UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

IN THE MATTER OF CALIFORNIA PACIFIC MEDICAL GROUP, INC. DBA BROWN AND TOLAND MEDICAL GROUP, A CORPORATION.

FTC Docket No. 9306

COMMENTS OF CITIZENS FOR VOLUNTARY TRADE

Proposed Consent Order Announced February 9, 2004
Comments Filed March 10, 2004

Pursuant to 16 C.F.R. § 3.25(f) and the Federal Trade Commission's publication of a proposed consent agreement in the above-captioned matter[1], Citizens for Voluntary Trade, a Virginia nonprofit corporation, files the following comments.

Relevant Facts

An independent practice association, or IPA, is a group of physicians and other health care providers, including hospitals, who contract with a managed care organization, such as a health maintenance organization (HMO) to provide services for managed care subscribers. Some IPAs share financial risk among its physician members, while others do not.

In 1992 four San Francisco IPAs merged into a 692-member IPA called California Pacific Medical Group (CPMG). By 1996, CPMG's patient base included about 135,000 subscribers. In August 1996, CPMG's members, all private practice physicians, merged with the University of California at San Francisco Medical Group, who were doctors employed by that university's hospital. The new IPA, called Brown & Toland Medical Group (BTMG), began operating in 1997 and included contracts with 14 HMOs representing about 178,000 subscribers. BTMG's network was composed of about equal numbers of private-practice and UCSF physicians.

[1] 69 Fed. Reg. 7,485-7,488 (Feb. 17, 2004).

The 1996 merger resulted in BTMG assuming control of UCSF's management organization, which handled services such as bill processing, filing reports, and paying member physicians their fees. BTMG converted this management organization into a for-profit entity in 1997, but this venture quickly ran into financial trouble. BTMG had difficulty financing its for-profit organization, however, and the IPA incurred a $4.5 million loss in October 1998. UCSF Stanford Health Care Center, the hospital employing BTMG's members, reportedly covered their physicians for losses related to this incident, an amount estimated at about $1 million. BTMG has since reduced the scope of its management organization, and BTMG claims it is no longer losing money. BTMG's reported 2002 revenue was $189 million.

In recent years, California consumers have left HMOs in favor of other types of managed care organizations. Dr. Kevin Grumbach, a UCSF professor and director of the Center for California Health Workforce Studies, described the change in the managed care climate in a December 2002 survey: "California led the nation's charge into managed care. Our study of the state's physicians tells us that California has now sounded the retreat . . . Private physicians are starting to abandon HMOs, IPAs and managed care networks".[2] One place physicians started going was preferred-provide organizations, or PPOs.

BTMG offered a traditional HMO product, but when those revenues began to decline in the late 1990s, the IPA began to offer a PPO product as well. PPOs allow individual consumers to choose from among multiple physicians within a network, while physicians receive a discounted fee for each patient treated. Many businesses that insure their employees prefer the PPO model because it is subject to less regulatory requirements than HMOs, and specific benefits can be added or dropped to control costs.

Because BTMG includes more than 1,500 providers, including about 650 in its PPO network, the FTC opened a formal investigation in 2002 to determine whether or not the PPO network complied with federal antitrust laws. After several months of negotiations, the FTC decided to file an administrative complaint against BTMG in July 2003, charging the IPA with violating §5 of

[2] "California Physicians are Dropping Out of Managed Care, According to UCSF Researchers". Available at http://www.futurehealth.ucsf.edu/press_releases/CWIdroppingout.html (December 2, 2002).

the Federal Trade Commission Act, which generally prohibits unfair methods of competition.

The FTC's complaint alleged that BTMG's PPO network was, in reality, a scheme to collectively fix and raise the prices for physician services in the San Francisco market. Under a 1993 FTC policy, any joint contracting by physicians with third-party payers is generally condemned as an antitrust violation, unless certain criteria are met regarding a groups' structure and business operations. BTMG initially rejected the FTC's argument, claiming the PPO was designed expressly to comply with federal antitrust policy.

In December 2003, BTMG and the FTC withdrew this case from adjudication, and opted to settle on terms favorable to the Commission. The proposed order now before the FTC prevents BTMG from jointly contracting with any third-party payer or insurer without the prior consent of the FTC. The proposed order states any future joint contracting by BTMG must be accompanied by significant pooling of financial risk or clinical integration. The FTC claims the proposed order will restore competition and lower consumer prices.

CVT's Standard of Analysis

Citizens for Voluntary Trade is a nonprofit, nonpartisan educational organization that analyzes antirust and competition laws from a pro-reason, pro-capitalism perspective. CVT seeks to expand the general public's understanding of these laws by providing meaningful context to individual cases, such as this one, where the rights of businesses are adjudicated in an administrative setting outside the courts and the marketplace. Our analysis serves both as an intellectual check on the work of the Federal Trade Commission, and as a means of applying the ethical values of reason, individual rights, and capitalism to contemporary public policy issues.

In analyzing the proposed order, CVT applies a standard of analysis consistent with our pro-reason, pro-capitalism approach to public policy. This means three things. First, we presume reason is man's only means of knowledge, and thus reason is the only objective standard for determining ethical values. Second, consistent with a reason-based epistemology and ethics, we presume men do not have the right to initiate force against one another, and that in an economic context, this means men must

deal with one another as *traders* who engage in voluntary exchange free of coercion. Finally, based on the first two criteria, we presume the only political system that promotes rational ethics and voluntary trade is one where the *sole* function of government is to identify and protect *individual rights*.

The United States Constitution, read in conjunction with the principles set forth in the Declaration of Independence, provide the framework for a government that satisfies the criteria stated above. Accordingly, the proposed order must ultimately be reconciled with the Constitution and its animating principles. To the extent particular statutes, including the Federal Trade Commission Act and related rules, conflict with the Constitution, we treat the constitutional principles as controlling.

Comments

CVT will address three questions in these comments: First, does the FTC's complaint state adequate grounds for prosecuting this case and obtaining relief; second, will the public benefit from the terms of the settlement; and third, did the FTC adequately protect the constitutional rights of BTMG in this proceeding. For the reasons set forth below, CVT answers all three of these questions in the negative.[3]

Comment 1: The complaint fails to state any rational basis for entering the proposed order.

Before the FTC can justify the terms of the consent order, it must first establish that a reasonable basis existed to charge BTMG with violating §5 of the FTC Act. Because more than 90% of FTC cases are settled without trial, CVT considers it essential to review the FTC's exercise of prosecutorial discretion. We conduct this review based only on the facts alleged in the complaint, BTMG's answer, the settlement documents, and any information independently obtained and verified by CVT. We give no deference to the FTC conclusions of law based on the political views of the

[3] CVT considered addressing a fourth question—does the FTC have jurisdiction in this matter—but because BTMG never challenged jurisdiction, either in its answer to the complaint or in the proposed order, we decline to address the issue here. For the record, however, CVT reiterates its general objection to the use of federal antitrust laws to govern the economic relationship between doctors within a single state or locality, given that state governments extensively regulate such relationships already.

commissioners, antitrust theories that lack substantial factual support, or speculation as to future events outside the FTC or BTMG's control.

a. Market definition.

In any antitrust case, the government or private plaintiff must first define the specific market allegedly harmed by the defendant's conduct. Although the "marketplace" conceptually incorporates all trade in all industries, for purposes of assessing a particular case, it is useful and necessary to define the particular geographic and economic sub-markets involved.

The FTC's complaint alternatively states the geographic market in this case as the "San Francisco metropolitan area" (paragraph 8) and the "city of San Francisco, California" (paragraph 22). It is unclear if the FTC considers the San Francisco "metropolitan area" the same geographic region as the city of San Francisco. The Bureau of the Census states the "San Francisco Metropolitan Statistical Area" (hereafter "SFMSA") is comprised of San Francisco, San Mateo, and Marin counties.[4] Because BTMG admitted it has affiliated physicians and HMO customers located "outside of San Francisco", we consider the SFMSA the geographic market in this case. The SFSMA has an estimated population of 1.79 million.

CVT does not have specific information regarding the number of licensed physicians within the SFMSA. According to the American Medical Association, however, there are approximately 91,000 non-federal physicians in the state of California.[5] Since physicians licensed in California may practice anywhere in the state—there's no legal distinction between a San Francisco doctor and a Los Angeles doctor—we presume the market for "physician services" includes the estimated 91,000 non-federal physicians residing within the state.

BTMG says 630 of its approximately 1,500 physicians participate in the PPO network at issue in this case. These 630 physicians thus constitute about .06% of all physicians within the relevant market. This figure obviously does not account for the actual wealth generated by the BTMG physicians within the SFMSA—

[4] The SFMSA's principal cities include San Francisco, Oakland, Freemont, Hayward, Berkley, San Mateo, San Leandro, Redwood City, Walnut Creek, Pleasanton, South San Francisco, and San Rafael.

[5] Non-federal physicians excludes physicians working directly for the federal government.

presumably they enjoy a greater market share than physicians outside the region—but in the absence of any statistical information from the FTC proposing a narrower construction of the market, CVT must judge the available figures. And these figures clearly demonstrate BTMG holds nothing approaching "monopoly power" or even sufficient numbers to unilaterally determine market prices.

b. Legal standard.

Section 5 of the FTC Act prohibits "[u]nfair methods of competition in or affecting commerce".[6] The precise definition of "unfair" competition is left largely to the FTC's discretion. In this case, the FTC claims that it was unfair for BTMG "to agree collectively on the prices and other competitively significant terms on which [BTMG physicians] would enter into contracts with health plans or other third-party payors".[7] The FTC concluded this conduct was unfair, and thus banned by §5, because it "had the purpose and effect of raising prices for physician services in San Francisco, California".[8]

A federal law is not valid under the U.S. Constitution unless it enables a rational citizen to understand *ex ante* what conduct is illegal. Thus, the FTC must have precisely and clearly defined "unfair competition" prior to BTMG's alleged transgressions of §5. Although the FTC cites no specific authority or definition in its complaint, we assume the Commission acted under its 1993 Statements of Antitrust Enforcement Policy in Health Care (the "Statements")[9], which reflect the policy views of the FTC and the Department of Justice's Antitrust Division. The Statements generally treat physician joint negotiating a *per se* antitrust violation in the absence of an unspecified level of "risk-sharing integration". In other words, unless physicians share financial risk by joining their practices at a clinical level, they are banned from jointly contracting with insurers and payers.

Before the government may regulate a business practice, it must first establish the constitutional and statutory authority to regulate at all. Here the FTC (and DOJ) constructed a two-part justification for the Statements' policy: First, the Statements presume physician

[6] 15 U.S.C. § 45(a)(1).
[7] Complaint, para. 1.
[8] *Id.*
[9] Available at http://www.ftc.gov/reports/hlth3s.htm.

joint contracting with payers is price fixing, a long-established *per se* violation of the Sherman Act; and second, the FTC treats all Sherman Act violations as "unfair competition" under §5.

In its answer to the complaint, BTMG did not contest the Statements or the FTC's view of physician contracting. Instead BTMG argued that it had complied with the Statements, and that its PPO network conducted itself "ancillary to a lawful joint venture". Gloria Austin, BTMG's chief executive, said in July 2003 that BTMG "developed our PPO model within the guidelines of the FTC and we firmly believe our model is good for patients and physicians".

The FTC disputed BTMG's claims that the PPO network had sufficient clinical integration to justify joint contracting activities. The complaint stated that the PPO physicians "do not share financial risk in connection with the provision of services to PPO enrollees" (paragraph 11). The complaint said that even if BTMG achieved clinical efficiencies in its other managed-care services, there was no "ongoing mechanism to ensure that those potential efficiencies are replicated in services provided by the PPO network" (paragraph 12). BTMG denied this allegation, but said it lacked adequate information to conclude whether its PPO members shared financial risk.[10]

The debate over BTMG's financial and clinical risk-sharing raises three questions: What constitutes enough risk-sharing and clinical integration to protect a physician group from antitrust prosecution? Does a lack of adequate risk-sharing support the conclusion that physician joint contracting is "unfair" competition? And did BTMG make a good-faith effort to comply with the rules set forth by the FTC?

On the first question, CVT finds there is no conclusive answer. Since there is no constitutional or statutory support for the FTC's requirement that physicians share financial risk as a precondition to any lawful joint contracting, the Commission is the sole arbiter of what constitutes "enough" risk-sharing. But neither the Statements nor the FTC's filings in this case provide an adequate definition. This is not a new problem. Physicians and attorneys that specialize in healthcare antitrust policy have long been unsure of the FTC's specific requirements for risk-sharing. Joseph Ardery of the law firm Frost Brown Todd recently wrote, in response to another

[10] Answer at 6.

pending FTC complaint against a physician group, said that the Statements are "helpful", but:

> they establish few bright line tests. Many physicians are left wondering: "What is the minimal amount of integration that I have to achieve with that other practice group, short of billing through a single entity, in order to work with them in negotiating the prices in our payor contracts?"[11]

CVT cannot answer this question. And despite developing their PPO model over several years in consultation with presumably competent antitrust attorneys, neither could BTMG. This leads us to infer that the FTC's standards for physician risk-sharing is insufficiently clear as to provide physicians with meaningful guidance on how to avoid antitrust prosecution.

The second question we asked bears substantial relation to the first. Since the FTC's risk-sharing guidelines are at best vague, there is a strong presumption against relying on them to support a charge of "unfair competition" against BTMG. At a minimum, fairness requires that all parties subject to a rule can reasonably understand the rule's meaning. Additionally, fairness implies that all parties to a rule are held to the same standard of conduct. It's unfair, for example, if a baseball game pitted a team of nine players against a team of six. But conversely, it is fair for a hockey team to play without one or two players as the consequence of a penalty. And in an regulatory context, it is unfair when the government subjects similarly-situated businesses to different rules of conduct, but unfairness is not an issue when businesses treated equally before the law produce different profit levels. Fairness does not require equal outcomes, only equal and non-discriminatory access.

In this case, the FTC-DOJ Statements intentionally subject physicians to different standards than those of the insurers and payers physicians contract with. On the legislative level, Congress has encouraged the formation of managed-care organizations through a combination of taxpayer subsidies, preferential tax treatment, and antitrust exemptions. Physicians do not enjoy this level of privilege, thus they come to the bargaining table in an "unfair" position. The FTC's policies compound this unfairness by

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[11] Joseph L. Ardery, "FTC Allegation of Physician Price Fixing May Lead to Useful Guidance". Available at http://www.frostbrowntodd.com/practice_areas/pdfs/MedNews_9-03Ardery.htm.

requiring an unspecified level of risk-sharing before physicians can meet payers on a more-even footing at the bargaining table. Put another way, individual customers can jointly contract through large insurers, but physicians don't enjoy the reciprocal ability to jointly contract with consumers. This is the most basic test of fairness there is. Accordingly, we conclude that BTMG's alleged failure to share risk and clinically integrate, even if true, does not constitute an adequate basis for maintaining a §5 claim.

The third question we raised—did BTMG make a good-faith effort to comply with FTC policy—does not directly address the question of whether the FTC is correct on the law. Having just concluded that the Commission erred above, we need not address that issue further. The question of good faith, however, goes to the FTC's exercise of prosecutorial discretion. Assuming that the FTC's risk-sharing standards were clear, and that BTMG violated them, the Commission's decision to issue a §5 complaint was, at best, a highly questionable allocation of the Commission's resources and staff. The record indicates that BTMG made every effort to comply with the FTC's rules—as BTMG could reasonably understand them—and that BTMG acted in good faith in its dealings with the FTC. BTMG's 2002 annual report discusses its efforts to comply with the FTC's policy:

> Physicians, often overworked and focused on clinical issues, are not well prepared or staffed to negotiate contracts with payors. Additionally, individual physicians often find it difficult to work with large payors and our HMO physicians have been frustrated with PPO payors because of "take it or leave it" contracts with substandard terms.
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> In response to these concerns, Brown & Toland began to build a new health care model to provide the same clinical and financial integration that we have for the HMO product to all health care insurance products. Because PPOs have been gaining significant market strength, our first step was to initiate a PPO model that would lead to full integration. This model was built with guidance from the law firm of Hanson Bridgett and we believe that our model follows the guidelines put forth by the Federal Trade Commission (FTC).We used the outside consultants

> of the Healthcare Practice Enhancement Network (HPEN), which surveyed physicians and medical groups in California to independently set fair market parameters for financial terms. Since 2002, on behalf of the Brown & Toland PPO network, a subset of the HMO physician network, Brown & Toland has been able to negotiate fair terms. Currently, Brown & Toland has seven PPO contracts. We have established that Brown & Toland PPO participating physicians apply many of the HMO tools acquired through membership in Brown & Toland to all of their BTMG patients – both HMO and PPO. This PPO contracting success brings us one step closer to the goal of full integration for these products.
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> We have been in communication with the FTC regarding our model and the agency has expressed concern about our ability to negotiate PPO contracts. We believe that we are following the current FTC guidelines appropriately. It is vital, however, that the FTC clarifies its guidelines for IPAs. We feel strongly that the complex medical environment requires that the FTC evolve to more clearly support the development of appropriate models for IPAs such as Brown & Toland so we can continue to provide benefits for consumers, regardless of the product.

The FTC has unrestricted discretion when deciding to issue an administrative complaint in §5 cases. Given this, the FTC must not make the decision to file a complaint capriciously. When an IPA enters into good-faith discussions with the FTC over a vague and disputed policy matter, the Commission, as agents of the American people, must make every effort to address the IPA's concerns *without* resorting to a costly, time-consuming administrative hearing or settlement process. That did not happen here, and based on the facts as we understand them, CVT concludes the FTC abused its discretion in filing a complaint against BTMG.

Comment 2: The proposed order will not benefit consumers.

Even if the complaint provided sufficient grounds to grant §5 relief, the FTC has failed to demonstrate how the remedies in the

proposed order will benefit consumers. Because the FTC's actions are predicated on its acting in the "public interest", it is necessary for the Commission to establish specific, tangible consumer benefits that are likely to result from a proposed order. In assessing such benefits it is not enough, in our view, for the FTC to simply assert something will happen. There must be ample factual, economic, or legal grounds supporting specific remedies.

The proposed order imposes numerous restrictions on BTMG's business practices, most with respect to joint contracting with insurers and payers. The complaint argues BTMG's previous actions resulted in its physicians receiving compensation at a higher rate than would have been achieved in a "competitive" market. Thus, the FTC's remedies are designed to lower consumer prices by restricting the ability of physicians to voluntarily contract with insurers and payers (unless they engage in the unspecified level of risk-sharing discussed above).

At the outset, we must establish what is meant by "consumers" in the context of this case. A rational observer might treat the consumer base as equivalent to the population of the geographic market, in this place the 1.79 million people living in the SFMSA. But the FTC's arguments do not support such a broad definition. For one thing, the settlement only addresses BTMG's relationship with individual consumers whose healthcare is paid for by a third party. Individuals who pay for their own healthcare entirely out-of-pocket—otherwise known as the *uninsured*—will derive no benefit from this settlement. This is a significant portion of the relevant population. About 13% of SFSMA residents (and about 22% of all California residents) have no third-party medical coverage. This 13% is totally excluded from the FTC's definition of consumer.

The bigger problem, however, is not the exclusion of uninsured patients from the "public" interest, but the exclusion of *insured* patients as well. For instance, consumers insured under HMO agreements are not taken into consideration, because only BTMG's PPO product is challenged here. More importantly, *all* patients are effectively excluded from the FTC's consideration, because the settlement is designed to lower prices only for the third-party payers, *not* individual consumers who rely on such payers.

Unlike many markets, where a consumer is a consumer, the healthcare market has two distinct consumer bases with often-opposing economic interests. The individual consumer base, patients, seek to maximize their care while minimizing out-of-

pocket costs. The third-party consumer base, consumers, conversely seek to minimize the care provided to patients while maximizing profits. Neither of these objectives are inherently unethical or irrational; they simply reflect different self-interests.

The problem arises when government agencies, like the FTC in this case, try to reconcile consumer differences by *force*, rather than allowing the free market to operate. Here, the FTC is operating under the unproven assumption that lowering third-party costs for physician services will improve the marketplace in general. This position reflects conventional governmental thinking on healthcare: What's good for insurers will be good for patients. This argument ignores several proven theories about healthcare economics.

First, the FTC creates a false dichotomy when it contrasts BTMG's alleged "price fixing" with the "benefits of competition" promised in the proposed order. If the proposed order works as intended, there won't be any more competition for physician services than there is now. Insurers won't start bidding for individual physician services; they'll simply present each physician in the BTMG network with a "take-it-or-leave-it" contract offer. Without the ability to join with other physicians, individual doctors will have no bargaining power against a large, well-financed insurer. On top of that, if a significant number of BTMG physicians individually reject a payer's offer, the FTC could infer, under the proposed order, that the physicians are engaged in a "group boycott", which is considered a §5 violation. Thus, there are only two likely outcomes resulting from the consent order: A physician will accept a payer's contract offer without complaint, or he will leave the market altogether.

Second, any cost savings insurers and payers realize from this settlement is unlikely to benefit individual consumers—the 87% or so of SFMSA residents with some form of health coverage. There is nothing in the proposed order that requires the insurer's cost savings be passed on to the individual patient. Indeed, in every §5 case brought against a physician group by the FTC, the Commission has never presented *any* evidence or analysis that shows patient cost declined as a result of a settlement with a physician group. Nor is there any evidence that suggests the quality of patient care has improved following a settlement. Indeed, a principal reason many physicians engage in joint contracting is to improve the quality and cost of care for individual patients. Dr. Mitchell Solod, a member of BTMG's board of

directors, offered one example of how it is the physicians, not the insurers, who best protect the interests of individual consumers:

> Many PPO contracts with individual physicians don't even cover the physician's costs of providing basic health care, including some immunizations for children. This forces parents to either pay, out-of-pocket, for these necessary shots, or delay immunizations until they have more money. That's not good for children and it's not quality health care. Brown & Toland, as a clinically integrated group, can manage these issues to the benefit of our patients.[12]

Insurers are accountable to their shareholders, not their customers. The entire third-party payer model for healthcare is based providing the most customers with the lowest passable quality of service. There is no other market, save government-run schools, where this economic model exists. The thinking embraced by the FTC's proposed order only exacerbates the problem. The FTC's answer to physicians' advocating a higher quality of care (at admittedly a higher price) is to drive a wedge between doctor and patient. If physicians can't jointly contract, they cannot collectively address deficiencies in customer service. While this gives third-party payers a free-hand to dictate market conditions, it does nothing to benefit the general public.

Finally, the FTC's fixation on costs unreasonably singles out physicians for blame. There are multiple independent factors that impact the cost of healthcare and third-party coverage. Advances in medical technology, including new pharmaceuticals and specialized equipment, often raise the cost of healthcare in the short-term as such advances are integrated into the market. State and federal regulation of healthcare also plays a substantial role in determining costs. New drugs and medical devices must meet expensive FDA testing requirements. State laws require insurers to cover certain people and conditions without regard to cost. The courts impose substantial punitive damage awards on physicians for medical malpractice, which increase the cost of malpractice insurance for all physicians. None of these factors were analyzed by the FTC in this case, yet all of them contribute far more to the cost

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[12] Brown & Toland Press Release (July 9, 2003). Available at http://www.brownandtoland.com/pr/2003_0710_ftc_pr_01.cfm.

of providing third-party medical coverage than BTMG's joint contracting activities.

Based on the factors discussed above, CVT concludes the FTC failed to properly identify the "public interest" in this case, and accordingly, the proposed order fails to propose any remedy that will benefit the public.

Comment 3: The proposed order violates the constitutional rights of BTMG and its member physicians.

The Constitution protects the individuals rights of all Americans, not just those individuals the government chooses to protect. Individual rights depend on *reciprocity*. Above, we discussed how the FTC improperly defined "consumers" in this case to narrowly benefit a small group at the general public's expense. But reciprocity goes to how the government treats consumers versus *producers*, in this case BTMG's member physicians. A free market is based on the government's protection of the right to contract. This means all parties to a contract must have equal rights before the law. But in this case, the FTC intentionally assigned BTMG physicians a lesser degree of contract rights based solely on the doctors' economic status. The Constitution, in our view, does not permit this form of classification under the First and Ninth amendments.

The First Amendment states, in relevant part, that "Congress shall make no law . . . abridging the freedom of speech . . . or the right of the people peaceably to assemble". The proposed order contains numerous *content-based* restrictions of BTMG's free speech and free assembly rights. Section II(B) prohibits BTMG from "[e]xchanging or facilitating in any manner the *exchange or transfer of information*" (italics added) between member physicians about the price or other substantive terms of third-party contract offers. In other words, if two BTMG physicians have lunch and discuss an insurer's latest contract offer, they would be in violation of the proposed order. This is a classic prior restraint, and the First Amendment does not permit such restraints under any circumstances. Furthermore, since the proposed order places a content-based restriction on the ability of BTMG physicians to assemble (as evidenced in the lunch example), the settlement also violates the First Amendment's free assembly clause.

The proposed order does more than restrict speech. It also restrains the economic liberty of BTMG physicians by expressly forbidding them from jointly contracting with third-party payers without the prior consent of the government. For example, Section II of the proposed order states that while BTMG may jointly contract under a "qualified risk-sharing" or "qualified clinical-integration" agreement, BTMG "shall bear the burden of proof" to demonstrate that joint contracting is "reasonably necessary". This requirement violates the liberty of BTMG and its physicians to contract with payers on terms of their mutual choosing. The freedom to contract is a basic economic right essential to man's well-being, and it is the FTC, not BTMG, which must bear the burden of proof to demonstrate that a prior restriction—especially one enacted outside the normal legislative or judicial process—is necessary to fulfill a constitutional objective.

The FTC Act derives its constitutional legitimacy from Article I, which grants Congress the exclusive power to "regulate Commerce . . . among the several States".[13] This power is often misconstrued as a license for the federal government to *regulate* the behavior of private parties in commerce. But the history, context, and philosophy underlying the Commerce Clause suggest a different context. The Framers sought the creation of a national economic market among the original 13 states. This necessitated a national authority vested with the power to prevent individual states—not individual producers or consumers—from enacting regulatory roadblocks, such as protective tariffs, that would prevent the free flow of goods and services "among the several States". The Commerce Clause addresses the *systems* of commerce, not its substance. That is left to individuals trading under the common law.

The Ninth Amendment further confirms the limited nature of the Commerce Clause's authority. The amendment states: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people". While the Constitution does not enumerate, for example, the right of physicians to jointly contract with insurers, the Ninth Amendment creates a presumption of liberty that protects individual rights against arbitrary government interference. It is the FTC's burden to justify its restrictions on BTMG's rights, not

[13] U.S. Const., Art. I, § 8, cl. 3.

BTMG's duty to prove the "reasonableness" of its rights. As CVT has discussed in great detail above, the FTC has not met this burden. The proposed order finds no refuge in the Commerce Clause, because restricting the ability of private parties to contract among themselves does nothing to protect the national economic marketplace from the provincialism of state governments.

The FTC's constitutional error stems from its mistaken view that there is a distinct class of "consumer rights" that exist independently of the individual rights enjoyed by all Americans. Under the consumer rights view, the government may restrict or revoke the economic liberties of producers when there is some showing—or even just an allegation—that consumers are negatively affected. Thus, the FTC justifies the proposed order's restrictions on BTMG by claiming they "benefit consumers". But neither the Commerce Clause nor the Ninth Amendment support a consumerist view of rights. Just as the Constitution creates a single, national economic market, it also creates a single, indivisible standard of individual rights. The FTC may not constitutionally discriminate against certain forms of economic activity to create special privileges for a narrow class of "consumers".

For all these reasons, notwithstanding the other independent objections raised herein, the proposed order is facially unconstitutional.

Conclusion

The proposed order fails to meet any of the criteria set forth by CVT, because both the order and the underlying complaint lack a foundation in the principles of reason, individual rights, and capitalism. Far from protecting the public interest, this settlement violates the constitutional rights of BTMG's physicians in order to benefit a narrow subset of the population—insurance companies and other third-party payers. There is simply no factual foundation for the FTC's broad promise of lower prices, increased competition, and improved services. Accodingly, the proposed order should be withdrawn, and the FTC should dismiss the complaint with all deliberate speed.

Respectfully Submitted,
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