support of RPF 386 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 397.:

RPF 397 is inaccurate and incomplete because the powers of attorney Respondent references also gave NTSP the right to handle "all contracting activity" on behalf of its designating member physicians, including price. (CX1065 at 3, CPF 214-218, 221-223, 225, 229, 240, 255). Further, the term "in any lawful manner" was never mentioned to Quirk as part of NTSP's explanation of its powers of attorney. (Quirk, Tr. 422). RPF 397 is also misleading since

CX1083 to which it cites are Quirk's handwritten notes recording NTSP's own statements of its actions and not an accurate account of NTSP's conduct in its use of the powers of attorney. (Quirk, Tr. 419). In fact, NTSP was using powers of attorney, with the same language, to negotiate prices with several health plans including United.

RPF 397 is also misleading in its use of the term "messenger" because it suggests that NTSP's acts were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction with the Health Care Statements' messenger model, and the antitrust laws they embody.

Moreover, some of the evidence cited in support of RPF 397 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 398.:

RPF 398 is irrelevant and inaccurate because it refers to NTSP's statements regarding actions that should have been taken rather than the actual actions that NTSP took in regards to the powers of attorney and United's rate offer. (CPF 214-225). NTSP even expressed to United that it would not "messenger" any offer United proposed that did not meet the Board's minimums to its member physicians. (Quirk, Tr. 342-343). Moreover, NTSP's own documents show that it would only accept a direct contract with United that "meets or exceeds" the fee schedule minimums set by the NTSP membership. (CX1066 at 2; CPF 221). Indeed, NTSP's Board rejected United's initial offer without presenting it to its member physicians. (CPF 178,

181, 190). RPF 398 is also irrelevant because NTSP only offered these explanations *after* United suggested that NTSP's actions were anticompetitive and cautioned that United may bring such actions to the attention of the appropriate state and federal agencies. (CPF 230, 245-246).

In addition, RPF 398 is misleading because CX1083 to which it cites are Quirk's handwritten notes recording NTSP's own statements of its actions and not an accurate account of NTSP's conduct in its practice of the messenger model. (Quirk, Tr. 419).

Some of the evidence cited in support of RPF 398 is self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 399.:

RPF 399 is irrelevant. In addition, RPF 399 is misleading since CX1083 to which it cites are Quirk's handwritten notes recording NTSP's own statements of its actions and not an accurate account of NTSP's conduct in its practice of the messenger model. (Quirk, Tr. 419).

Additionally, RPF 399 is misleading in its use of the term "messenger" because it suggests that NTSP's acts were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction to the Health Care Statements' messenger model, and the antitrust laws they embody.

Moreover, some of the evidence cited in support of RPF 399 is self-serving testimony from Dr. Deas, a witness with personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 400.:

RPF 400 is irrelevant because it does not have any bearing on the actions NTSP actually took in strengthening its collective bargaining power through its communication to United that it collected powers of attorney during this time. (CPF 221-225). Indeed, when United approached NTSP physicians for a direct contract at higher rates than those under their former HTPN arrangement, these same physicians not only rejected United's offer but referred United to NTSP as their contracting agent. (CPF 228-229).

RPF 400 is also inaccurate since United obtained copies of Fax Alerts #52 and #56 in which NTSP solicited powers of attorney from all its member physicians and later reported the collection of 107 powers of attorney. (Quirk, Tr. 320-331; *See* CX1051, 1051A).

401. The powers of attorney were never delivered to United or used. (Quirk, Tr. 328, 418-19; Van Wagner, Tr. 1749).

Response to Finding No. 401.:

RPF 401 is misleading and vague in its use of the term "used." NTSP "used" the powers of attorney it collected from its member physicians in its greater strategy of strengthening its collective bargaining power with United in order to obtain a direct contract at its demanded rates. (CPF 224). NTSP's collection of these powers of attorney from its member physicians prevented United from being able to directly contract with many of the terminated NTSP physicians. In particular, some of the NTSP physicians who rejected United's offer for a direct contract even referred United to NTSP as their bargaining agent at the encouragement of NTSP. (CPF 136, 223, 229). It was because of NTSP's possession of these powers of attorney in addition to its other anticompetitive conduct that United increased its rate offers to other local IPAs in a backdoor effort to directly contract with the terminated physicians. (CPF 226-227).

RPF 401 is also incomplete since United obtained copies of Fax Alerts #52 and #56 in which NTSP solicited powers of attorney from all its member physicians and later reported the collection of 107 powers of attorney. (Quirk, Tr. 320-331; *see* CX1051, 1051A).

Furthermore, RPF 401 is irrelevant because it does not have any bearing on the actions NTSP actually took in strengthening its collective bargaining power through its collection of powers of attorney during this time.

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).

Response to Finding No. 402.:

RPF 402 is irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United. Additionally, RPF 402 is misleading in its use of the term "messengered" because it suggests that NTSP's acts were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction to the Health Care Statements' messenger model, and the antitrust laws they embody.

Moreover, the evidence cited in support of RPF 402 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. Other than Van Wagner's unrelieable and self-serving testimony, there is nothing in the record, including NTSP's own documents, that suggests that NTSP's Board minimums were designed to predict a high enough level of participation deemed sufficient to activate NTSP's network. If NTSP's contention were true, NTSP should not have ultimately entered into a contract with United since a very low number of physicians - approximately 10% of the total NTSP membership - accepted United's HMO and PPO offers. (CX1000). In fact, if a high level

of participation were NTSP's true concern, there was no need for NTSP in the first instance to negotiate with United and/or terminate the NTSP physicians since, as of March of 2001, United already had two-thirds of NTSP's physicians under contract. (CPF 174).

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).

Response to Finding No. 403.:

RPF 403 is wholly irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United.

Furthermore, RPF 403 is inaccurate and is not supported by reliable evidence, but rather by self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. Other than Van Wagner's unreliable and self-serving testimony, there is nothing in the record, including NTSP's own documents, that indicates that NTSP reported United to the Texas Department of Insurance ("TDI") in 2000. NTSP approached TDI only after NTSP had already rejected the United offer, terminated its member physicicans' HTPN-United contracts, and solicited powers of attorney from its member physicians. NTSP contacted the Texas Commissioner of Insurance to complain about prices as part of its effort to cause United to succumb to its fee demands. (CPF 247, 257). Moreover, TDI's actions were only applicable to HMOs whereas NTSP's price-fixing conduct was primarily focused on the PPO side. (CPF 179, 239, 251, 254).

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).

Response to Finding No. 404.:

Any issue regarding compliance with state law has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

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)).

Response to Finding No. 405.:

RPF 405 is misleading and incomplete. Negotiations between NTSP and United ended when NTSP's Board rejected United's offer and United refused to capitulate to NTSP's supra-competitive fee demands. (CPF 177, 181, 192, 201). As a result, NTSP terminated a group contract with United via HTPN, solicited powers of attorney to enable it to negotiate "all contracting activity" on behalf of its member physicians with United and orchestrated a public relations campaign against United. (CX1062). In light of all those actions, United was forced to offer ASIA as well as the terminated physicians, all of which United previously had under contract, increased reimbursement rates in order to restore the adequacy of its network. (CPF 182-228). Moreover, NTSP member physicians who signed the powers of attorney were effectively prevented from dealing with United, other than through NTSP. (CPF 223). In fact, many members complied with the powers of attorney and NTSP's recommendations, and when approached by United for direct contracts, referred United back to NTSP as their "contracting agent." (CPF 226-228). Thus, United's direct contracting efforts and even its increased offers to other local IPAs were not enough to remedy the damage caused to United's network. Consequently, United made NTSP a new enhanced offer that was the equivalent of United's offers

to ASIA and MCNT. (CPF 250).

The Fax Alert Respondent cites, CX1074, was sent *after* United expressed to NTSP its antitrust concerns regarding NTSP's activities and further cautioned that it would bring such actions to the attention of the proper state and federal agencies. (CPF 230).

Moreover, some of the evidence cited in support of RPF 405 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding.

Finally, RPF 405 is NTSP's admission that there is no need to meet its price minimums to activate the network. Therefore, there is no need to fix prices to get alleged benefits, as NTSP claims only are available through activating its network.

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)).

Response to Finding No. 406.:

RPF 406 is incomplete and misleading. United approached NTSP again due to NTSP's termination of the HTPN-United contract and the resulting collective pressure United was under from customers to restore its network adequacy. (CPF 250, 257). Although United raised its offered rates to ASIA and MCNT, NTSP understood that this increase was a result of NTSP's anticompetitive activities. (CPF 227).

Furthermore, the offer to MCNT was not an independent move by United, as Respondent suggests. Since 2000, MCNT, a medical group of primary care physicians, was a member of NTSP. Consequently, MCNT physicians (also referred to as "Unity" physicians) were not only aware of NTSP's minimum rates as internally communicated but even contributed to

developing these minimums by participating in NTSP's polling, and had access to NTSP's non-risk contracts. (CX0060 at 5; CX0067 at 5; CX0611; CX1199 (Van Wagner, Dep. at 165-167); CX0617; CX1195 (Van Wagner, Dep. at 69)). Moreover, MCNT received numerous fax alerts in which NTSP expressed its opinion about the financial terms of the United offer (CX1042; CX1051A); and executed powers of attorney for NTSP to collectively negotiate financial terms with United. (CX1002 (MCNT physicians listed among physicians executing powers of attorney for NTSP in connection with the United offer)).

Therefore, NTSP and MCNT staff shared views about the appropriateness or inappropriateness of the United offer, as evidenced by NTSP's own documents. (*See* CX1016).

RPF 406 is additionally misleading in its use of the term "messengered" because it suggests that NTSP's acts were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction to the Health Care Statements' messenger model, and the antitrust laws they embody.

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).

Response to Finding No. 407.:

RPF 407 is wholly irrelevant because it has no bearing on NTSP's price-fixing conduct in its negotiations with United. RPF 407 is also vague as to when such an agreement was made; therefore RPF 407 may also be irrelevant on the basis of the time period involved.

Furthermore, NTSP has never performed any utilization management, quality control management or disease management services for United's patients. (CPF 173).

The evidence cited in support of RPF 407 is self-serving testimony from Karen

Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding.

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).

Response to Finding No. 408.:

RPF 408 is inaccurate in part. CIGNA acquired Health Source in late 1997, not 1999. With that correction, Complaint Counsel does not disagree with the proposed finding.

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).

Response to Finding No. 409.:

RPF 409 is misleading in part. CIGNA sent letters to doctors who had a contract with Healthsource requesting that they permit assignment of their Health Source contracts with CIGNA. (Grizzle, Tr. 696-697). By requesting the physicians' consent for the assignment, it was clear to CIGNA that the physicians could – and did in some cases – refuse assignment. (Grizzle, Tr. 768).

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).

Response to Finding No. 410.:

RPF 410 is incomplete and misleading. NTSP learned of the letters and orchestrated a concerted refusal of its member physicians to assign their Health Source contracts to CIGNA in order to negotiate as a collective on behalf of the membership (Van Wagner, Tr.

1752; CX0332). NTSP provided and sent to its members a sample letter refusing the contract assignment and directing CIGNA to negotiate with NTSP as their agent, as well as an agency agreement that authorized NTSP to negotiate on the behalf of consenting members. (In the same communication, NTSP informed its members that termination of the members' Health Source provider agreements would risk "depleting [CIGNA's] Health Source provider network.").

In response to the assignment letters, CIGNA received 40 letters all virtually identical to the sample letter provided by NTSP, representing more than 50 NTSP member physicians, in which NTSP physicians refused to assign to CIGNA the Healthsource agreement, and directed CIGNA to negotiate with NTSP on their behalf. (CX0760 (verbal acts); Grizzle, Tr. 696-698, 709, 724). After receiving these letters, CIGNA realized that the NTSP physicians would not directly contract with CIGNA and that CIGNA would need to deal with NTSP. (Grizzle, Tr. 697, 709-710, 747). As a result of NTSP's collective negotiations, CIGNA entered into a contract with NTSP that had rates significantly higher than CIGNA's standard physician rates in Fort Worth. (Grizzle, Tr. 715-716; Grizzle, Tr. 723-724).

411. NTSP sought a risk contract with Cigna, beginning in 1999. (Grizzle, Tr. 775; Van Wagner, Tr. 1754-55; CX 763, *in camera*).

Response to Finding No. 411.:

RPF 411 is not relevant and complete. While CIGNA had at various times hoped to negotiate a risk contract with NTSP, CIGNA entered into several collectively-negotiated, fee-for-service contracts with NTSP that had significantly higher rates than CIGNA's other Fort Worth contracts. (Grizzle, Tr. 715-716; Grizzle, Tr. 723-724). These contracts – the Letter of Agreement, the First Addendum, and the Second Addendum – were fee-for-service contracts that did not contain any risk-sharing elements. (CX0764, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04);* CX0769; CX0771 at 1, *in camera (Order on Non-*

Party CIGNA's Motion for In Camera Treatment, 04.23.04)).

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).

Response to Finding No. 412.:

RPF 412 is both misleading and irrelevant. While NTSP and CIGNA did discuss a potential risk-sharing arrangement since 1999, Mr. Grizzle did not testify that "most" of NTSP and CIGNA's discussions from 1999 to 2003 related to risk contract proposals. In fact, Mr. Grizzle testified that CIGNA's risk-sharing discussions were separate from negotiations relating to CIGNA and NTSP's fee-for-service contracts. (Grizzle, Tr. 809). Notwithstanding this mischaracterization, the amount of time that CIGNA and NTSP spent discussing a separate risk-sharing agreement is not relevant because the evidence is indisputable that CIGNA entered into several collectively-negotiated, fee-for-service contracts with NTSP that had significantly higher rates than CIGNA's other Fort Worth contracts. (Grizzle, Tr. 715-716; Grizzle, Tr. 723-724).

413. NTSP and Cigna entered into a Letter of Agreement (LOA) in October of 1999. (Van Wagner, Tr. 1756; CX 782A, *in camera*).

Response to Finding No. 413.:

Complaint Counsel does not disagree with RPF 413.

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).

Response to Finding No. 414.:

Complaint Counsel does not believe that RPF 414 is relevant and complete. While the LOA contemplated entering into a risk-sharing agreement relatively quickly, NTSP and CIGNA were unable to agree to a risk-sharing arrangement and thus the fee-for-service LOA

continues to operate. (CX0764, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*). In addition, the LOA only covered fee-for-service rates for CIGNA's HMO business and not its PPO business. The First Amendment, which was entered into in January of 2000, was a fee-for-service contract between NTSP and CIGNA that did not contemplate a risk-sharing agreement in the future. (CX0769). Thus, the evidence is indisputable that CIGNA entered into collectively-negotiated, fee-for-service contracts with NTSP that had significantly higher rates than CIGNA's other Fort Worth contracts. (Grizzle, Tr. 715-716; Grizzle, Tr. 723-724).

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*).

Response to Finding No. 415.:

Complaint Counsel does not disagree with RPF 415.

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).

Response to Finding No. 416.:

Complaint Counsel does not disagree with RPF 416.

417. The 1999 LOA was amended in January of 2000 (first amendment) to add a PPO product. (CX 769).

Response to Finding No. 417.:

Complaint Counsel does not disagree with RPF 417.

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*).

Response to Finding No. 418.:

With regard to the use of the term "breached," RPF 418 encompasses a legal conclusion and thus is inappropriate for findings of fact, and should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs.

While there was an issue between CIGNA and NTSP regarding fee schedules, this issue was resolved and the LOA has not been terminated by either party and is still in effect today. (Grizzle, Tr. 797; Van Wagner, Tr. 1758).

419. Cigna's payment problems continued until December of 2000, when NTSP requested a schedule of compliance. (CX 792, *in camera*).

Response to Finding No. 419.:

Complaint Counsel does not disagree with the proposed finding.

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).

Response to Finding No. 420.:

With regard to the use of the term "breached," RPF 420 encompasses a legal conclusion and thus is inappropriate for findings of fact, and should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. In addition, RPF 420 is incorrect and misleading. The First Addendum to the LOA did not require that the PPO fee schedule be adjusted annually, while the Second Addendum, entered into two months after the First Addendum, explicitly called for an annual adjustment of HMO rates. (CX0769; CX0771, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*; Grizzle, Tr. 714; Grizzle, Tr. 740). Thus, CIGNA was not in violation of any term in the First Addendum. (Grizzle, Tr. 740).

421. The 1999 LOA was amended in May of 2000 (second amendment) {[redacted]} (CX 770, *in camera*).

Response to Finding No. 421.:

RPF 421 is incomplete and misleading. CIGNA and NTSP entered into the Second Amendment because the HMO contract was set to expire in April of 2000. The Second Amendment continued NTSP and CIGNA's HMO contract and explicitly called for adjusting the HMO schedule to current year RBRVS. (CX0771, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*). In the middle of 2001, even though the First Addendum did not require that the PPO rates be adjusted to current year RBRVS, NTSP demanded that CIGNA adjust the PPO rates annually. (Grizzle, Tr. 740). In order to maintain its critical relationship with NTSP, CIGNA immediately agreed to adjust the PPO rates annually. (Grizzle, Tr. 740-741, CX800 at 2).

422. {[redacted]} (Grizzle, Tr. 927, *in camera*; Van Wagner, Tr. 1764-66).

Response to Finding No. 422.:

Complaint Counsel does not disagree with RPF 422.

423. Cigna breached the LOA {[redacted]} 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*).

Response to Finding No. 423.:

With regard to the use of the term "breached," RPF 423 encompasses a legal conclusion and thus is inappropriate for findings of fact, and should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. In addition, RPF 423 is incorrect and misleading. The LOA does not

explicitly deal with an assignment of the carve-out. (CX0764, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*). CIGNA believed that the LOA did not allow NTSP's cardiologists to join the CIGNA fee-for-service contract if the carve-out was assigned. (Grizzle, Tr. 725).

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*).

Response to Finding No. 424.:

Complaint Counsel does not disagree with RPF 424.

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).

Response to Finding No. 425.:

Complaint Counsel agrees that the contract between CIGNA and APN was a risk contract but disagrees that the subsequent discussions between NTSP and APN related to a risk contract. APN offered NTSP a fee-for-service schedule for its cardiologists that was not a risk-sharing contract. (Grizzle, Tr. 933-934, Van Wagner, Tr. 1768). NTSP rejected APN's offer and sent a letter to APN, stating that the offer "was shared with affected members of NTSP's Cardiology Division and NTSP's board. At this point, we must decline your proposal as it does not meet our minimum reimbursement levels." (CX0349; CX0777A; Grizzle, Tr. 726-727).

426. NTSP's contract with Cigna provided, {[redacted]} (RX 20, *in camera*).

Response to Finding No. 426.:

Complaint Counsel does not disagree with RPF 426.

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

Response to Finding No. 427.:

RPF 427 is misleading and inaccurate. Rick Grizzle testified that CIGNA defined family practitioners, internal medicine physicians, and pediatricians as primary care physicians rather than specialists. (Grizzle, Tr. 780-781).

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).

Response to Finding No. 428.:

With regard to the use of the term "breached," RPF 428 encompasses a legal conclusion and thus is inappropriate for findings of fact, and should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. In addition, RPF 428 is incorrect and misleading. At the time of the LOA, NTSP's membership did not include primary care physicians. At the time of the contract, CIGNA already had signed up an adequate number of primary care physicians – many of whom later joined NTSP – and did not need additional ones. (Grizzle, Tr. 733-734; Grizzle, Tr. 718-719). If NTSP's primary care physicians were allowed to participate in the NTSP/CIGNA contract, CIGNA's costs would increase significantly. (Grizzle, Tr. 733-734; Grizzle, Tr. 718-719). Accordingly, the LOA did not include a clause that allowed primary care physicians to participate in the NTSP/CIGNA contract and CIGNA did not believe that they were permitted to participate. (Grizzle, Tr. 718).

Van Wagner offered her own definition of the contractual term "specialist," as it appears in the CIGNA contract, to justify NTSP's attempts to pressure CIGNA to include primary

care physicians in the contract. (Van Wagner, Tr. 1762-1763). Van Wagner testified that the term "specialist," {[redacted]} (CX0771, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*), references a defined term in NTSP's Participation Agreement and Bylaws. (Van Wagner Tr. 1762-1763). Not only does NTSP's Participation Agreement fail to contain a defined term for "specialist;" but NTSP's bylaws actually contain *separate* definitions for "Medical Specialty Physicians" and "Primary Care Physician or PCP." (CX0311; CX0275 at 5 ("The term Primary Care Physician" or "PCP" shall mean those Participating Physicians who provide primary care medical services.")).

429. {[redacted]} (Grizzle, Tr. 940-42, *in camera*).

Response to Finding No. 429.:

RPF is inaccurate and misleading. {[redacted]}

(Grizzle, Tr. 940-942, *in camera* (*see Grizzle, Tr. 752-754*)).

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).

Response to Finding No. 430.:

With regard to the use of the term "breached," RPF 430 encompasses a legal conclusion and thus is inappropriate for findings of fact, and should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. In addition, RPF 430 is incorrect and misleading. NTSP wanted CIGNA to allow the NTSP primary care physicians to opt in to the CIGNA contract even though CIGNA

already had many of these same physicians already under a lower fee contract. (Grizzle, Tr. 733-734). These primary care physicians were not part of the original CIGNA and NTSP contractual arrangement. (Grizzle, Tr. 733, 749). NTSP's demand would have increased CIGNA's cost significantly without providing any benefit to CIGNA and thus CIGNA refused to allow NTSP's primary care physicians to opt in to the higher fee contract. (Grizzle, Tr. 734). In response, NTSP orchestrated and executed a concerted refusal to deal, terminating the NTSP/CIGNA PPO contract for the stated purpose of securing the inclusion of NTSP's primary care physicians. (CX0802, Grizzle, Tr. 749). Not only does NTSP's Participation Agreement fail to contain a defined term for "specialist;" but NTSP's bylaws actually contain *separate* definitions for "Medical Specialty Physicians" and "Primary Care Physician or PCP." (CX0311; CX0275 at 5 ("The term Primary Care Physician" or "PCP" shall mean those Participating Physicians who provide primary care medical services.")).

431. The 1999 LOA was amended in August of 2001 (third amendment) {[redacted]} (Grizzle, Tr. 942-43, *in camera*; Van Wagner, Tr. 1771; CX 809, *in camera*).

Response to Finding No. 431.:

RPF 431 is inaccurate and misleading. CIGNA and NTSP's original agreement permitted only NTSP's "specialists," not primary care physicians to participate in the contract. (CX0764, *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 04.23.04)*. Thus, the Third Amendment did not honor the original contract. Instead, as a result of NTSP's termination notice and its critical importance to CIGNA's network, CIGNA succumbed to NTSP's demands by agreeing to negotiate a third amendment to the NTSP/CIGNA contract which allowed for the inclusion of NTSP's primary care physicians, and the future inclusion of

specialists who were previously carved-out of the CIGNA contract. (Grizzle, Tr. 749-751; Van Wagner, Tr. 1771; CX0810 *in camera (Order on Non-Party CIGNA's Motion for In Camera Treatment, 06.29.04)*).

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

Response to Finding No. 432.:

With regard to the use of the term "breached," RPF 432 encompasses a legal conclusion and thus is inappropriate for findings of fact, and should be disregarded pursuant to *Chicago Bridge and Iron Co.*, Docket 9300 (June 12, 2003) and this Court's May 26, 2004 Order on Post Trial Briefs. In addition, RPF 432 lacks evidentiary support because Van Wagner, Tr. 1770 does not reference CIGNA's primary care physician capitation payments.

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).

Response to Finding No. 433.:

RPF 433 is incomplete and misleading. {[redacted]} (Grizzle, Tr. 755, 879-880, *in camera (see Grizzle, Tr. 752-754)*). {[redacted]} (Grizzle, Tr. 882-883, *in camera (see Grizzle, Tr. 752-754)*). {[redacted]} (Grizzle, Tr. 881-882, *in camera (see Grizzle, Tr. 752-*

754)). {[redacted]} (Grizzle, Tr. 880, *in camera (see Grizzle, Tr. 752-754)*, 896, *in camera (See Grizzle, Tr. 752-754)*).

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).

Response to Finding No. 434.:

RPF 434 is inaccurate and misleading. NTSP's CIGNA contract did not provide significant incentives for NTSP to improve performance under the contract. {[redacted]} (Grizzle, Tr. 755, 879-880, *in camera (See Grizzle, Tr. 752-754)*). {[redacted]} (Grizzle, Tr. 881-882 *in camera (see Grizzle, Tr. 752-754)*). {[redacted]} (Grizzle, Tr. 880, *in camera (see Grizzle, Tr. 752-754)*, 896, *in camera (See Grizzle, Tr. 752-754)*).

435. {[redacted]} (Grizzle, Tr. 946-47, *in camera*; Van Wagner, Tr. 1974).

Response to Finding No. 435.:

Complaint Counsel does not disagree with RPF 435.

436. {[redacted]} (Grizzle, Tr. 946-47, *in camera*; Van Wagner, Tr. 1974). NTSP missed the bonus by only $3 PM/PM. (Van Wagner, Tr. 1974-75).

Response to Finding No. 436.:

Complaint Counsel does not disagree with the first sentence of RPF 436. With regard to the second sentence, Van Wagner's statement regarding how close NTSP was to making their targets is not supported by documents or Grizzle's testimony. In any event, NTSP failed to meet these targets or any subsequent performance based targets.

437. {[redacted]} impossible to reach. (Grizzle, Tr. 947-48, *in camera*; Van Wagner, Tr. 1974-76).

Response to Finding No. 437.:

RPF 437 is inaccurate and misleading. CIGNA did not believe that the targets should be revised and thus they were not changed. (Grizzle, Tr. 947-48, *in camera*; Van Wagner, Tr. 1974-76). In addition, Van Wagner's testimony is not supported by the documents or other testimony; in fact, [redacted]).

438. {[redacted]} (Grizzle, Tr. 886, 945-46, *in camera*; Van Wagner, Tr. 1525-26).

Response to Finding No. 438.:

Cigna has not provided the PPO data because it is not possible to gather this data in

a meaningful way. HMO flat file data is gathered through the primary care physician gatekeeper. Without the gatekeeper, there is no way to track a patient and procedures in a meaningful way. Cigna's PPO program does not utilize a gatekeeper function. Thus, the PPO flat file data does not exist in a form that would be useful or meaningful in terms of monitoring physician performance and utilization. (Grizzle, Tr. 756).

439. Based on Cigna's data, NTSP runs cost analyses, code patterns, and high-acuity patient reports for individual providers. (Van Wagner, Tr. 1532).

Response to Finding No. 439.:

RPF is incomplete and not supported by the evidence. CIGNA has not seen any analysis that NTSP has done with this data and is not aware of any analysis. (Grizzle, Tr. 755-756). Van Wagner's testimony is not supported by the documents or other testimony.

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).

Response to Finding No. 440.:

Complaint Counsel believes that RPF 440 is irrelevant.

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).

Response to Finding No. 441.:

Complaint Counsel believes that RPF 441 is irrelevant.

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. 1772-1773).

Response to Finding No. 442.:

Complaint Counsel believes that RPF 442 is irrelevant.

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)).

Response to Finding 443:

RPF 443 is irrelevant because NTSP's negotiation of risk contracts with Blue Cross is not a relevant issue in this case.

444. NTSP is currently in discussions with Blue Cross regarding a risk contract. (Van Wagner, Tr. 1719-20).

Response to Finding 444:

RPF 444 is irrelevant because NTSP's negotiation of risk contracts with Blue Cross is not a relevant issue in this case. Also, RPF 444 is irrelevant in that it refers to prospective actions.

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).

Response to Finding 445:

RPF 445 is irrelevant as well as unreliable. At trial, Van Wagner specifically did not recall the concrete offer made by Blue Cross. (Van Wagner, Tr. 1721). Moreover, the only evidence cited in support of RPF 445 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding. (*See also* CPF 72).

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).

Response to Finding 446:

RPF 446 is irrelevant as well as unreliable. The terms of the HTPN offer are unclear from the two documents cited by Respondent. (RX1275; CX0416). If anything, RPF 446 is NTSP's admission that there is nothing, other than its price-fixing activity and the desire to negotiate higher prices, to prevent NTSP from messengering health plan offer to its members, even below its set minimums. RPF 446 is NTSP's admission that in fact NTSP had the discretion to decide when, and under which circumstances, a health plan offer will be sent out to the members to opt in/out.

The use of the term "messengered" in RPF 446 is misleading because it suggests that NTSP's actions were in compliance with the Health Care Statements' messenger model, while in fact NTSP's price-fixing activity, including the use of polls and its setting of Board minimum prices, is in direct contradiction to the Health Care Statements' messenger model and the antitrust laws they embody.

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).

Response to Finding 447:

RPF 447 is irrelevant and also unreliable in that the only evidence cited in support of RPF 447 is self-serving testimony from Karen Van Wagner, a witness with substantial personal and financial interest in the outcome of this proceeding.

RPF 447 is again admission by NTSP that its price-fixing activity is not necessary to activate the network.

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)).

Response to Finding 448:

RPF 448 is inaccurate and unreliable in that Van Wagner's testimony did not address Blue Cross' contracting needs in Tarrant County (Van Wagner, Tr. 1720). The document offered by NTSP in support of RPF 448 was authored *by NTSP*, not by Blue Cross (CX0709), and is unreliable to the extent it purports to address Blue Cross' contracting needs in Tarrant County. Moreover, even if Blue Cross did not enter into a direct non-risk contract with NTSP, this says nothing about Blue Cross' need for NTSP's *physicians*. (*See*, by analogy, CRF 405). In fact, the greater weight of the evidence shows that health plans must have NTSP *physicians* to serve Fort Worth clients (CPF 91).

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))

Response to Finding 449:

RPF 449 is irrelevant; additionally, NTSP has cautioned its physicians to avoid undermining NTSP solidarity and its pricing consensus. (*See* CPF 131).

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).

Response to Finding 450:

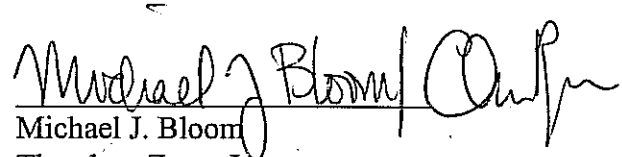
RPF 450 is irrelevant. Any issue regarding compliance with state law has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

451. NTSP's review of Blue Cross contracts intensified after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-73).

Response to Finding 451:

RPF 451 is inaccurate and misleading. Van Wagner did not testify about how NTSP's review of Blue Cross contracts changed, if at all, after contacts with the Texas Department of Insurance. (Van Wagner, Tr. 1772-1773). Moreover, any issue regarding compliance with state law has no bearing on, and does not in any way justify, the price-fixing charges detailed in the Complaint. Further, the alleged prior extrinsic acts of a health plan should have little or no weight. *See* Fed. R. Evid. 608(b).

Respectfully submitted,



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July 8, 2004

CERTIFICATE OF SERVICE

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

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

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

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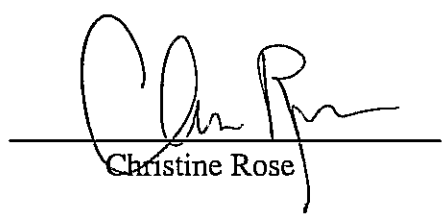
and by email upon the following: Gregory S. C. Huffman (gregory.huffman@tklaw.com), William Katz (William.Katz@tklaw.com), and Gregory Binns (gregory.binns@tklaw.com).



Christine Rose