PUBLIC

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

DOCKET NO. 9312

In the Matter of

NORTH TEXAS SPECIALTY PHYSICIANS,

Respondent.

INITIAL DECISION

D. Michael Chappell
Administrative Law Judge

Date: November 15, 2004

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I. INTRODUCTION

A. Summary of Decision

This is a horizontal price fixing case. The Federal Trade Commission ("FTC") charges that Respondent North Texas Specialty Physicians ("NTSP"), on behalf of its participating physicians, collectively bargained with health insurance plans in order to obtain higher prices or more favorable economic terms in contracts for physician services.

Respondent NTSP is an independent practice association ("IPA") of approximately 500 physicians, the vast majority of whom are specialists who practice in Fort Worth, Texas. NTSP physicians are a significant presence and make up a large percentage of practitioners in many specialities in the Fort Worth area. One the functions of NTSP is to receive offers from health insurance plans of Health Maintenance Organization ("HMO") or Preferred Provider Organization ("PPO") contracts ("non-risk contracts") to provide physician services in the Fort Worth, Texas area. Upon receipt of a payor offer of a non-risk contract, Respondent evaluates the offer and determines whether to send it – messenger it – to its participating physicians. Respondent does not messenger to its physician members any offers on non-risk contracts that fall below minimum rates established by the NTSP Board ("Board minimums"). NTSP establishes Board minimums by conducting polls among its physician members that ask each physician to disclose the minimum price that he or she would accept to provide medical services pursuant to a non-risk contract.

In its defense, Respondent asserts that it did not negotiate economic terms of non-risk contracts. Respondent further asserts that it is entirely proper for Respondent to determine whether or not to send contract offers it receives from health care members to the physicians who participate in NTSP.

The government proved its case. As explained in detail in the findings of fact and analysis below, the evidence establishes that physicians participating in NTSP, who are otherwise competitors of each other, communicated to NTSP the minimum prices that they were willing to accept for physician services and that NTSP used this information to negotiate higher rates and more favorable terms for non-risk contracts than those initially offered by various health insurance plans. Through the use of price information collected from its physician members to leverage increased offers or better terms from health insurance payors, NTSP has engaged in a

combination, contract, or conspiracy that has unreasonably restrained trade. Accordingly, Complaint Counsel has demonstrated a violation of Section 5 of the FTC Act. The appropriate remedy is an order to cease and desist.

B. Summary of Complaint and Answer

The FTC issued its Complaint in this matter on September 16, 2003. The Complaint charges that Respondent, acting as a combination of competing physicians, has restrained competition by negotiating and entering into agreements among its participating physicians on price; refusing or threatening to refuse to deal with payors except on collectively agreed upon terms; negotiating fees in payor contracts for NTSP's participating physicians; and refusing to submit payor offers to participating physicians unless and until price and other competitively significant terms conforming to NTSP's contract standards have been negotiated. Complaint ¶ 12. The Complaint further alleges that the acts of Respondent have had the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Fort Worth area in the following ways: price and other forms of competition among NTSP's participating physicians were unreasonably restrained; prices for physician services were increased; and health plans, employers, and individual consumers were deprived of the benefits of competition. Complaint ¶ 23. The Complaint charges that the combination, conspiracy, acts, and practices alleged in the Complaint constitute unfair methods of competition in or affecting commerce in violation of Section 5 of the Federal Trade Commission Act, as amended, 5 U.S.C. § 45. Complaint ¶ 24.

In its Answer, filed on October 7, 2003, Respondent denied the material allegations of the Complaint and asserted the following defenses: that it is a memberless non-profit corporation and therefore is not subject to the jurisdiction of the Federal Trade Commission; that NTSP's conduct does not constitute commerce as defined in the Federal Trade Commission Act; that NTSP has the right as an entity under *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919) to refuse to become a party to another's contract or transaction; and that NTSP's conduct has been fair, reasonable, and justified. Answer p. 3.

C. Procedural Background

On March 2, 2004, Complaint Counsel filed a Motion for Partial Summary Decision. Also on March 2, 2004, Respondent filed a Motion for Summary Decision. Respondent's motion was denied by Order dated April 9, 2004. Complaint Counsel's motion was denied by Order dated April 14, 2004. Both motions were denied on the ground that genuine issues of material fact raised by the pleadings could only be properly determined after an evidentiary hearing.

The final prehearing conference was held in Fort Worth, Texas on April 27, 2004. Trial commenced immediately following the prehearing conference. Nearly 1,500 exhibits were admitted and 17 witnesses testified, either live or by videotape. Trial concluded on May 25, 2004.

On June 16, 2004, both parties filed proposed findings of fact, post trial briefs, and conclusions of law. Complaint Counsel filed its response to Respondent's brief and proposed findings of fact on June 30, 2004, and filed a corrected response to Respondent's proposed findings of fact on July 1, 2004. Respondent filed its response to Complaint Counsel's brief and proposed findings of fact on June 30, 2004. Closing arguments were heard on July 21, 2004.

The hearing record was closed pursuant to Commission Rule 3.44(c) by Order dated June 8, 2004. Rule 3.51(a) of the Commission's Rules of Practice states that an Initial Decision shall be filed "within ninety (90) days after closing the hearing record pursuant to § 3.44(c) . . . or within such further time as the Commission may by order allow upon written request from the Administrative Law Judge." 16 C.F.R. § 3.51(a). Ninety days from the close of the record was September 7, 2004. By Certification for Extension of Time to File Initial Decision dated August 25, 2004, the Commission was requested to extend the time for filing this Initial Decision by sixty days, until November 8, 2004. By Order dated September 17, 2004, the Commission granted this request and extended the date for filing the Initial Decision until November 8, 2004.

Rule 3.51(a) also states that an Initial Decision shall be filed within one year "after the issuance of the administrative complaint, except that the Administrative Law Judge may, upon a finding of extraordinary circumstances, extend the one-year deadline for a period of up to sixty (60) days." 16 C.F.R. § 3.51(a). The Complaint in this matter was issued on September 16,

2003. One year from the issuance of the Complaint was September 16, 2004. By Order dated September 14, 2004, extraordinary circumstances were found to extend the one-year deadline for a period of up to sixty days, until November 15, 2004.

D. Evidence

This Initial Decision is based on the exhibits properly admitted in evidence, the transcript of trial testimony, and the briefs, proposed findings of fact and conclusions of law, and replies thereto submitted by the parties. Citations to specific numbered Findings of Fact in this Initial Decision are designated by "F."

Under the Commission's Rules of Practice, a party or a non-party may file a motion seeking *in camera* treatment for material, or portions thereof, offered into evidence. 16 C.F.R. § 3.45(b). The Administrative Law Judge may order that such material be placed *in camera* only after finding that its public disclosure will likely result in a clearly defined, serious injury to the entity requesting *in camera* treatment. 16 C.F.R. § 3.45(b). Pursuant to Commission Rule 3.45(b), several orders were issued granting *in camera* treatment to material that met the Commission's strict standard. In addition, when the parties sought to elicit testimony at trial that revealed information that had been granted *in camera* treatment, the hearing went into an *in camera* session.

In instances where a document or certain trial testimony has been given *in camera* treatment, but the portion of the material cited to in this Initial Decision does not rise to the level necessary for *in camera* treatment, such material is disclosed in the public version of this Initial Decision, pursuant to Commission Rule 3.45(a) (the ALJ "may disclose such *in camera* material to the extent necessary for the proper disposition of the proceeding"). *In camera* material that is used in this Initial Decision is indicated in bold font and braces ("**{ }**") in the *in camera* version; it is redacted from the public version of the Initial Decision, in accordance with 16 C.F.R. § 3.45(f).

This Initial Decision addresses only material issues of fact and law. Proposed findings of fact not included in this Initial Decision were rejected, either because they were not supported by the evidence or because they were not dispositive or material to the determination of the

allegations of the Complaint or the defenses thereto. The Commission has held that Administrative Law Judges are not required to discuss the testimony of each witness or all exhibits that are presented during the administrative adjudication. *In re Amrep Corp.*, 102 F.T.C. 1362, 1670 (1983). Further, administrative adjudicators are "not required to make subordinate findings on every collateral contention advanced, but only upon those issues of fact, law, or discretion which are 'material.'" *Minneapolis & St. Louis Ry. Co. v. United States*, 361 U.S. 173, 193-94 (1959).

II. FINDINGS OF FACT

A. Background

1. Organization of and contracting by physician practices

1. Physicians often organize their practices into medical groups, which operate as single integrated entities having a single CEO, accountant, office manager, and staff. (Casalino, Tr. 2795-96).

2. Physicians and medical groups often contract with health plans in order to increase the volume of patients available to them. (Frech, Tr. 1288-89).

3. Competing physicians and medical groups sometimes enter into arrangements with others to form independent practice associations, known as IPAs. IPAs are looser combinations of medical groups formed for the purpose of negotiating contracts with managed care health plans. (Casalino, Tr. 2796; Frech, Tr. 1292).

4. IPAs generally lack direct authority to control the practices of their member physicians. (Casalino, Tr. 2799-2800).

2. Health care insurance and managed care

5. Historically, most health care insurance coverage was indemnity insurance. The prevalence of indemnity insurance skewed incentives in such a way that consumers often neither sought to reduce price by seeking lower-priced providers, nor quantity by seeking to avoid over-utilization. (Frech, Tr. 1282-83).

6. Managed care was introduced to address these deficiencies and control the cost of health care services through health plan contracting with physicians, control of utilization, and management of care. (Frech, Tr. 1282-84, 1289).

7. One form of managed care is the Health Maintenance Organization ("HMO"). HMOs generally feature small provider panels, low co-payments for patients, and broad administrative controls to limit utilization, with no coverage for patients who choose providers outside the network. (Frech, Tr. 1283-84).

8. HMO contracts can involve a variety of physician compensation structures. In some instances, participating physicians are paid a stated fee for each service rendered. This compensation structure is referred to as fee-for-service. (Mosley, Tr. 131-32).

9. A less tightly controlled form of managed care is the Preferred Provider Organization ("PPO"). Relative to HMOs, PPOs generally involve fewer administrative controls and higher patient co-payments to limit utilization, but larger physician panels and greater access to out-of-network physicians, albeit at a reduced rate of reimbursement. (Frech, Tr. 1283-84).

10. The Medicare RBRVS fee schedule is Medicare's Resource Based Relative Value System ("RBRVS"), a system developed by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for each service rendered to Medicare patients. (Frech, Tr. 1286; Wilensky, Tr. 2144).

11. Health plans that contract with physicians on a fee-for-service basis often do so based on a stated percentage of the Medicare RBRVS fee schedule, which provides reimbursement rates for a large number of specific procedures. (Frech, Tr. 1286; Mosley, Tr. 137; Grizzle, Tr. 692-93).

12. The Medicare RBRVS establishes weighted values for each medical procedure, such that the application of a percentage multiplier (such as 100% for Medicare itself), enables one to determine the fees for thousands of different services simultaneously. (Frech, Tr. 1286).

3. Distinction between risk and non-risk agreements

13. In a risk sharing agreement ("risk contract"), sometimes referred to as a capitation agreement, physicians participating in an HMO are paid (or share) a set dollar amount stated per member, per month, irrespective of the quantity of services rendered. (Frech, Tr. 1293; Mosley, Tr. 131-32; Wilensky, Tr. 2177-78).

14. Capitation agreements shift the risk of overutilization of medical services to the capitated physician or physician group. (Quirk, Tr. 255; Mosley, Tr. 206; Lovelady, Tr. 2638). Physicians respond to capitation and other incentive systems by modifying their utilization and other practice patterns. (Frech, Tr. 1293-94; Casalino, Tr. 2811; Lovelady, Tr. 2640-41).

15. In a non-risk sharing agreement ("non-risk contract"), physicians are paid under a fee-for-service reimbursement arrangement. (CX 1177 (Grant, Dep. at 78); CX 1198 (Vance,

Dep. at 36)). In fee-for-service arrangements, physicians do not bear the risk of overutilization of physician services because payments are made for the services provided. (Frech, Tr. 1346-47).

16. PPOs generally utilize non-risk sharing agreements where the insurance company contracts to reimburse providers at a predetermined level for services performed by the physicians. (Mosley, Tr. 134).

B. North Texas Specialty Physicians

1. Organization and composition

17. NTSP is an IPA located in Fort Worth, Texas. (CX 311 at 1; CX 1196 (Van Wagner, 08.29.02 IHT at 8)). It is a nonprofit 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)).

18. NTSP does not function as a clinically integrated organization for patients seen under non-risk contracts. (Casalino, Tr. 2877).

19. NTSP was formed in 1995 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 1675; RX 1676).

20. NTSP carries on business for the pecuniary benefit of its member physicians. (CX 311 at 10-11 and CX 275 at 30-31 ("NTSP shall use its best efforts to market itself and its Participating Physicians to Payors and to solicit Payor offers for the provision of Covered Services by Participating Physicians"); CX 310 (stating that NTSP physician's ability to negotiate "substantially improved" by NTSP; noting NTSP's discussions with payors "should lead to contracts that are more favorable than we would be able to achieve individually or through other contracting entities"); CX 159 at 2 (noting contractual issues addressed by NTSP include "maintaining minimal reimbursement standards for its member physicians")).

21. NTSP, as an organization, receives its revenue from risk contracts and a one time fee of $1,000 from each physician. (Van Wagner, Tr. 1552).

22. From January 1, 1999 to December 22, 2003, NTSP purchased $1,047,819.86 from vendors with billing addresses outside of Texas. (CX 1203; CX 1195 (Van Wagner, 01.20.04 Dep. at 77)). For example, NTSP purchased $457,373.09 of stop loss insurance from McPhee & Associates, a California insurance broker. (CX 1203; CX 1195 (Van Wagner, 01.20.04 Dep. at 81)).

23. NTSP's Board of Directors ("Board") is made up of eight physicians. Under NTSP's organizational documents and under Texas law, NTSP's directors, other than an "Officer Director," must be physicians who are actively engaged in the practice of medicine. (CX 275 at 7; Van Wagner, Tr. 1493-94; *see also* TEX. OCC. CODE ANN. § 162.001 (Vernon 2004)).

24. The Board of Directors is elected from among NTSP's member physicians and meets once a week. (Van Wagner, Tr. 1493-94).

25. NTSP has a salaried, core administrative staff of eight people, including executive director Karen Van Wagner, provider relations staff, provider sponsored network ("PSN") development and contracting staff, data processing staff, credentialing staff, and clerical support staff. (Van Wagner, Tr. 1494-95; RX 1674).

26. NTSP's Medical Executive Committee includes the chairs of each of NTSP's specialty divisions who are elected by the member physicians within each specialty. (Deas, Tr. 2559-60; CX 275 at 5).

27. Karen Van Wagner, Ph.D. is NTSP's executive director. Van Wagner joined NTSP in 1997, roughly a year after the organization was established. (Van Wagner, Tr. 1461-62).

28. Dr. Thomas Deas is the current president and chairman of the Board of NTSP. In addition to heading the Medical Executive Committee, Deas is a medical director of NTSP. (Deas, Tr. 2524, 2556).

29. Dr. William Vance was one of the founding members of NTSP, serving as its president from 1996 until 2001. Vance was a member of the Medical Management Committee from its inception through 2002. In addition, he was the chairman of NTSP's cardiology section. His role within NTSP ceased when his practice group, Consultants in Cardiology, withdrew from NTSP in April 2002. (CX 1198 (Vance, Dep. at 9, 48, 49)).

30. Dr. John Johnson, III is a medical physician and a current member of NTSP's Board of Directors. (CX 1182 (Johnson, Dep. at 6, 13)).

2. Member physicians

31. NTSP has member physicians in eight counties in and around the Dallas/Fort Worth Metroplex. (Van Wagner, Tr. 1468-69). Approximately 85-88% of NTSP's member physicians are located in Tarrant County, with the majority located in Fort Worth. (Van Wagner, Tr. 1471; CX 1196 (Van Wagner, 08.29.02 IHT at 15-16)).

32. At the time of trial (April 2004), NTSP had approximately 480 participating physicians. (Van Wagner, Tr. 1510, 1518). In 2003, NTSP had approximately 575 participating

physicians, practicing in 26 different specialties, who had signed NTSP's Physician Participation Agreement ("PPA"). (CX 311 (physician participation agreement); RX 3118 (Maness Report ¶¶ 4, 19)). In 2001, NTSP had as many as 652 physicians. (CX 209 at 2 ("NTSP has become a 'gorilla network' with approximately 124 PCP's [primary care physicians] . . . and 528 specialists.").

33. NTSP member physicians attend general membership meetings, pay dues, and elect NTSP's Board. (CX 1178 (Hollander, Dep. at 21-24, 34)).

34. NTSP member physicians are organized into specialty divisions, based on field of practice. (Van Wagner, Tr. 1510).

35. NTSP's member physicians have distinct economic interests, reflecting their separate clinical practices. (CX 1182 (Johnson, Dep. at 21); *see also* CX 524 (roster of NTSP member physicians listing multiple physicians and/or physician groups practicing the same specialty in Fort Worth)).

36. Many NTSP physicians and physician practices are in competition with one another. (CX 1182 (Johnson, Dep. at 21) ("We compete for patients. We compete at the different hospitals at which we work."); CX 550 (noting that NTSP's disagreements with payors were supported by its membership despite the fact that "short term advantage and perceived best interest are always controversial and potentially divisive, weakening the strength that our numbers provide.")).

3. Overview of NTSP's functions

37. NTSP was founded in 1995 to allow a group of specialist physicians to accept economic risk on medical contracts and to participate in the medical decision-making process. NTSP has since broadened its activities to include entering into and messengering non-risk contracts and has expanded its membership to include primary care physicians ("PCPs"). (RX 1675; Vance, Tr. 587-88; Wilensky, Tr. 2158-59).

38. The Board manages the organization, determines NTSP's minimum contract prices, and evaluates contract offers. If a payor offer is at or above Board minimum rates (*infra* F. 83-90) and is otherwise acceptable, NTSP will messenger the offer to its member physicians. (CX 275 at 5; Van Wagner, Tr. 1642-43; Vance, Tr. 595-96; CX 1177 (Grant, Dep. at 22-24); CX 1174 (Deas, Dep. at 42)).

39. NTSP represents its member physicians and provides administrative expertise to review contracts, confront timely payment issues, and lobby government agencies for physician issues. NTSP has evolved into a forum for its member physicians to cooperate and discuss the general and specific business of medicine and receive advice and information. (CX 350).

40. NTSP's Medical Executive Committee transmits information and feedback, including the status of fee-for-service contract discussions, between NTSP's staff and Board and the membership. (CX 1174 (Deas, Dep. at 20-21); Deas, Tr. 2560).

41. NTSP communicates with its member physicians by sending faxes called "Fax Alerts" which keep its member physicians informed of the activities of NTSP, including contractual issues. (CX 1178 (Hollander, Dep. at 48); CX 1198 (Vance, Dep. at 54)).

42. NTSP holds "general membership meetings" to provide contracting updates for specific payor negotiations and to discuss and share NTSP's poll results with the membership. (CX 1178 (Hollander, Dep. at 21-23); CX 182; CX 183; CX 184; CX 186; CX 187).

4. Contracts with health insurance providers

43. NTSP "is in the business of" contracting with health maintenance organizations, health care networks and other payors to provide health care services through physicians and physician groups who have contracted with NTSP to provide health care services. (CX 311 at 1 (WHEREAS Recital of NTSP PPA)).

44. One of NTSP's functions is to negotiate reimbursement terms in contracts with health plans on behalf of NTSP's member physicians. (CX 159 at 2 ("Contracting issues addressed by NTSP this past year included . . . maintaining minimal reimbursement standards for its physicians."); CX 350 ("NTSP was started in an attempt to provide a seat at the table of medical business for the individual specialty physicians . . . . NTSP, through PPO and risk contracts, has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source."); CX 1182 (Johnson, Dep. at 10-11) ("NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups to hopefully be able to secure contracts, improve patient care, and provide a voice at the table for physicians. . . . [It was] to represent physicians . . . in obtaining contracts from businesses or insurance companies or in dealing with hospitals.")).

45. NTSP analyzes 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, 08.29.02 IHT at 56-57)). This review benefits physicians. (CX 1182 (Johnson, Dep. at 11) ("As a busy physician, I had relatively little time to look at contracts, and oftentimes did not understand the legal language in contracts, so having another organization that could review contracts and educate me as to the terms in the contracts" was a benefit.)).

46. NTSP originally focused on negotiating shared-risk contracting with health plans, but as the market moved away from risk-sharing arrangements, NTSP increasingly sought to negotiate and did negotiate non-risk contracts. (CX 195).

47. In 2001, NTSP accepted risk on only approximately 32,000 lives. (CX 616 at 2 (NTSP takes professional risk on approximately 20,000 commercial and 12,000 Medicare lives)).

48. In March 2001, NTSP's Board of Directors stated 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." (CX 83 at 3).

49. NTSP has one risk-sharing contract – the one it shares with PacifiCare. (CX 1177 (Grant, Dep. at 19)). Within the past five years, NTSP also had a risk contract with AmCare. (CX 1196 (Van Wagner, 08.29.02 IHT at 14); CX 1195 (Van Wagner, 01.20.04 Dep. at 15)).

50. NTSP has approximately twenty fee-for-service contracts, covering many more lives. (CX 1196 (Van Wagner, 08.29.02 IHT at 14); *see also* CX 265, *in camera* (listing, by health plan, lives covered under NTSP's non-risk contracts)).

51. Sixty percent of NTSP's physicians participate in fee-for-service contracts. Roughly half of those physicians participate in risk-sharing contracts. Some of these physicians participate in NTSP through a participation agreement under which they can gain access to NTSP's non-risk contracts, but are not eligible to participate in NTSP's risk contract. (CX 616 at 2-12; CX 1197 (Van Wagner, 08.30.02 IHT at 182, 228-29); Van Wagner, Tr. 1830; CX 1194 (Van Wagner, 11.19.03 Dep. at 37-38)).

C. Relevant Market

52. In contracting for health plan services, Fort Worth employers demand significant coverage by physicians who practice in the Fort Worth area and who admit patients to Fort Worth hospitals. (Grizzle, Tr. 688-89, 722; Frech, Tr. 1304-05; Mosley, Tr. 141-42; Quirk, Tr. 276-77, 280; Jagmin, Tr. 1104-07).

53. To be competitively marketable to Fort Worth area employers, health plans must include many physicians who practice in a variety of fields in the Fort Worth area. (Grizzle, Tr. 688-89, 720, 722; Jagmin, Tr. 1104-07).

54. When buying health coverage, employers look for networks that include all of the tertiary care hospitals in an area, most of the other hospitals within the area, and a broad selection of physicians in the locale, including a wide selection of specialists within each specialty. (Jagmin, Tr. 971-72, 1102-03; Quirk, Tr. 270-72, 275-76).

55. Health plans try to assemble and market a panel of physicians that will satisfy employers' preferences for greater access to a wide array of conveniently located physicians, without compromising the overall cost of care. (Quirk, Tr. 270-72; Jagmin, Tr. 972).

56. Fort Worth employers typically would consider a network adequate if it had physicians within ten miles of at least 85%, and preferably 90%, of its employees. (Mosley, Tr. 141-42).

57. NTSP physicians agree that Fort Worth specialists are better able to address the needs of patients (and primary care physicians) located in Fort Worth than physicians located elsewhere. (*E.g.,* CX 583 at 1-2 (Johnson, an NTSP member physician, writing: "[o]bviously a provider network whose business is based *entirely* here in Fort Worth is better positioned to address the needs of both patients and physicians.") (*emphasis in original*). *See also* CX 1187 (McCallum, Dep. at 59) (NTSP Board member testifying that Dallas physicians compete in a different market than NTSP physicians)).

58. A large network of physicians located in Dallas or in the Mid-Cities, defined as the areas including Arlington, Hurst, Euless, Bedford, Colleyville, and Southlake (CX 1196 (Van Wagner, 08.29.02 IHT at 16), would not be marketable to Fort Worth employers if the network did not also have a large number of appropriate physicians located in Fort Worth. (Mosley, Tr. 142-43; Jagmin, Tr. 1103-04; Quirk, Tr. 280-82).

59. A network of physicians located in Dallas or the Mid-Cities that did not also have a large number of appropriate physicians located in Fort Worth would not achieve the geographic access required by employers with large numbers of Fort Worth employees and would not be acceptable to employers, even if they were discounted by five or ten percent, relative to those areas. (Mosley, Tr. 142-43; Quirk, Tr. 279-80).

60. If all Fort Worth physicians increased prices by five percent, health plans serving Fort Worth employers would not be able to avoid the price increase by substituting away from Fort Worth. (Grizzle, Tr. 723; Quirk Tr. 280-82; Jagmin, Tr. 1103-04).

61. NTSP physicians are a significant presence in the Fort Worth area. NTSP physicians make up a large percentage of Tarrant County practitioners in several medical specialties: 80% for pulmonary disease, 68.6% for urology, and 58.8% for cardiovascular disease. (Frech, Tr. 1299). Tarrant County includes Fort Worth and several surrounding cities. (Quirk, Tr. 420; Maness, Tr. 1992).

62. A loss of NTSP's physicians from a health plan's network would have "a very deleterious affect" on the health plan's ability to market its product in Tarrant County. (Jagmin, Tr. 1091). One health insurance plan's representative testified that, without NTSP's physicians, it would suffer from significant holes in coverage for a number of specialties in Fort Worth. ({ }, *in camera*).

63. NTSP has stated that a health plan attempting to serve the employees of the City of Fort Worth "would not be able to satisfy employer/employee match or network access standards without NTSP Physicians Participating in the Network," and that, "NTSP is the only stable physician organization left in the Tarrant County market." (CX 1042. *See also* CX 576 at 3 (NTSP stating that "without NTSP specialists in the Aetna network, a severe network inadequacy problem will exist in Fort Worth.")).

D. Contract, Combination, or Conspiracy

1. Physician Participation Agreement

64. NTSP and its participating physicians enter into the Physician Participation Agreement ("PPA"), establishing their relationship. (CX 276 at 1).

65. The PPA grants NTSP the right to receive all payor offers and imposes on the participating physicians a duty to promptly forward those offers to NTSP. (CX 276 (Fax Alert stating that NTSP shall have "exclusive right, on behalf of its members, to receive all payor offers"); CX 275 at 24 ("NTSP shall have the right to receive all Payor Offers made to NTSP or Physician . . . If Physician receives a Payor Offer, . . . Physician will promptly forward such Payor Offer to NTSP for further handling in accordance with the provisions of this Agreement.")).

66. The PPA grants NTSP a right of first negotiation with payors, with each physician agreeing that he or she will refrain from pursuing offers from a health plan until NTSP notifies them that NTSP is permanently discontinuing negotiations with the health plan. (CX 275 at 2; CX 276; CX 311 at 8; Deas, Tr. 2405-06; CX 1178 (Hollander, Dep. at 68) ("And there were various criteria like time limits that the participating physician[s] generally agreed that they would just wait and after that time limit was expired, then they were free to negotiate on their own.")).

67. With respect to "Non Risk Payor Offers," the PPA states:

> [p]romptly after receiving any Non Risk Payor Offer, NTSP shall deliver to Physician and each other Participating Physician the Fee Schedule and other economic provisions of the Non Risk Payor Offer. Physician shall have ten (10) business days within which to accept or reject such Fee Schedule and economic provisions, with the understanding that if Physician fails so to accept or reject within such 10-day period, Physician shall be deemed to have accepted such Fee Schedule and economic provisions.

> If the Participating Physicians who approve and who are deemed to have approved the Non Risk Payor Offer constitute 50% or more of all Participating Physicians, then NTSP, on behalf of Physician, shall notify the Payor of the acceptance and proceed with negotiation and execution of a Payor Agreement.
>
> If 50% or more of the Participating Physicians request that NTSP submit a counter-proposal to the applicable Payor, then NTSP shall submit the counter-proposal to such Payor. If the counter-proposal is accepted, then NTSP, on behalf and as agent of Physician, shall proceed with negotiation and execution of a Payor Agreement with respect to such counter-proposed offer.
>
> If the counter-proposal is not accepted by the Payor but the Payor submits its own counter-proposal, then such counter-proposal shall be treated as a new payor offer and will be submitted to Participating Physicians in accordance with the preceding provisions.

(CX 275 at 25-26).

68. Although under the PPA, NTSP is obligated to deliver to each physician the fee schedule and other economic provisions of a non-risk payor offer (CX 275), NTSP delivered only those offers which were approved by NTSP and which met minimum levels established by the Board, as determined by the results of a poll. (Van Wagner, Tr. 1706; CX 1196 (Van Wagner, 08.29.02 IHT at 29-30) (the Board does not send to physicians offers below the minimal acceptable level as determined by the results of a poll.)).

69. With respect to "Payor Offers Rejected by NTSP," the PPA states:

> If NTSP rejects any Payor Offer and advises the Participating Physicians in writing that it is permanently discontinuing negotiations or if the Participating Physicians who approved and who are deemed to have approved a Non Risk Payor Offer constitute less than 50% of all Participating Physicians, then NTSP shall have no further responsibilities with respect thereto and any Participating Physician shall have the right to pursue such Payor Offer on its own behalf.

(CX 275 at 26).

70. NTSP has urged its member physicians to avoid undermining NTSP's role in negotiating contracts on behalf of its member physicians. (*E.g.*, CX 550 (Vance's "Open Letter to the Membership": "We must continue to move forward as a group or we will surely falter as individuals"); CX 380 at 3 (NTSP warning its physicians that physician fees will decline unless

"NTSP or someone can provide a unifying voice for physicians"); CX 400 at 2 (NTSP warning its member physicians that without their support "it is likely NTSP will not be around the next time Aetna, Cigna, or United come to town" with unsatisfactory rate proposals.)).

71. NTSP cannot and does not bind any member physician or physician group to non-risk contracts. (Frech, Tr. 1362-64; Van Wagner, Tr. 1637, 1777).

72. NTSP's member physicians can and do contract with health plans outside of NTSP, either directly, through financially integrated physician groups, or through other IPAs. (Quirk, Tr. 288-89; Van Wagner, Tr. 1564, 1637; Deas, Tr. 2432).

73. There are no agreements between one or more NTSP member physicians to not participate in or to reject a non-risk payor offer. (Frech, Tr. 1365; Maness, Tr. 2048).

74. NTSP's member physicians and physician groups do not consult with each other when making decisions on non-risk payor contracts. (Maness, Tr. 2049-50).

75. NTSP's member physicians and physician groups do not know what any other physician or physician group will do in response to a non-risk payor offer. (Frech, Tr. 1436-37; Maness, Tr. 2044-46; Deas, Tr. 2423).

2. Power of attorney forms

76. In the process of negotiations with United Healthcare ("United") and with Aetna Health, Inc. ("Aetna"), NTSP has solicited and obtained power of attorney forms from its member physicians, giving NTSP the legal authority to negotiate non-risk contracts on behalf of those member physicians. (CX 1173 (Deas, IHT at 56-57); Palmisano, Tr. 1250-51. *E.g.,* CX 347 at 2; CX 1061 at 1).

77. The power of attorney forms that NTSP provided to its physicians with respect to contract negotiations with United and Aetna state:

> The undersigned . . . appoints, with full power of substitution, North Texas Specialty Physicians . . . as attorney-in-fact to act for me in any lawful way with respect to all contracts and agreements (including without limitation all prospective contracts or agreements) with and/or involving the undersigned and . . . [United Health Care / Aetna].
>
> This power of attorney grants to the agent the authority to act on the undersigned's behalf regarding the foregoing described agreements in all respects, including the authority to negotiate the

terms of, enter into, execute, amend, modify, extend or terminate any such agreements.

(CX 1061-1103 (United); CX 347-404 (Aetna)).

78. In distributing the power of attorney forms to its member physicians, NTSP has instructed its physicians to inform health care payors' representatives that NTSP is his or her contracting agent and to instruct the health care payor to contact NTSP with respect to contracting activity. (CX 1066 (United); CX 548 (Aetna)).

79. NTSP also includes in power of attorney solicitations information about the number of physicians who already have executed the power of attorney forms. (CX 1066 ("Thus far, NTSP has received 107 signed documents from NTSP member physicians assigning NTSP power of attorney to act on their behalf in regard to all contracting activity between themselves and United Healthcare."); CX 548 (NTSP sent 180 power of attorney authorizations in regard to Aetna HMO and PPO commercial products)).

80. With respect to negotiating with Cigna Healthcare ("Cigna"), NTSP requested its member physicians to sign an "authorization form" to allow NTSP to serve as its physicians' agent. (CX 332).

81. NTSP physicians have referred health plans that sought to contract directly with them back to NTSP, at times noting that the deferral was based on agency or power of attorney held by NTSP. (Beaty, Tr. 454-60; Grizzle, Tr. 696-98, 701, 709; CX 760 (exhibit admitted as an exception to the hearsay rule for verbal acts and not for the truth of the matter asserted therein ["limited admission"]). *See also* CX 1178 (Hollander, Dep. at 116) ("[I]f an NTSP physician had signed an agency agreement specifying that NTSP was to be their exclusive agent in connection with these contracts, then my understanding was that [the payor] had to deal with NTSP and not with the individual physician himself.").

82. NTSP has advised health plans during rate negotiations for fee-for-service contracts and at other times that it represented NTSP member physicians, through power of attorney forms, (Roberts, Tr. 540-41), or otherwise (CX 760 (limited admission) (letters from NTSP physicians to Cigna citing NTSP as their contracting "agent"); Beaty, Tr. 454-60).

3. Board minimums

83. "Board minimums" are the minimal acceptable rates for NTSP to enter into non-risk contracts with health plans. (Van Wagner, Tr. 1921; Frech, Tr. 1324). Payor offers falling below Board minimums are rejected by NTSP. (Frech, Tr. 1324. *E.g.*, F. 127, 154, 300, 341).

84. NTSP establishes Board minimum prices for use in negotiating non-risk contracts with health plans. (Van Wagner, Tr. 1642-43; Frech, Tr. 1321; *e.g.*, CX 274 (Fax Alert stating:

NTSP "utilizes these minimums when negotiating managed care contracts on behalf of its participants.")).

85. Board minimums are also used by NTSP to predict when the participation rate of NTSP's member physicians will be high enough for NTSP to messenger an offer to its member physicians. (Deas, Tr. 2433; Maness, Tr. 2079-80). Multiple times over several years, NTSP has informed health plans that its physicians have established minimum fees for NTSP-payor agreements and that NTSP will not forward to its member physicians, or enter into a contract, based on payor offers that do not satisfy those fee minimums. (Van Wagner, Tr. 1822-24; CX 1196 (Van Wagner, 08.29.02 IHT at 63, 154)).

86. Board minimums may have been utilized as early as 1997. (CX 1042 (2001 Fax Alert from NTSP to its member physicians stating "NTSP board minimums have remained constant for four years.")). NTSP conducted its first poll in either 1998 or 1999. (CX 1194 (Van Wagner, 11.19.03 Dep. at 86-87)).

87. NTSP conducts polls to determine minimum reimbursement rates for use in negotiation of non-risk contracts with health plans. (Van Wagner, Tr. 1639 ("We contact our physicians and we ask them to respond to a . . . survey on . . . what they believe are acceptable fees that they want to see in the nonrisk contracts."); CX 1196 (Van Wagner, 8.29.02 IHT at 27 ("Every year the Board asks the members to tell them what they consider to be appropriate reimbursement. . . . Once a year we poll the members and get that information from them.")); *e.g.*, CX 565).

88. NTSP's polling form explains to the member physicians that each year, "NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants." (CX 387 at 1; CX 633).

89. NTSP's polling form asks each physician to disclose the minimum price that he or she would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. (CX 565; CX 1196 (Van Wagner, 08.29.02 IHT at 27)).

90. NTSP's member physicians are asked to indicate their price selection by placing a check mark next to one of several pre-printed Medicare RBRVS ranges. (CX 274; CX 565; CX 633).

91. By quoting a particular percentage of RBRVS, one can establish the prices for thousands of different services simultaneously. By using the Medicare index and a percentage of Medicare as a conversion factor, voluminous price information is reduced to a single dimension. (Frech, Tr. 1287).

92. NTSP's member physicians and physician groups do not consult with each other when responding to the poll. (Maness, Tr. 2049-50; Lonergan, Tr. 2718).

93. After receiving the poll responses, NTSP calculates the mean, median, and mode ("averages") of the minimum acceptable fees identified by its physicians and establishes its minimum contract prices. (Van Wagner, Tr. 1640; CX 103; CX 387).

94. NTSP informs its physicians of the average poll results and NTSP's minimum contract prices based thereon. (Van Wagner, Tr. 1644. *E.g.,* CX 393, CX 430, CX 1042).

95. NTSP physicians are informed only of the mean, median, and mode of the poll responses. They do not know how any other specific physician or physician group responded to the polls. (Van Wagner, Tr. 1641-44; Frech, Tr. 1436-37; Maness, Tr. 2044-46; Deas, Tr. 2423).

96. On October 15, 2001, the NTSP Board received annual poll results. Based on the poll results, NTSP established minimum prices of 125% of 2001 Medicare RBRVS for HMO products and 140% of 2001 Medicare RBRVS for PPO products as minimally acceptable fee schedules for health plan contracts. (CX 103 at 4; CX 389).

97. On November 11, 2002, NTSP conducted another annual poll to determine minimum reimbursement rates for use in negotiation of HMO and PPO products and anesthesia contracts with health plans. On its polling form sent to physicians, NTSP included the prior year's poll results, reported by mean, median, and mode. (CX 430).

98. The results of the 2002 annual poll by mean, median, and mode, for HMO were 131%, 135%, and 135%; for PPO, 146%, 145%, and 145%. NTSP reported these figures to its member physicians and stated that the "poll's objective is to identify what reimbursement levels NTSP members deem acceptable." (CX 432).

99. By providing this pricing information to its member physicians, NTSP effectively informs the physicians of the potential reward for entering into a contract with health plans through NTSP, as opposed to entering into a contract with a health plan by directly negotiating with the health plan. (Frech, Tr. 1326).

100. Such price information sharing reduces each physician's uncertainty as to the conduct of its competitors in the aggregate. (Frech, Tr. 1327; *see also* CX 1170 (Blue, Dep. at 33) (poll results provide "a guideline where we saw the numbers, we would like to have these rates, if possible, and it kind of gave you an idea of where the market was. So if I got other communications independently and some . . . [were] paying 80 percent of Medicare, but it looked like a lot of plans were paying 110 percent, then 80 percent of Medicare sounded pretty low.")).

E. NTSP's Dealings with Several Health Plans

1. United Healthcare Services, Inc.

a. Corporate structure

101. United Healthcare Services, Inc., is a wholly owned subsidiary of United Healthcare through which United Healthcare offers its PPO and other non-HMO products in Texas. (Quirk, Tr. 234-35, 239, 241, 247-48). United Healthcare of Texas is a wholly owned subsidiary of United Healthcare through which United Healthcare offers its HMO products in Texas. (Quirk, Tr. 235, 247-48). [United Healthcare Services and United Healthcare of Texas are collectively referred to as "United."]

102. United Healthcare is a subsidiary of United Health Group, a publicly traded company. (Quirk, Tr. 248; Wilensky, Tr. 2156). The success or failure of United's Texas entities are reflected in the stock price of United Healthcare. (Quirk, Tr. 248).

103. United contracts with multi-state employers, some of whom are domiciled outside of Texas but have employees in Texas, such as Raytheon and Home Depot. (Quirk, Tr. 253-54).

104. If health care costs rise in the Ft. Worth area, the pricing of the overall package to Raytheon or other national companies would be affected. (Quirk, Tr. 254-55).

105. Since 1999, Thomas J. Quirk has been the CEO for the North Texas and Oklahoma Region of United Healthcare Services, Inc., and the President, Chairman of the Board and the CEO of United Healthcare of Texas. (Quirk, Tr. 234-36).

106. Quirk oversees all of United's operations for the North Texas and Oklahoma regions, which include sales for commercial employers, municipalities and school districts; account management for United's existing customers and network operations, which encompass contracting with physicians, hospitals, and other provider networks; and maintenance of those relationships. (Quirk, Tr. 235-36).

b. NTSP's negotiations with United in 1998

107. In July 1998, NTSP informed its member physicians that United was attempting to standardize its physician agreements by, among other things, changing the fee schedule. (CX 1005 (Fax Alert #79)).

108. In Fax Alert #79, NTSP sent its physicians an agency agreement for the purpose of obtaining consent to enter into negotiations. NTSP stated that "[b]ecause United Healthcare has the potential to be a major payor in this market place, the NTSP Board wishes to contact them and negotiate on behalf of its membership." (CX 1005 at 2).

109. NTSP explained later that it was United's attempt to change fee schedules that prompted NTSP negotiations with United. (CX 1014).

110. NTSP encouraged its member physicians to "refrain from responding to United Healthcare while NTSP's request for agency status [was] being tabulated." (CX 1005 at 2 (capitalization omitted)).

111. Some of NTSP's physicians authorized NTSP to negotiate with United on their behalf. (*E.g.*, CX 1006 (July 15, 1998 letter from Deas of Gastroenterology Associates of North Texas to Van Wagner allowing NTSP to serve as its agent in regard to future negotiations, including price terms, with United and instructing NTSP not to agree to any fee schedules lower than 135% of 1997 Medicare RBRVS for United's HMO product and 147% for United's PPO product); Deas, Tr. 2573-77).

112. On August 20, 1998, NTSP requested, and United granted, an extension on the time line for the assignment of contracts. (CX 1008). NTSP informed its member physicians of the extension and instructed them that they did not need to sign or return any documents or contracts to United. (CX 1008).

113. In September 1998, NTSP proposed to United that the Dallas Medicare RBRVS be used in calculating the rates for its HMO and PPO products for NTSP physicians, and informed its member physicians of this proposal in Fax Alert #94. (CX 1010).

114. NTSP also informed its member physicians in Fax Alert #94 that "[f]or many specialists, Dallas rates are approximately three to five percent higher than PPO rates applied to Tarrant County." (CX 1010 at 2).

115. On October 27, 1998, in Fax Alert #101, NTSP informed its member physicians that discussions with United had been productive, that the parties agreed to extend the deadline, and that member physicians need not take any action with regard to standardizing their United contract until this extension expired. (CX 1011).

116. United made an offer to NTSP on a non-risk contract that was below the rates available to NTSP participating physicians through another IPA, Health Texas Provider Network ("HTPN"). (Van Wagner, Tr. 1726-27).

117. HTPN, which is an affiliate IPA of Baylor Health Care System, is an organization of employed as well as independent contracted physicians in Dallas. NTSP and HTPN had an arrangement whereby NTSP member physicians would be allowed to access HTPN's payor offers. NTSP did not participate in discussions with payors regarding economic terms of HTPN contracts. (Van Wagner, Tr. 1559-60; Quirk, Tr. 311-12; RX 1947).

118. On December 2, 1998, in Fax Alert #112, NTSP informed its member physicians that NTSP proposed to United that NTSP's physicians contract with United through HTPN. (CX 1012).

119. On March 9, 1999, in Fax Alert #12, NTSP recommended to its member physicians that they transition their existing contracts into a standard United contract, and assured them that this would have no effect on the reimbursement rates that they were receiving under their current contract. NTSP further informed its member physicians that "we [NTSP] continue our discussions with United Healthcare on proposed fee schedules for these products." (CX 1014).

120. Ultimately, a significant number of NTSP physicians accessed United through the NTSP-HTPN arrangement. (CX 1015).

c. NTSP's negotiations with United in 2001

121. Beginning in March 2001, NTSP member physicians contacted NTSP, asking that NTSP seek and obtain a contract with United. (CX 1117 at 1). On March 14, 2001, NTSP expressed to United its "desire for a group contract reflecting today's market." (CX 1117 at 2; Quirk, Tr. 284-89).

122. NTSP targeted United because NTSP believed that United's rates were below market rates. (CX 211 at 3 (NTSP informing its Primary Care Physician Council that they had identified United as a re-negotiating target, noting that United was becoming a significant player in the Fort Worth market and that United's rates were well below market)).

123. NTSP's discussions with United involved fee-for-service contracts. (Quirk, Tr. 291, 293-94).

124. As of March 2001, United had contracts with approximately two-thirds of the NTSP physicians, either directly or through other organizations, such as HTPN. (Quirk, Tr. 288-89). Therefore, United concluded that there was no need to enter into an agreement with NTSP. (Quirk, Tr. 289-90).

125. On April 12, 2001, NTSP reported at its Primary Care Council Meeting that the reimbursement rates under the United-HTPN contract – 130% of 1997 St. Anthony RBRVS (145% Radiology) for HMO, 145% of 1997 St. Anthony RBRVS for POS, and 145% of 1997 St. Anthony RBRVS for PPO – were below market. (CX 209 at 3; CX 1015 at 4). A majority of NTSP physicians had accepted this contract in 1999 through NTSP's affiliation with HTPN. (CX 1015 at 1).

126. In or about May 2001, notwithstanding its view that United already had a sufficient network in Fort Worth, United offered to NTSP its then standard rates in the Fort Worth area: 110% of 2001 Dallas RBRVS, which was the equivalent of 115% of 2001 Tarrant County

RBRVS, to NTSP. United's offer extended one rate for both HMO and PPO products. (CX 87 at 7; CX 89 at 3; Quirk, Tr. 290, 297-98).

127. NTSP did not messenger the May 2001 offer to its physicians and rejected it for two reasons: (1) it fell below NTSP's Board minimums; and (2) it extended one rate for all products, instead of different rates for HMO and PPO products. (Quirk, Tr. 300-01; CX 87 at 7).

128. On June 19, 2001, a United representative wrote to an NTSP representative, explaining that United's offered rates were identical for HMO and PPO reimbursement because, from the physician's standpoint, each United patient is administratively the same. (CX 1027).

129. On June 25, 2001, the NTSP Board discussed United's rate offer and rejected it. (CX 89 at 3; Quirk, Tr. 300-01).

d. NTSP's discussions with the City of Fort Worth

130. In 2001, NTSP physicians provided health care to the majority of employees of the City of Fort Worth and their dependents under NTSP's risk contract with PacifiCare. (Mosley, Tr. 148-49, 203).

131. The City of Fort Worth, in 2001, decided to become self-insured and began accepting bids from payors to become the administrator of its health plan. (Mosley, Tr. 148-49). One of the bidders against PacifiCare was United. (Mosley, Tr. 203-05; Van Wagner, Tr. 1743).

132. NTSP learned, in the spring of 2001, that United was negotiating with the City of Fort Worth to provide health care coverage to city employees and their dependents. (CX 89 at 3).

133. NTSP believed that United was threatening to displace an NTSP risk contract. (Mosley, Tr. 206-07; Quirk, Tr. 363-65). If the City of Fort Worth selected United, the effect would be to remove this major employer's patients from NTSP's risk network (PacificCare) and substitute in its place a four-year-old non-risk contract that NTSP had with United through HTPN. (Van Wagner, Tr. 1728-29; CX 1042).

134. NTSP also had concerns about the adequacy of United's network and utilization management for the City's patient population and about United's ability to provide care to the City. (Van Wagner, Tr. 1729-35; Deas, Tr. 2424-25, 2429-30; Mosley, Tr. 185-87; Vance, Tr. 856-57; CX 1031).

135. During its negotiations with United, beginning in June 2001, NTSP encouraged its Board members to contact "any city council members they know to let them know that United's panel is not adequate." (CX 89 at 3).

136. NTSP also urged its primary care physicians to contact the Mayor and city council members to educate them about the situation with United and ask for help. (CX 211 at 3).

137. NTSP, on July 13, 2001, provided to its member physicians model letters for the purpose of contacting city officials. Attached to Fax Alert #44 was a sample letter to the Mayor of Fort Worth with the fax number for the Mayor and the names, addresses, fax numbers, and email addresses of the members of the city council. The sample letter included the following statements:

> Many of my patients are city employees or dependants and I/we have enjoyed caring for and managing their health for years. . .
>
> I look forward for your assistance in communicating to United that they offer a reasonable solution to this situation so I/we can continue to see City Employees and their dependants without disruption. . .
>
> In the best interest of my/our current City of Ft. Worth patients, I/we ask for your assistance in resolving this dispute before the City transitions to United Health Care.

(CX 1042 at 4).

138. On July 2, 2001, NTSP member physicians Blue, Vance, Deas, and Grant signed a letter addressed to the Mayor of Fort Worth bearing NTSP's letterhead. The letter asserted that United's rates were "well below market benchmarks" and that "NTSP simply has not and will not accept United's request for our participation in their provider network for your employees." The letter also asserted that "the City may experience significant network disruption once United officially begins their duties (up to 588 doctors no longer available)." (CX 1029 at 3-4; *see also* CX 1031 (July 9, 2001, letter from Vance to the Mayor of Fort Worth, stating that the City's recent switch to United placed the relationship between the City employees and their physicians "in serious jeopardy," that the United offer was "significantly below market," and stating that unless "this contractual issue is resolved," there was the "likelihood that NTSP members will no longer be available to city employees.")).

139. Other NTSP physicians wrote letters to the Mayor of Fort Worth reflecting the points discussed by NTSP in Fax Alert #44. (CX 1036; CX 1037; CX 1041; CX 1046).

140. NTSP, as an existing provider for the City of Fort Worth, arranged a meeting with the City and communicated to the City NTSP's concerns about the adequacy of United's panel and the cost impact on the City if the City were to change from the PacifiCare risk contract to the United non-risk contract. (Mosley, Tr. 186-87, 192-93; Van Wagner, Tr. 1744; Deas, Tr. 2424-25, 2429-31).

141. At the September 13, 2001 meeting with the City, NTSP representatives also told the City that United had offered rates on a non-risk contract with NTSP that were unacceptable to NTSP and that NTSP was going to reject the United offer. NTSP told the City that they may have a significantly different network on October 1, 2001, when the City would transition from PacifiCare to United. (Mosley, Tr. 186-87; CX 1042).

142. The NTSP Board informed its member physicians in Fax Alert #44, dated July 13, 2001, that NTSP Board members met with the Mayor of Fort Worth regarding the "possible inadequacy of the United network" and stated that although they "got the attention of the Mayor, our work is not done." (CX 1042).

143. Jim C. Mosley, a health care consultant to the City of Fort Worth, contacted a representative of United and shared with United the City's concerns regarding the continuation, maintenance, and preservation of the then existing United network. The possibility that City employees might lose access to NTSP physicians was a matter of concern to the City. United was requested to maintain the network without compromising costs. (Mosley, Tr. 173, 179-80, 182; Quirk, Tr. 309).

144. On September 13, 2001, NTSP met again with representatives of the City of Fort Worth. NTSP told the City that United's new, increased PPO reimbursement offer to NTSP physicians was still unacceptable. NTSP further expressed concerns about United's practice of "bundling" claims, pursuant to which physicians who provided multiple services on a single occasion were reimbursed at a single, bundled rate (lower than the rate at which each service would be compensated if billed separately). NTSP expressed its view that United's bundling practice under-compensated physicians. (Mosley, Tr. 185-93; CX 1075).

145. Following the September 13, 2001 meeting between NTSP and the City of Fort Worth, NTSP wrote a letter to the City of Fort Worth informing the City that United continued to offer low rates. (CX 1075 (Letter from Deas to City Manager for the City of Fort Worth, noting that despite some "positive movement," United's overall rates "may still prove inadequate" and this "may affect the overall size of United's physician network")).

146. NTSP's September 13, 2001 letter to the City of Fort Worth also reported that several physician's offices refused to contract with United unless a group contract through NTSP was negotiated on their behalf and noted that NTSP's termination notice to HTPN would take effect October 21, 2001. Notification letters to patients could be sent as soon as October 1, 2001, the same day as the City was supposed to transition to United. (CX 1075).

e. Continued negotiations and termination of HTPN contract

147. On July 9, 2001, NTSP informed United that United's current offer of 110% RBRVS (Dallas conversion factors) for all products was below the Board minimums that NTSP

could accept. NTSP told United that the Board minimums were 125% RBRVS for HMO and 140% RBRVS for PPO (Tarrant County conversion factors). (CX 1034 at 1; Quirk, Tr. 299-01).

148. On July 13, 2001, in Fax Alert #44, the NTSP Board informed all NTSP member physicians that NTSP and United were in agreement as to basic fundamental language terms but "far apart in agreeing to a market reimbursement fee schedule." (CX 1042 at 1).

149. The NTSP Board also noted in Fax Alert #44 that many NTSP physicians were contracted with United through HTPN. The rates under the United-HTPN contract were indexed to 114% of 2001 Tarrant County RBRVS for HMO and 127% of 2001 Tarrant County RBRVS for PPO and were reported to be below or little above Medicare for many NTSP specialties. (CX 1042). The NTSP Board contrasted the NTSP minimums of 125% of 2001 Tarrant Medicare RBRVS for HMO and 140% of Tarrant Medicare RBRVS for PPO with United's direct offer to NTSP of 110% 2001 Dallas Medicare RBRVS for all products. (CX 1042).

150. The NTSP Board, in Fax Alert #44, also informed the member physicians that "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." (CX 1042).

151. On July 23, 2001, the NTSP Board approved the termination of its participation in the United-HTPN contract. (CX 91; CX 1051B). At that time, 101 of NTSP's physicians contracted with United through the United-HTPN contract. The rest of NTSP physicians contracted with United were through direct contracts (77) or through another IPA or other organizations. (CX 1055; CX 1057; Quirk, Tr. 302-04).

152. The effective date of termination was to be October 20, 2001, less than three weeks after the City of Fort Worth had planned to transition its employee health plans from PacifiCare to United. (CX 1051B; CX 1042 at 1).

153. On July 23, 2001 NTSP sent a letter to United, submitting its ninety day notice of its termination of participation in all United products offered through HTPN ("termination letter"). NTSP sent a copy of the July 23, 2001 termination letter to the Mayor of the City of Fort Worth. (CX 1118; Quirk, Tr. 312-13).

154. NTSP explained to its member physicians, by Fax Alert #52 dated August 9, 2001, that the United contract through HTPN was terminated because United offered rates below Board approved minimums and because of United's proposal of a single fee schedule for both HMO and PPO. (CX 1062).

f. Poll results used to establish Board minimums

155. United's May 2001 offer to NTSP of 110% of current Dallas Medicare RBRVS fee schedule fell below NTSP's Board minimums that had been determined by the Board based on

the result of polling. (CX 1042).

156. Subsequent to the May 2001 offer, NTSP completed its annual reimbursement poll. As NTSP informed its member physicians, "[t]his poll's objective is to identify what reimbursement levels NTSP members deem acceptable." (CX 393).

157. On October 29, 2001, in Fax Alert #83, NTSP communicated to its member physicians the results of NTSP's annual reimbursement poll of NTSP member physicians' acceptable rates on both HMO and PPO levels. (CX 393).

158. The results of the 2001 annual poll for HMO were 128.46% (mean), 127% (median), and 127% (mode). The results for PPO were 142.07% (mean), 144.5% (median), and 144.5% (mode). "All percentages index to current Medicare rates and represent[] the percentage of Medicare that the 'average NTSP physician' would find acceptable for the next twelve months on HMO and PPO products." (CX 393).

159. On October 29, 2001, NTSP held a general membership meeting in which the offer from United was detailed along with the latest poll results which reflected a higher minimum for PPO than United's fee proposal. The PPO rate was listed as an "open issue." (CX 186 at 1).

g. Power of attorney forms

160. On August 9, 2001, in Fax Alert #52, NTSP solicited power of attorney forms from NTSP member physicians because, "[a]s with previous contracts, several members have requested that NTSP act on their behalf in regards to all contracting activity between themselves and United Health Care." (CX 1062).

161. The power of attorney provided to the physicians with Fax Alert #52 explained to them that "[t]his power of attorney grants to the agent the authority to act on the undersigned's behalf regarding the foregoing described agreements in all respects, including the authority to negotiate the terms of, enter into, execute, modify, extend or terminate any such agreements." (CX 1062 at 2-3).

162. A copy of Fax Alert #52 was obtained by United. Quirk made a handwritten notation on this copy indicating United's view that United needed to redevelop a network strategy for Tarrant County. (CX 1051; Quirk, Tr. 320-21).

163. United decided to try to recruit the terminated NTSP physicians directly. (CX 1056; CX 1057 at 1). In August 2001, shortly after receiving NTSP's termination letter, United made the decision that David Beaty, Senior Network Account Manager for United, would contact all of the affected NTSP physicians whose contracts with United through HTPN were to be terminated by NTSP. (Quirk, Tr. 334; Beaty, Tr. 452, 454).

164. Beaty wrote to these physicians, inviting them to continue participation in United's network under a direct contract with United, and offered them the same reimbursement rates as they were receiving under the HTPN-United agreement. Some physicians accepted this offer. (Quirk, Tr. 334; Beaty, Tr. 452; CX 1068).

165. On August 24, 2001, in Fax Alert #56, NTSP informed its member physicians that NTSP had been receiving calls from some NTSP physicians regarding direct contract offers that they had received from United. NTSP reported that the rates paid to the NTSP physicians through the United-HTPN arrangement were below the NTSP acceptable Board minimums and noted that this had been NTSP's reason for terminating the HTPN arrangement. (CX 1066).

166. NTSP also informed its member physicians, in Fax Alert #56, that NTSP would "continue to pursue a direct contract with United Healthcare that meets or exceeds the fee schedule minimums set by the NTSP membership." (CX 1066).

167. Also, through Fax Alert #56, NTSP informed its member physicians that it had already received 107 executed power of attorney forms "from NTSP members assigning NTSP power of attorney to act on their behalf in regard to all contracting activity between themselves and United Healthcare," and sought the submission of executed powers by additional member physicians. (CX 1066 at 1-2; *see also* CX 1002 at 1-12).

168. NTSP advised those physicians who had signed the power of attorney forms that they "should inform all United representatives who contact you that NTSP is your contracting agent for United Healthcare and instruct them to contact NTSP directly." (CX 1066 at 1; *see also* CX 1002 at 1-12).

169. United obtained a copy of Fax Alert #56 and learned that NTSP had gathered 107 power of attorney forms from physicians and that NTSP was continuing to solicit additional power of attorney forms to be used in collective bargaining with United. (Quirk, Tr. 326-27, 330-31; CX 1051A).

h. United offers increased rates

170. In the summer of 2001, United increased its offer to All Saints Integrated Affiliates ("ASIA"), another Fort Worth IPA through which 113 NTSP physicians had contracts with United. (CX 1055; Quirk Tr. 345; 336-37). United's offer to ASIA was 125% of 2001 Tarrant County RBRVS for HMO and 130% of Tarrant County RBRVS for PPO. (Quirk, Tr. 345). United made this offer to Medical Clinic of Northern Texas ("MCNT") also. (CX 1119 at 1).

171. In September 2001, United also extended the offer of 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO to the NTSP physicians whose contracts through HTPN had been terminated. (CX 658; *see also* CX 1119).

172. More than ten physicians' groups participating in NTSP did not respond to United's offer at this rate, even though it was higher than rates they had prior to their pending termination, effective October 21, 2001, by NTSP. (Beaty, Tr. 454-55).

173. United's account representative contacted the physician groups that had rejected the new United offer. (Beaty, Tr. 454-55; CX 658; CX 1119). Some of those groups responded that they rejected United's offer for a direct contract because NTSP was negotiating on their behalf. (Beaty, Tr. 455, 459-60).

174. On September 5, 2001, NTSP held a general membership meeting, at which Van Wagner updated NTSP's member physicians on recent progress in contract negotiations with United. (CX 1076; CX 158).

175. On September 7, 2001, United declined NTSP's offer to attend an NTSP Board meeting. (CX 1121).

176. On September 13, 2001, in Fax Alert #60, NTSP reported to its member physicians that United had increased reimbursement levels "via a contract amendment with ASIA, as well as individual direct offers to several NTSP physicians." (CX 1076).

177. As a result of the increased offers, NTSP deferred activation of the power of attorney forms for two weeks, subject to NTSP's reconsideration. (CX 1076).

178. On September 19, 2001, NTSP informed its member physicians that in order to allow NTSP to consider the increased United offer available through ASIA or directly, NTSP would defer any further action until September 27, 2001. NTSP would then contact each member who previously gave a power of attorney to determine if those member physicians desired additional action by NTSP on their behalf. Member physicians who considered individual contracts with United were invited to review the proposed negotiated group contract. (CX 1079).

179. In a September 20, 2001 letter, United accepted NTSP's invitation to meet with the NTSP Board. (CX 1080; Quirk, Tr. 338-39).

180. On September 21, 2001, Van Wagner updated NTSP's Medical Executive Committee on contract negotiations with United. (CX 198 at 2).

181. On September 24, 2001, United representatives met with NTSP's Board. NTSP stated that it opposed United's offer of one rate for all products because the offer was below Board minimums, which were different for HMO and PPO products. NTSP told United's representatives that PPO rates should be higher than HMO rates. (Quirk, Tr. 340-41, 344).

182. At the September 24, 2001 meeting, the NTSP Board also told United that NTSP's

contractual arrangement with HTPN enabled NTSP to terminate the arrangement for United's products on behalf of its physicians. (CX 1081; Van Wagner, Tr. 1727-28).

183. In a September 24, 2001 letter, Deas invited United to reopen negotiations. (CX 1084).

184. On September 24, 2001, NTSP sent a letter to its member physicians with a summary of terms to be included in any direct contract with United. The summary discussed price related terms, including: (1) United's reimbursement methodologies should not translate into less than what Medicare would have paid; and (2) a fee maximum change from 80% of usual and customary to 100% of usual and customary. (CX 1064).

185. On or about October 10, 2001, United sent NTSP a new offer. United offered NTSP an increased rate of 125% of 2001 of Tarrant County RBRVS for HMO and 130% of Tarrant County RBRVS for PPO. (CX 1088; CX 1096; Quirk, Tr. 347-49).

186. NTSP and United signed a contract for 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO, effective November 1, 2001. (CX 1095 at 10).

187. The new contract represented an increase of 10% from the initial HMO offer and of 15% from the initial PPO offer. (Quirk, Tr. 290, 297-98). *Compare* CX 87 at 11 (for both HMO and PPO, 115% of Tarrant County RBRVS) *with* CX 1095 (for HMO, 125%; for PPO, 130% of 2001 Tarrant County RBRVS).

188. The contract was an increase from United's initial offer to NTSP. But, it was the same rate that United had previously offered other IPAs – ASIA and MCNT. (CX 1119). It was also a lower rate than the one given to HTPN in February 2001. (CX 1099).

189. On November 1, 2001, in Fax Alert #84, NTSP sent the contract to its member physicians to opt in or opt out, indicating that the contract was a result of negotiations and that the 125% of the 2001 Tarrant County RBRVS for the HMO was "at the average level of acceptable reimbursement." NTSP noted to its member physicians that the PPO rate of 130% of Tarrant County RBRVS was below the acceptable average reimbursement levels determined by the NTSP Board, based on the poll results. (CX 1097; Van Wagner, Tr. 1642-43).

190. Vance, a former NTSP President who at the time was a member of the NTSP Board of Directors, summarized NTSP's success in these United negotiations to his medical group, in an effort to convince the group to continue their membership with NTSP:

> United Health Care came to town six months ago and offered a straight 110% of Medicare contract. . . . Through the efforts of NTSP lobbying the City [of Fort Worth] and [terminating] a group

> contract with Health Texas, United blinked. United was so eager to dilute our effectiveness that they refused to negotiate with NTSP but offered an improved contract thru ASIA. The fees in the [ASIA] contract are very close to the numbers that NTSP presented as market rates for [Fort Worth] and were rejected out of hand by United officials. United has now returned to the table with NTSP at the direct request of the [C]ommissioner of the Dept[.] of Insurance. This United negotiation is a template for other efforts that will need to occur in the near future and would best be coordinated by NTSP.

(CX 256; *see also* CX 1199 (Vance, Dep. at 310-11)).

191. The level of acceptance of the NTSP/United contract by NTSP member physicians was low. (CX 1100). Fax Alert #95, dated November 19, 2001, indicates that 258 NTSP member physicians responded. (CX 1100). For HMO, 24% accepted and 76% rejected the contract. For PPO, 23% accepted and 77% rejected the contract. (CX 1001 at 2).

i. NTSP reported United to Texas Department of Insurance

192. 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. 1772).

193. NTSP's Board Minutes of September 24, 2001, reported that Deas met with the Texas Commissioner of Insurance to discuss predatory pricing by health plans. The Commissioner stated that he would send letters to CEOs of major plans cautioning them against predatory pricing activities. Deas also discussed with the Commissioner the impact of HMO and PPO contracting revisions on Tarrant County physicians. (CX 100 at 3-4).

194. In August 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).

2. Cigna Healthcare

a. Corporate structure

195. Cigna of Texas is a subsidiary of Cigna Healthcare ("Cigna") which has its corporate headquarters in Philadelphia, Pennsylvania. (Grizzle, Tr. 669). Cigna Corporation reports consolidated earnings for the entire corporation, including Cigna of Texas. (Grizzle, Tr. 669-70).

196. A change in revenue and earnings for Cigna of Texas would affect the revenues and earnings for the entire corporation. (Grizzle, Tr. 670).

197. When Cigna contracts with multi-state employers, a single contract is signed. (Grizzle, Tr. 682). A change in costs for Cigna of Texas could affect the health insurance costs of an employer with multi-state coverage. (Grizzle, Tr. 683).

198. An increase in Cigna's costs would increase premiums which could affect Cigna's competitiveness in other states. (Grizzle, Tr. 683-85).

199. Mr. Rick Grizzle is the vice president of network development for Cigna Healthcare, with responsibilities for contracting and managing provider services in Texas, Oklahoma, and Louisiana. (Grizzle, Tr. 666-67).

b. Cigna's acquisition of Healthsource and initial contacts with NTSP

200. In late 1997, Cigna purchased Healthsource, a company which offered both HMO and PPO products, covering approximately one million lives nationally. Many NTSP member physicians had direct contracts with Healthsource. (Grizzle, Tr. 695, 767-70).

201. For physicians with agreements with both Cigna and Healthsource, Cigna, in July 1998, informed physicians that their contracts under Healthsource would be terminated and assigned to Cigna. (CX 332; Van Wagner, Tr. 1752-53).

202. For physicians with agreements with only Healthsource, Cigna, in July 1998, requested that physicians assign their contracts from Healthsource to Cigna and informed physicians that if they did not wish to assign their contracts to Cigna, they could continue under their Healthsource agreements, as long as Healthsource products were being offered in the marketplace. (CX 332; Van Wagner, Tr. 1752-53).

203. Healthsource subsequently went out of business. (Grizzle, Tr. 770).

204. Some NTSP physicians went to NTSP regarding the change in their Healthsource contracts and requested that NTSP contact Cigna. (Van Wagner, Tr. 1752). NTSP did contact Cigna regarding these issues. (Van Wagner, Tr. 1753-54).

205. NTSP sent to its member physicians a sample letter refusing the contract assignment from Healthsource to Cigna and directing Cigna to negotiate with NTSP as their agent. NTSP also sent its member physicians an agency agreement that authorized NTSP to negotiate on the behalf of consenting member physicians. NTSP informed its physicians that "if 50% or more of NTSP member physicians concur that agency is appropriate, NTSP will contact CIGNA and Healthsource directly in regards to this matter." NTSP advised "its members not to consent to

the assignment of your Healthsource provider agreements to CIGNA." (CX 332 (*emphasis omitted*)).

206. Cigna received 40 letters, all virtually identical to the sample letter provided by NTSP, representing 52 NTSP member physicians, in which NTSP physicians did not agree to assign to Cigna their Healthsource agreements, and which directed Cigna to negotiate with NTSP on their behalf. (CX 760 (limited admission); Grizzle, Tr. 696-98, 709, 724).

207. The physicians who did not agree to assign their Healthsource agreement to Cigna believed that they had the right to do so. (Van Wagner, Tr. 1753-54; Grizzle, Tr. 768).

208. Upon receiving these letters, Cigna concluded that the 52 physicians who had sent Cigna letters would not directly contract with Cigna and that Cigna would need to approach NTSP instead. (Grizzle, Tr. 697, 709-10, 747).

209. Cigna has entered into direct contracts with some NTSP physicians independent of NTSP. (Grizzle, Tr. 724). In some instances, the direct contract between Cigna and physician is at a higher reimbursement rate than the Cigna/NTSP contract. (Deas, Tr. 2410).

c. NTSP's negotiations with Cigna

210. Beginning in 1999, NTSP sought a risk contract with Cigna. (Grizzle, Tr. 775; Van Wagner, Tr. 1754-55; CX 764, *in camera*). NTSP and Cigna were unable to agree to a risk-sharing arrangement. (Van Wagner, Tr. 1758; CX 764, *in camera*).

211. Cigna and NTSP have entered into several fee-for-service agreements. These agreements are: the Letter of Agreement, the First Amendment, the Second Amendment, and the Third Amendment. (CX 764, *in camera*; CX 769; CX 771 at 1, *in camera*; CX 809, *in camera*; CX 810, *in camera*; Grizzle, Tr. 715-16; Grizzle, Tr. 723-24).

(i) Letter of Agreement, First Amendment

212. NTSP and Cigna entered into a Letter of Agreement (LOA) in October of 1999. The LOA only covered fee-for-service rates for Cigna's HMO business, and not its PPO business. (Grizzle, Tr. 710-11; CX 782A, *in camera*).

213. Under the LOA, Cigna agreed to reimburse NTSP specialists, with the exception of cardiologists/cardiovascular surgeons, gastroenterologists, urologists, oncologists, and podiatrists, on a fee schedule equal to 125% of the 1998 Dallas County RBRVS. (Grizzle, Tr. 710-14; CX 782A, *in camera*; CX 764 at 1, *in camera*).

214. Cigna entered into this agreement with NTSP because Cigna believed that the core group of NTSP, the specialists in Fort Worth, were critical for Cigna. (Grizzle, Tr. 719-20).

215. The LOA was entered into by NTSP and Cigna in anticipation of a risk contract and specifically called for the establishment of a risk contract within a short time. (Van Wagner, Tr. 1757-58; CX 784, *in camera*; CX 782A, *in camera*).

216. The 1999 LOA was amended in January 2000 (First Amendment) to add PPO coverage for NTSP specialists at a reimbursement rate of 135% of Dallas County 1998 RBRVS. (CX 769; Grizzle, Tr. 714).

217. Cigna's representative, Grizzle, testified that the reimbursement rate of 125% of RBRVS on HMO and 130% of RBRVS on PPO was somewhere between 15 and 20 percent higher than Cigna's standard rates. Grizzle also testified that the rates Cigna paid to NTSP were in the "general ballpark" of the rates Cigna paid to other IPAs {
}. (Grizzle, Tr. 716, 958-59, *in camera*).

(ii) Conflicts between NTSP and Cigna

218. NTSP believed that Cigna had breached its contract with respect to how fee schedules were loaded into Cigna's system. There were instances of a change in the fee schedule as called for by the contract where NTSP would later find that Cigna had failed to load the changes. NTSP complained to Cigna regarding Cigna's failure to pay in accordance with the agreed upon schedule and informed Cigna that NTSP considered the failure a material breach. (Grizzle, Tr. 797; Van Wagner, Tr. 1769; CX 792, *in camera*; RX 497; RX 960, *in camera*; RX 1486, *in camera*).

(iii) Second Amendment

219. NTSP also believed that Cigna breached the LOA and First Amendment by not adjusting the fee schedule to current year RBRVS. (Grizzle, Tr. 799-800; Van Wagner, Tr. 1979-80).

220. The 1999 LOA was amended in May 2000 (Second Amendment) to clarify the proper year of RBRVS reimbursement. While the First Amendment to the LOA did not require that the fee schedule be adjusted annually, the Second Amendment explicitly called for an annual adjustment of the HMO and PPO schedule to current year { } RBRVS. (CX 769; CX 770, *in camera*; CX 771, *in camera*; CX 800 at 2; Grizzle, Tr. 715, 740-41).

(iv) Cardiologists

221. Under the LOA, Cigna agreed to reimbursement of "NTSP specialists, with the exception of NTSP cardiologists/CV [cardiovascular] surgeons, gastroenterologists, urologists, oncologists and podiatrists." (Grizzle, Tr. 710-14; CX 782A, *in camera*).

222. NTSP's cardiologists were carved out of the LOA. (Grizzle, Tr. 927, *in camera*; Van Wagner, Tr. 1764-66).

223. In a carve out arrangement, certain specialists or services are outside of a capitation plan and are paid in some other manner. (Frech, Tr. 1434).

224. Although NTSP's cardiologists were initially carved out of the LOA, an addendum to the LOA gave a right of first refusal for NTSP's cardiologists to participate with Cigna if Cigna's carve out agreements with cardiologists were terminated. (Grizzle, Tr. 927, *in camera*; Van Wagner, Tr. 1764-66; CX 770, *in camera*).

225. Regarding Cigna's need for cardiologists, Cigna had contracted with American Physician Network ("APN") for cardiology services. (Grizzle, Tr. 726-27, 929-30, *in camera*).

226. In July 2000, Cigna informed NTSP that the carve out arrangment that Cigna had with NTSP had been assigned to APN and told NTSP to work out an agreement with APN. (Grizzle, Tr. 929-30, *in camera*; Van Wagner, Tr. 1768; CX 775).

227. Cigna viewed its action as an assignment of the contract and believed that the LOA did not allow NTSP's cardiologists to join the Cigna fee-for-service contract if the carve out had been assigned. (Grizzle, Tr. 725).

228. NTSP viewed Cigna's action as Cigna's termination of the cardiologists' carve out agreement. NTSP believed that Cigna had breached the LOA by refusing to give NTSP's cardiologists a right of first refusal to participate in the NTSP agreement. (Grizzle, Tr. 929-30, *in camera*; Van Wagner, Tr. 1766-68; CX 775; CX 776; CX 784; CX 785, *in camera*).

229. NTSP sent Cigna a letter, dated August 2, 2000, stating that NTSP was exercising its option under the terms of the present Cigna arrangement for NTSP cardiologists to participate under the terms of the HMO arrangement. (CX 776).

230. APN subsequently submitted a fee-for-service offer to NTSP's cardiologists. (Grizzle, Tr. 726-27).

231. NTSP rejected APN's offer, in a letter dated October 6, 2000, which stated 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." (CX 777A; Grizzle, Tr. 726-27).

232. In an October 16, 2000 letter from NTSP to Cigna, NTSP stated that NTSP's Cardiology Division and Board found Cigna's proposal to be "woefully inadequate. The financial arrangements proposed were well below the agreed upon fee schedule contained in the

NTSP/Cigna agreement. As a result, [APN] was notified on October 6, 2000 that [their] proposal was declined, as it did not meet minimum reimbursement levels." (CX 777).

233. The October 16, 2000 letter from NTSP to Cigna also states that "[o]bviously Cigna's failure to resolve this issue may affect current NTSP participation and future dialogue with Cigna regarding a PSN [provider sponsored network] type risk arrangement." (CX 777; Grizzle, Tr. 730).

234. NTSP believed that it had the right to terminate its contract with Cigna if what NTSP believed to be Cigna's breaches of contract were not cured. (Grizzle, Tr. 797; Van Wagner, Tr. 1769-71; RX 497; RX 960, *in camera*; RX 1486, *in camera*).

235. Cigna performed an analysis of the impact of the potential loss of NTSP's physicians from its network. Cigna determined that NTSP's termination would leave it with gaps in specialty coverage in the Fort Worth area. (Grizzle Tr. 730-31 (stating that Cigna took the threat seriously because NTSP presents "a fairly unified force, well-represented and looked like a strong entity . . . working in Fort Worth"); CX 779, *in camera* (charting impact of NTSP termination by specialty)).

236. Within the next twelve months, APN went bankrupt and dissolved. Cigna then allowed NTSP's cardiologists to participate in the Cigna/NTSP agreement. (Grizzle, Tr. 731-32, 937 (*in camera*); Van Wagner, Tr. 1768).

(v) Third Amendment: primary care physicians

237. Under the 1999 contract between Cigna and NTSP, Cigna agreed to reimburse "NTSP specialists," with the exception of those specialists explicitly carved out. (Grizzle, Tr. 710-14; CX 782A, *in camera*).

238. NTSP sought to have its primary care physicians ("PCPs") included under its contract with Cigna. By letter dated November 9, 2000, NTSP wrote to Cigna expressing its belief that the agreement between Cigna and NTSP was in serious jeopardy due to Cigna's refusal to allow NTSP cardiologists to participate at the contracted rate. NTSP wrote: "in an effort to maintain NTSP network participation during this critical period of open enrollment, I believe a timely good faith gesture by Cigna would be appropriate." One of the terms which NTSP would consider was that, "Cigna immediately allow all of NTSP's sub-contracted Primary Care Physicians the option to participate under the terms of our HMO and PPO agreements." (CX 786, *in camera*; Grizzle, Tr. 732).

239. Cigna had already contracted with a sufficient number of primary care physicians at lower rates than those under the NTSP agreement. Allowing NTSP's primary care physicians to opt in to the NTSP/Cigna specialist contract would increase Cigna's costs with no additional benefit to Cigna. (Grizzle, Tr. 718-19, 733-34).

240. In order to maintain the relationship with NTSP and despite increasing its costs, Cigna offered NTSP's primary care physicians a tiered reimbursement fee schedule in which the primary care physicians would initially receive NTSP's specialist rates and would, over time, return back to a "market level." (Grizzle Tr. 735-36).

241. In December 2000, NTSP rejected Cigna's offer on behalf of its primary care physicians. (Grizzle, Tr. 736; CX 791 ("NTSPs Board absolutely cannot and will not negotiate or offer an agreement in which our PCP partners are paid less than our specialists . . . . The 125% of the then current Dallas (not Tarrant County) RBRVS must stand as per our current agreement.")).

242. On June 7, 2001, NTSP sent an email to Cigna requesting that Cigna bring NTSP primary care physicians into the NTSP/Cigna agreement on the PPO product. (CX 800 at 1).

243. By return email that same day, June 7, 2001, Cigna reiterated its resistance to NTSP's demands to include NTSP's primary care physicians at NTSP's specialist rates. (CX 800 at 2; Grizzle, Tr. 740-41).

244. NTSP subsequently, on June 12, 2001, sent a notice of termination letter to Cigna, providing Cigna with 60 days notice. NTSP's letter stated, NTSP "look[s] forward to utilizing the next 60 days in resolving the issue of Cigna not allowing our affiliated Primary Care Physicians to participate under the terms of our PPO agreement." (CX 802).

245. In response to NTSP's notice of termination letter, Cigna and NTSP negotiated a third amendment to the NTSP/Cigna contract. (Grizzle, Tr. 749-51; Van Wagner, Tr. 1771; CX 810, *in camera*).

246. The 1999 LOA was amended in August 2001 (Third Amendment) {

} (Grizzle, Tr. 749-51, 755, 942-43, *in camera*; Van Wagner, Tr. 1771-72; CX 809, *in camera*; CX 810, *in camera*).

247. The Third Amendment is the current contract under which Cigna and NTSP were operating at the time of trial (April 2004), and was set to expire September 14, 2004. (CX 809, *in camera*; CX 810, *in camera*).

248. Cigna estimated that it would cost Cigna { } to add more NTSP physicians to the NTSP/Cigna arrangement. These additional physicians were already individually-contracted with Cigna at "market rates." (CX 814, *in camera*). Cigna realized no benefit from having these additional NTSP physicians in the network. (Grizzle, Tr. 877-79, *in camera*).

(vi) Third Amendment: terms

249. The contract between NTSP and Cigna that was current at the time of trial, April 2004, the Third Amendment, is a non-risk agreement. (CX 809, *in camera*; CX 810, *in camera*; F. 251-55).

250. Under the Third Amendment, PPO reimbursement is at a rate of { } and HMO reimbursement is at a rate of { }. (CX 809, *in camera*; CX 810, *in camera*).

251. In NTSP's summary of the contract terms, NTSP characterizes the agreement as a "non-risk agreement." (CX 810, *in camera*).

252. The Third Amendment does include: capitation payments, a pay-for-performance provision, and a withhold provision. (Van Wagner, Tr. 1758-59, 1761; F. 253-55).

253. { } (Grizzle, Tr. 755, 879-80, *in camera*).

254. { } (Grizzle, Tr. 880, 896, 946-48, *in camera*; Van Wagner, Tr. 1974-76).

255. { } (Grizzle, Tr. 881-82, *in camera*).

d. NTSP reported Cigna to Texas Department of Insurance

256. NTSP 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).

257. In August 2001, the Texas Department of Insurance 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 Cigna's failure to comply with clean claims laws. (RX 3103).

258. In September 2001, the Texas Attorney General investigated Cigna's payment methodology. (CX 108 (Board minutes reporting Office of Attorney General's letter); RX 1290; RX 1651).

3. Aetna Health, Inc.

a. Corporate structure

259. Aetna Health, Inc., ("Aetna") is a wholly owned subsidiary of Aetna, Inc., which has its headquarters in Hartford, Connecticut. (Roberts, Tr. 474).

260. Aetna provides health insurance coverage in the North Texas area. In the Fort Worth area, Aetna currently has approximately 40,000 to 50,000 HMO members and 100,000 PPO members. (Roberts, Tr. 474; Jagmin, Tr. 981).

261. Aetna's network has about 7,200 physicians in the Dallas-Fort Worth Metroplex. (Jagmin, Tr. 1121).

262. Aetna's clients in the Fort Worth area include national companies such as Bell Helicopter and Lockheed Martin. (Roberts, Tr. 476).

263. When Aetna pays a claim in Texas, it is paid from premiums which may have come from states outside of Texas. (Roberts, Tr. 476).

264. Aetna's performance in the Fort Worth area affects Aetna's national performance because any profits or losses roll up and appear on the financial statements of the publicly traded parent company. (Roberts, Tr. 474, 477).

265. Dr. Christopher Jagmin is currently the medical director for medical policy. (Jagmin, Tr. 969). Jagmin works for Aetna, Inc., based out of Blue Bell, Pennsylvania, and he consults and advises for the North Texas area. (Jagmin, Tr. 972, 974).

266. Mr. David Roberts is employed by Aetna Health, Inc., as a network vice-president. He has worked for Aetna Health, Inc., (or another subsidiary of the national company) since 1999, when Aetna acquired Prudential. Prior to 1999, Roberts worked for Prudential. In May 2001, Roberts assumed responsibility for contracting with physicians in the North Texas area. (Roberts, Tr. 468-70).

b. NTSP's relations with Aetna through HMS and MSM

267. In 1994, many physicians signed an 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).

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

269. Many of the physicians who had contracts with HMS signed participating physician agreements with NTSP. (RX 832).

270. In 1997, NTSP believed that HMS had 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).

271. NTSP was appointed by NTSP's participating physicians to represent them in the contract dispute with HMS. (Van Wagner, Tr. 1681).

272. In 1999, during the time of the contract dispute between NTSP and HMS, HMS became Medical Select Management ("MSM"). Contracts between physicians and HMS were assigned to MSM. (RX 832).

273. The contract between MSM and Aetna, which served about 115,000 patients, was primarily a "global risk deal," through which Aetna delegated almost all the medical risk to MSM under an HMO plan. (Jagmin, Tr. 984-85, 997). MSM also had a non-risk PPO contract with Aetna. (RX 832).

274. Many of NTSP's participating physicians had been contracted with MSM to provide physician services pursuant to MSM's agreements with Aetna. (Jagmin, Tr. 982).

275. In June 1999, NTSP, as the class representative for its participating physicians, sued HMS and MSM. The class action lawsuit against HMS and MSM alleged that HMS and MSM refused to honor the terms of the 1994 contract. (Van Wagner, Tr. 1652-53; RX 335; RX 849; CX 1172 (Collins, Dep. at 6-9)).

c. NTSP's initial contract negotiations

276. In late 1999, NTSP initiated a meeting with Aetna and proposed a direct contracting relationship between Aetna and NTSP, that would not involve MSM, under a risk contract. (Jagmin, Tr. 981-84; Van Wagner, Tr. 1700; CX 531). This meeting did not develop into broader negotiations. (Jagmin, Tr. 988-89).

277. Around April 2000, NTSP again initiated negotiations with Aetna to discuss a direct contract between NTSP and Aetna. (Jagmin, Tr. 989-90).

278. In early June 2000, NTSP met with Aetna to discuss future business and contract arrangements. (CX 177). NTSP told Aetna that its physicians might leave the MSM contract

because of what NTSP perceived to be MSM's continuing breaches of contract and financial problems. (Jagmin, Tr. 983-84; Van Wagner, Tr. 1652-53, 1692-95, 1700; CX 531).

279. Subsequent to the June 2000 meeting between NTSP and Aetna, Aetna discussed internally the possible contracting scenarios with NTSP and concluded that the most favorable scenario was keeping NTSP's physicians within Aetna's current contract through MSM, rather than signing a separate contract with NTSP. This conclusion was based on Aetna's belief that a separate contract would duplicate administrative costs. (CX 525 at 1-2).

280. The internal Aetna discussion considered a scenario in which Aetna would lose most of NTSP's member physicians. This turn of events was envisioned by Aetna as a realistic possibility if NTSP's member physicians were to pull out of the MSM contract, Aetna were to fail to reach an agreement with NTSP, and only a few of NTSP's member physicians were to contract with Aetna directly. Aetna's conclusion was that this scenario would create undesirable holes in particular specialities and perhaps service areas. Under the same scenario, Aetna was also "very concerned" with the fact that many of its health plan members, especially "given their national client base," would complain that their doctor was no longer in the network. (CX 525; Jagmin, Tr. 1000-02).

281. In these internal Aetna discussions, NTSP was perceived as representing the "majority of the preferred SPECs [specialists] in [Fort] Worth," and as specialist-dominated. (CX 525 at 2).

282. In Fax Alert #55, dated August 7, 2000, Van Wagner informed NTSP member physicians that "NTSP has started negotiations with Aetna in regards to a risk and non-risk contract. As of this date, a term sheet has been received and is being reviewed. It is the goal of both parties to implement a new contract effective January 1, 2001. Given the stages of our negotiation, NTSP will know in approximately thirty days whether or not a direct contract with Aetna will be in the best interest of its members." NTSP asked its member physicians to allow NTSP to continue discussions with Aetna for the next thirty days. (CX 942 at 2).

283. An October 5, 2000 Fax Alert informed NTSP physicians that NTSP had filed suit against MSM on behalf of its member physicians and that NTSP had begun discussions with Aetna on a direct contract for Aetna HMO patients. The Fax Alert sought physicians to sign a power of attorney to authorize NTSP to represent them:

> In order to pursue these initiatives to their maximum outcome, having NTSP act as the members' agent and attorney in fact in negotiations, amendments, extensions and/or terminations of Aetna contracts was suggested.
>
> A Motion was made and passed that 66% of all affected NTSP physicians should agree to NTSP's role as agent or attorney in fact

regarding this matter.

> Attached to this fax is a copy of a Power of Attorney for each member's consideration. If you wish NTSP to represent you as your attorney in fact regarding your contracts with Aetna US HealthCare, . . . please sign below and fax return to the NTSP offices. . . .

(CX 347 at 1-2).

284. The power of attorney appointed NTSP to act as the signatory attorney in fact with respect to "all contracts and agreements (including without limitation all prospective contracts or agreements)" with Aetna, MSM, and other entities. (CX 347 at 4).

285. In October 2000, negotiations between NTSP and Aetna for a risk contract ended without an agreement. (Jagmin, Tr. 1006-09; CX 540 at 1).

d. Continued negotiations on a non-risk contract

(i) Initial proposals

286. In October 2000, after NTSP and Aetna determined that they could not agree on a risk contract, NTSP and Aetna continued to negotiate for a non-risk contract only. (Jagmin, Tr. 1004-05; CX 717 at 4; CX 544 at 3).

287. With respect to rates for anesthesiologists, Aetna's initial offer to NTSP, in October 2000, was $40 per unit. NTSP told Aetna that anesthesia unit rates for a PPO product were between $46 and $48 in the market. (Jagmin, Tr. 1017, 1034-35, 1045; CX 544 at 2, 3). In an October 20, 2000 letter, Aetna informed NTSP that an anesthesia rate of $46 to $48 was too high. (CX 540 at 4; Jagmin, Tr. 1017).

288. With respect to HMO and PPO products, Aetna's initial offer to NTSP, in October 2000, was based on a reference schedule that uses the same relative value units from the RBRVS schedule, but places a different multiplier on different specialties' services, based on supply and demand. (Jagmin, Tr. 1012-13). Aetna's initial offer aggregated to about 111% to 112% RBRVS for HMO and about 123% to 125% RBRVS for PPO, with some specialities being offered more or less than the aggregate, based on the scarcity or abundance of the particular specialty of the physician. (Jagmin, Tr. 1015-16, 1022-24).

289. In October 2000, NTSP sought from Aetna a non-risk contract with uniform rates of 125% RBRVS for HMO and 140% RBRVS for PPO. (Jagmin, Tr. 1023, 1033-34, 1040-41; CX 543 at 3-4).

290. NTSP's proposed rates of 125% of RBRVS for HMO and 140% of RBRVS for PPO were the same rates that physicians had been receiving for providing services to Aetna patients through the MSM contract. (Jagmin, Tr. 1023; Van Wagner, Tr. 1697; CX 538). (*Compare* RX 968, *in camera*, *with* RX 24 at 21).

291. NTSP's proposal for both HMO and PPO was a uniform rate for all physicians, instead of the different rates to each speciality that Aetna initially had offered. (CX 543 at 3-4; Jagmin, Tr. 1023).

292. Aetna expressed concern to NTSP that a uniform rate based off of Medicare RBRVS would impose overpayment to some NTSP specialties, while other NTSP physicians might choose not to participate on the basis of underpayment, which might require Aetna to have to contract with those physicians individually at a higher rate. (Jagmin, Tr. 1031-32).

293. NTSP informed Aetna that it would not be involved in any non-risk contract that proposed different rates for different member physicians. (Roberts, Tr. 523-24; Jagmin, Tr. 1165).

294. Aetna's representative talked to physician groups to try to contract with them directly. Some of those physicians referred Aetna back to NTSP. (Jagmin, Tr. 1042-44).

295. Aetna, at the time of these negotiations, was concerned about losing physicians because it was late in the enrollment period, the time when employees choose their health plans or change their prior selections. (Jagmin, Tr. 990-91; 1060-61).

296. On November 7, 2000, NTSP sent a letter to "NTSP Members," providing them with a termination letter that NTSP's Board of Directors "is sending to . . . MSM on your behalf. . . . This termination letter notifies MSM that they are in material breach of your 1994 contract regarding the Aetna HMO." (CX 546).

297. On November 20, 2000, NTSP sent Aetna an email informing Aetna that NTSP physicians would no longer serve Aetna's patients through MSM:

> North Texas Specialty Physicians' (NTSP) 260 doctors have treated Aetna patients for over ten years. . . . We are pleased that Aetna has contacted us in an effort to work out the details for a direct contracting relationship. . . . If a direct contracting relationship between NTSP and Aetna is accomplished, all of Aetna's PPO lives will be served directly by NTSP physicians. In addition, approximately 15,000 of the 100,000 Aetna HMO covered lives will have direct access to NTSP doctors. The remaining approximately 85,000 Aetna HMO covered citizens are contracted through Medical Select Management's Aetna contract.

> As of today, NTSP has notified Medical Select Management that under current contractual conditions, NTSP physicians can no longer participate.

(CX 559).

298. By November 20, 2000, Aetna made a new offer of a uniform rate based on RBRVS and increased its offer to 116% RBRVS for HMO and 140% for PPO. Aetna's offer on anesthesia rates remained at $40 per unit. (CX 561; Jagmin, Tr. 1044-45, 1076-77).

299. With respect to Aetna's PPO and anesthesia offer, Van Wagner informed Aetna that she thought that Aetna's PPO fee schedule of 140% of current Medicare RBRVS would be "well received when we messenger it out by all except anesthesia. . . . [A]s you know their contracting minimums on PPO rates were not met." Jagmin understood that most member physicians would accept the 140% rate for PPO, but that no anesthesiologist would sign up under the contract. (CX 558 at 2; Jagmin, Tr. 1052).

300. With respect to Aetna's HMO offer, NTSP did not present Aetna's HMO offer to its member physicians because the rate fell below the established Board minimums. (Van Wagner, Tr. 1927-28).

301. Aetna's representative met with NTSP's Board and had conversations with Board members and with Van Wagner and NTSP's Director of Managed Care, David Palmisano, in which both physicians and NTSP staff conveyed to Aetna that NTSP's Board minimum was 125% of RBRVS for HMO and that NTSP did not have the authority to messenger any contracts below these rates. (Jagmin, Tr. 1021-23; CX 571).

(ii) Power of attorney forms

302. At the same time that NTSP and Aetna were discussing the non-risk contract, Van Wagner sent Aetna a list of the physicians to whom NTSP had sent power of attorney forms seeking delegation of NTSP as the organization that would conduct negotiations for them. (Jagmin, Tr. 1029; CX 534).

303. Jagmin asked both physicians and NTSP staff about the power of attorney forms and was told that the power of attorney forms assigned to NTSP direct contracting efforts between Aetna and the physicians. (Jagmin, Tr. 1029).

304. On November 10, 2000, Van Wagner informed Jagmin that NTSP had sent approximately 180 power of attorney forms from NTSP member physicians to MSM, and told Jagmin that the powers of attorney cover any direct contracting with Aetna. (CX 558 at 2).

305. Aetna believed that, with these power of attorney forms, NTSP would be

representing individual physicians in negotiating with Aetna if Aetna did not enter into a contract with NTSP. (Jagmin, Tr. 1051; CX 558).

306. Because Aetna believed that NTSP was going to represent each one of the individual physicians or physician groups in a direct contract negotiation, Aetna believed that there was pressure for Aetna to enter into a contract with NTSP. (Jagmin, Tr. 1058-60).

307. In a November 2001 NTSP Board meeting that was attended by an Aetna representative, the power of attorney forms that NTSP had collected from its member physicians were referenced during the discussions between NTSP and Aetna on the proposed rates for a non-risk contract. (Roberts, Tr. 537-39).

(iii) Re-polling of NTSP member physicians

308. By November 21, 2000, Aetna and NTSP had reached an agreement on 140% of current Medicare RBRVS for PPO, but had not reached an agreement on HMO rates, with NTSP seeking across the board 125% of Medicare RBRVS and Aetna seeking across the board 116% of Medicare RBRVS. The parties also had not reached an agreement on anesthesia rates. (CX 561; Jagmin, Tr. 1071-72).

309. NTSP discussed its negotiations with Aetna at an NTSP general membership meeting on November 21, 2000. (CX 180).

310. By Fax Alert #81, dated November 29, 2000, NTSP informed its member physicians that Aetna's then current offer was an across the board fee schedule of 140% of current Medicare RBRVS for its PPO product, an across the board fee schedule of 116% of current Medicare RBRVS for its HMO product, and $40 per unit for anesthesia rates for both the HMO and PPO products. (CX 565).

311. NTSP informed its member physicians in Fax Alert #81:

> In keeping with the minimum compensation standards as conveyed from the membership earlier this year, [Aetna's] PPO offer of 140% of current Medicare approximates an acceptable minimum standard. The minimum standard previously shared by the membership on an HMO product is 125% of current Medicare or approximately 9% less than Aetna's present offer. . . .
>
> Because this is a fee-for-service offering falling below the minimum as previously shared via the messenger model to the NTSP Board, we are re-polling the membership on the acceptability of the present Aetna offering.

Please check in the space below what your minimum acceptable range of compensation for the Aetna HMO product is.

(CX 565).

312. The polling ballot listed ranges of rates for selection by NTSP's member physicians. Aetna's offered amounts (116% for HMO, $40-42 per unit for anesthesia) were listed as the lowest "minimum acceptable range of compensation" that NTSP physicians could select on the polling ballot. (CX 565 at 2; Van Wagner, Tr. 1929-30).

313. As reported at NTSP's December 4, 2000 Board meeting, sixty-one responses had been received, with the majority choosing the 121%-130% range. At that meeting, it was also noted that the termination of the contract with Aetna through MSM would be carried out in thirteen days. (CX 74 at 4).

314. On December 8, 2000, NTSP conveyed the poll results to Aetna: "the numbers on the messenger model return for the [HMO] product are as follows . . . mean: 124.89% of current medicare; mode 127.38% of current medicare; median 123.70% of current medicare." NTSP wrote to Aetna that "this response is essentially the current reimbursement rate for [A]etna [HMO] lives not attached to [MSM]." (CX 571).

315. Aetna then convened an internal meeting and concluded that increasing its offer by 9% to match NTSP's proposal meant losing money on NTSP HMO services. (Jagmin, Tr. 1080).

316. On December 11, 2000, NTSP sent Fax Alert #84 to its member physicians, containing the following statements: "The membership's message that a 125% of current Medicare HMO fee schedule is required has been transmitted to Aetna and a response on this final contractual item is expected within the next 24 to 36 hours . . . . NTSP Continues To Act As Your Agent Both With Aetna Direct And With MSM. At This Point, No Further Action Is Required On Your Part . . . . Please refer all contacts and materials received from either Aetna or MSM to NTSP directly." (CX 573 (*emphasis omitted*)).

(iv) Aetna agrees to NTSP's proposals

317. NTSP wrote to Aetna on December 12, 2000 to inform Aetna that Van Wagner had "polled the Board informally today" and that the NTSP Board "would urge [A]etna to reconsider their position on not accepting the members['] poll results on compensation for the [HMO] direct contract." (CX 578).

318. On December 13, 2000, after receiving instructions from his general manager and regional manager to reject the HMO terms and to attempt to finalize a PPO only contract, Jagmin replied to NTSP, agreeing to proceed with the PPO contract, and stated to NTSP that "the physician expectations for the HMO contracts are not acceptable to Aetna and are rejected."

(CX 580 at 1; *see also* CX 582 at 1; Jagmin, Tr. 1082-83).

319. On December 15, 2000, NTSP received Aetna's final proposed IPA agreement which repeated Aetna's position: "Per your discussion with Chris Jagmin, MD, non HMO based products to be paid at 140% of then current RBRVS per the Fort Worth, TX geographic locality. Anything with no established rate is paid at Company's then current Reasonable Equitable Fee Schedule (REF). Anesthesia services at $40 per unit." (CX 660).

320. The conflict between NTSP and Aetna received publicity in the marketplace. (Jagmin, Tr. 1005-06, 1081-92). Aetna received calls from large employers in Tarrant County such as the Arlington independent school district and other employers and brokers. (Jagmin, Tr. 1083, 1094).

321. On December 18, 2000, Van Wagner reported to the NTSP Board that the PPO arrangement had been completed. Van Wagner referred the Board to a letter from Commissioner Montemayor concerning complaints that the Texas Department of Insurance had recently received from physicians. Van Wagner further "reported that NTSP will continue to negotiate with Celina Burns [General Manager] of Aetna on an HMO contract. There was a lengthy discussion on an acceptable fee schedule. The membership's response when polled was 125%. The Board instructed NTSP to present 125% on a direct contract." (CX 76 at 2-3).

322. Later on December 18, 2000, Van Wagner wrote to Aetna with a status update that reflected that NTSP's proposal was: for PPO, 140% of current Medicare RBRVS, anesthesia at $45.00; for HMO, 125% of current Medicare RBRVS, anesthesia at $43.00. (CX 585).

323. Ultimately, Aetna agreed to NTSP's terms. On December 19, 2000, Aetna wrote to NTSP and proposed: for PPO, 140% of current Medicare RBRVS, anesthesia at $45.00; for HMO, 125% of current Medicare RBRVS, anesthesia at $43.00. (CX 585 at 1).

324. NTSP responded to Aetna on December 19, 2000, stating that NTSP would send out a notice to its member physicians notifying them that the PPO and HMO offers are within the messenger minimums. NTSP further informed Aetna that it would tell its member physicians that they could choose whether or not to participate in the offerings. (CX 589).

325. In Fax Alert #85, sent to NTSP member physicians on December 19, 2000, NTSP notified its member physicians of the agreed upon rates and stated, "[t]he rates agreed upon for the direct HMO reimbursement and the PPO reimbursement meet NTSP minimum messenger model standards as shared by our members. Because of this, the Board has accepted these reimbursement levels as appropriate in completing contractual discussions in regards to these products." (CX 586 at 10).

326. NTSP forwarded the NTSP-Aetna contract to its member physicians. (CX 597; CX 615 at 1; CX 611 at 2 ("NTSP is pleased to present two new NTSP contract offerings to all

NTSP Members . . .")). Ultimately, 188 NTSP member physicians signed the NTSP-Aetna contract. (Jagmin, Tr. 1088).

327. The rates of the NTSP-Aetna contract are increased from Aetna's initial proposal. *Compare* Jagmin, Tr. 1015-16, 1022-24; CX 544 at 2, 3 (for HMO, aggregated to about 111% to 112% RBRVS, and anesthesia at $40 per unit; for PPO, aggregated to about 123% to 125% RBRVS, and anesthesia at $40 per unit) *with* CX 585 (for HMO, 125% RBRVS, and anesthesia at $43 per unit; for PPO, 140% RBRVS, anesthesia at $45 per unit).

328. The rates in the 2000 Aetna-NTSP contract were identical to the Aetna-MSM rates, a contract Aetna had with another IPA. (Jagmin, Tr. 1132-33; Van Wagner, Tr. 1697, 1701-02, 1708-09).

329. Aetna's representative, Roberts, testified that Aetna's reimbursement rates to NTSP were higher than rates for other IPAs for similar services. Roberts also testifed that a straight comparison could not be easily made because it depends on the total package of services that an IPA or a physician group might bring to the discussions. (Roberts, Tr. 472-73).

330. On July 10, 2001, Vance's practice group recorded the following from their practice group's Board of Directors meeting:

> Aetna is now offering a 95% of Medicare contracts for all commercial business. This contract was not presented to a solo practitioner, but to Texas Oncology, a very large corporate entity. This aggressive contracting by Aetna bodes ill for any small entities attempting to contract with Aetna this year. NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term the entire NTSP network last year. As I have argued for a number of years, physicians divided will be cannon fodder in this business. The hope that the Cardiology IPA will protect us from these gorillas is unrealistic. Even a 700 doctor organization such as NTSP may make only a ripple in the water in the coming days but is much more effective than any other organization at this time. Without NTSP's influence this last two years, our market level of reimbursement would be significantly below its present level.

(CX 256).

e. Subsequent contract negotiations

331. On August 10, 2001, NTSP submitted to Aetna a non-risk contract proposal that would incorporate NTSP's medical management and utilization management functions. NTSP's clinical integration proposal incorporated the existing NTSP-Aetna rates (125% for HMO and 140% for PPO of then current Medicare RBRVS) and proposed a contract period of three years.

(CX 616; Roberts, Tr. 472-73, 488, 508, 550-51, 560; Van Wagner, Tr. 1709-12).

332. On September 28, 2001, Aetna wrote to NTSP, stating Aetna's intention to continue discussions to finalize a mutually acceptable new agreement before the end of 2001, to commence on February 1, 2002. Aetna's letter terminated Aetna's existing agreement with NTSP, effective January 31, 2002. (CX 644, *in camera*; Roberts, Tr. 489-90).

333. The renegotiation between Aetna and NTSP involved only non-risk components. (Roberts, Tr. 487).

334. On October 8, 2001, the NTSP Board reviewed Aetna's termination letter and decided to continue negotiations with Aetna. (CX 102 at 1-3).

335. Van Wagner informed the Board that Aetna's new proposed rates would be lower and that negotiations would be arduous. (CX 102 at 1-3).

336. On October 15, 2001, the NTSP Board received and accepted the results of the 2001 annual poll. The acceptable contract minimums as estabished by the annual poll were 125% of current Medicare RBRVS for HMO and 140% of current Medicare RBRVS for PPO. The Board meeting minutes further reported: "[t]his year's polling of NTSP members as per a messenger model indicates these levels have not changed. The Board accepted this information and instructed staff to use these levels as minimally acceptable fee schedules for HMO and PPO contract offers." (CX 103 at 4-5).

337. On October 29, 2001, NTSP shared the poll results with its member physicians at a general membership meeting at which member physicians also received an update on the ongoing Aetna negotiations. (CX 186).

338. On October 30, 2001, Aetna proposed to NTSP an "Aetna Market Based Fee Schedule. For PCPs and Specialists this is 85% / 115% for the HMO Based Plans and 95% / 129% for the Non-HMO Based Plans." Aetna's "market-based fee schedule" refers to a fee schedule that Aetna uses primarily for individual physicians, but is also used with some IPAs and some groups. (CX 629; Roberts, Tr. 492-93, 568).

339. The rates Aetna offered NTSP on October 30, 2001 were based off of then current Dallas RBRVS. The proposal also included a "steering incentive," a 10% increase to those rates, for physicians in certain speciality areas that steered outpatient procedures to one of Aetna's preferred outpatient surgery centers. (CX 629; Roberts, Tr. 492-93, 568).

340. NTSP rejected Aetna's proposal of a 10% steering fee for some specialties because the reimbursement methodology would not be applied to all of NTSP's physicians. (Roberts, Tr. 523-24; Van Wagner, Tr. 1771).

341. NTSP never distributed Aetna's October 30, 2001 offer to its membership, lacking Board authority to do so. (Van Wagner, Tr. 1713-14; Roberts, Tr. 495).

(i) NTSP's claims of efficiencies

342. On November 1, 2001, NTSP sent utilization data to Aetna and in an attached letter advocated against a decrease in NTSP's then current fee schedule. NTSP stated: "[a]lthough NTSP's current fee schedule is higher than that proposed by Aetna at the unit cost level, budget to actual PMPM [per member, per month] historical figures indicate that significant savings will accrue to Aetna given historical utilization patterns of NTSP physicians." (CX 553).

343. Aetna believed that it was "critical to [their] organization" to determine if NTSP's efficiency claims were valid. Aetna believed that, "if, in fact, there were efficiencies and we couldn't come to terms [with NTSP], then when those services went to other physicians in the marketplace, then the costs would actually go up . . . so it was critical to us [Aetna] that we do an in-depth review of this data and try to determine if there were efficiencies and, if there were, to make sure this contract continued." (Roberts, Tr. 497).

344. NTSP provided to Aetna data derived from NTSP's risk contract with PacifiCare, though NTSP did not provide the underlying data. (Van Wagner, Tr. 1911-14; Roberts, Tr. 506-07, 520-21, 578-79).

345. Aetna was not able to run an analysis of NTSP physicians compared to other physicians due to problems with Aetna's own data. (Roberts, Tr. 560-61).

346. Due to the limited data provided by NTSP and deficiencies in Aetna's own internal data, Aetna could neither validate or invalidate NTSP's claims of clinical efficiencies. (Roberts, Tr. 504-05).

(ii) No agreement on non-risk contract

347. On November 6, 2001, Aetna informed NTSP that its analysis of Aetna's own data did not support NTSP's efficiencies claims. "In light of this review of our data, we can not identify significant management objectives that would require any adjustment to [the] proposed fee schedule." (CX 501; Roberts, Tr. 502-03, 524-27).

348. On November 7, 2001, NTSP replied that although negotiations would proceed, "[t]o ask high performing physicians to take pay cuts because others have not done as well will be a difficult sell." NTSP also noted that Aetna would meet with the NTSP Board. (CX 502).

349. On November 12, 2001, Aetna representatives attended an NTSP Board meeting and addressed Aetna's proposal. Aetna offered an overall reimbursement average of 118% for the HMO product and 133% for the PPO contract. (CX 106). At that Board meeting, NTSP

proposed a compromise between the parties at a rate level in the low 120s, which was below NTSP's offer of 125%, but above Aetna's offer of 118%. (Roberts, Tr. 537-39).

350. At the November 12, 2001 Board meeting, NTSP informed Aetna that NTSP had collected signed power of attorney forms from its member physicians. (Roberts, Tr. 540-41).

351. Following the November 12, 2001 Board meeting, NTSP did not distribute Aetna's offer to its member physicians because the offer was below Board minimums. (CX 503; Roberts, Tr. 542-43; Van Wagner, Tr. 1642-43, 1776; Deas, Tr. 2433).

352. On November 19, 2001, the Board reviewed Aetna's latest proposal to NTSP. Van Wagner reported that it was essentially the same proposal, which was less than the minimum rates that the membership had messengered as acceptable. (CX 107 at 2-3).

353. On December 3, 2001, Aetna wrote to NTSP informing it that Aetna believed that NTSP's current level of reimbursement was not competitive and that termination of the Aetna-NTSP agreement would be effective on January 31, 2002. (CX 640).

354. On December 7, 2001, NTSP informed its member physicians that Aetna's proposal fell "below payment rates our members have messengered to NTSP as acceptable to continue negotiations." NTSP informed its members that they may contract directly with Aetna or request that Aetna re-open negotiations with NTSP. (CX 643).

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

356. After terminating the contract, Aetna sent direct offers to NTSP's member physicians. NTSP's member physicians were not prevented from dealing directly with Aetna, and Aetna was able to contract directly with many of the physicians who had been part of the NTSP-Aetna contract. (Roberts, Tr. 544-46; RX 1076; RX 9).

f. Aetna investigated by Department of Justice, Texas Attorney General, and Texas Department of Insurance

357. In June 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 1999, Aetna signed a consent order. (RX 3100).

358. In May 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).

359. The Texas Commissioner of Insurance issued admonishment letters to Aetna in December 2000 and October 2001 questioning misrepresentations Aetna and MSM were making in contract discussions and questioning the adequacy of Aetna's provider network. (CX 586; RX 3105 (Aetna ordered to pay restitution and fines for violations through October of 2001); CX 508 (Aetna's response referencing Commissioner's letter)).

360. The Texas Attorney General issued an Assurance of Voluntary Compliance ("AVC") to Aetna in April 2000. (RX 1302; CX 505). Chris Jagmin, an Aetna medical director, was disciplined in August 2001 for violating the AVC by making false representations. (RX 339). NTSP was notified of the Assurance of Voluntary Compliance with Aetna and of Jagmin's disciplinary notice. (CX 103).

361. NTSP reported several payors, including 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).

362. In November 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).

363. 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).

F. No Valid Procompetitive Justifications

1. No meaningful efficiencies

364. NTSP is not clinically integrated for patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1878; Casalino, Tr. 2877; Frech, Tr. 1351-52).

365. NTSP does not engage in case management for PPO patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1878).

366. NTSP's medical director has no responsibility for controlling costs for patients covered under NTSP's non-risk contracts. (Deas, Tr. 2552-53).

367. NTSP's medical management committee does not evaluate the care of patients covered under NTSP's non-risk contracts. (Deas, Tr. 2550-51).

368. NTSP's hospital utilization management program does not apply to patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1837-38).

369. NTSP's information systems do not include data for patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1837-41; Deas, Tr. 2488). The absence of an electronic medical records system for its non-risk patients prevents NTSP from implementing an effective reminder system for patient care at the point of care. (Casalino, Tr. 2839).

370. NTSP does not operate or refer patients to any disease management programs or patient registries which would improve health care quality for patients with specific, long-term conditions such as diabetes or congestive heart failure for patients covered under NTSP's non-risk contracts. (Casalino, Tr. 2812-14; Van Wagner, Tr. 1834-35, 1877).

371. Disease management programs typically include a nurse case manager who maintains regular contact with each patient; monitors indices of each patient's health; ensures that each patient takes prescribed medications; directs each patient to specialist physicians; and encourages each patient to participate in relevant patient education programs. (Casalino, Tr. 2812-13).

372. NTSP does not provide feedback to physicians concerning patient care under NTSP's non-risk contracts. (Lonergan, Tr. 2722-24).

373. NTSP does not require adherence to its clinical guidelines and protocols for its fee-for-service physicians and patients. (Van Wagner, Tr. 1843-44). NTSP does not provide reminders to physicians at the point of care to employ the guidelines and protocols and does not monitor physicians' adherence to them. (Casalino, Tr. 2837-39; Van Wagner, Tr. 1843-44).

374. NTSP's goal of enhanced teamwork among its physicians is hindered by the lack of pediatricians, obstetricians, and cardiologists in NTSP, forcing NTSP patients needing the services of these core specialists to seek physicians outside of NTSP. (Casalino, Tr. 2854-56).

375. NTSP does not engage in meaningful patient education. The patient education features of its web site were created in 2004, after this Complaint was issued, and are largely limited to links to other public web sites. (Casalino, Tr. 2844-48).

2. No significant spillover benefits

376. NTSP engages in utilization and quality control efforts in connection with two health plan agreements: its risk contract with PacifiCare, and, to a lesser extent, its HMO contract, but not its PPO contract, with Cigna. (Van Wagner, Tr. 1830-54).

377. 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. 2864-65).

378. NTSP is hindered in implementing organized processes for patients under non-risk contracts because it lacks data for these patients. (Casalino, Tr. 2868-69; Frech, Tr. 1352-53).

379. NTSP physicians who do not participate in NTSP's shared-risk contract are unlikely to learn and apply techniques to control costs and to improve quality that are developed or learned in the context of that risk-sharing arrangement. (Casalino, Tr. 2859-60; Frech, Tr. 1353-54).

380. Negotiation of rates in non-risk contracts is not necessary for any efficiencies achieved from NTSP's risk panel to spillover to NTSP's non-risk panel. (Deas, Tr. 2577 (asserted spillovers from NTSP's risk to fee-for-service contracts are "completely unrelated" to NTSP's setting of minimum contract prices); Frech, Tr. 1347-51 (any spillover is unrelated to setting of Board minimums and joint negotiation)).

III. ANALYSIS AND CONCLUSIONS OF LAW

A. Jurisdiction

The Complaint charges Respondent North Texas Specialty Physicians ("NTSP") with violating Section 5 of the Federal Trade Commission Act, as amended ("FTC Act"). 15 U.S.C. § 45. Section 5(a)(2) of the FTC Act gives the Commission jurisdiction "to prevent persons, partnerships, or corporations . . . from using unfair methods of competition in or affecting commerce . . . ." 15 U.S.C. § 45(a)(2); *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1327 n.2 (7th Cir. 1981). *See also McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 241-42 (1980); *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 745-46 (1976). The FTC Act defines "corporation" to include "any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members. . . ." 15 U.S.C. § 44. *See also Community Blood Bank v. FTC*, 405 F.2d 1011, 1015-16 (8th Cir. 1969). The FTC Act definition of commerce includes "commerce among the several States." 15 U.S.C. § 44.

The "Commission has only such jurisdiction as Congress has conferred upon it by the Federal Trade Commission Act." *Community Blood Bank*, 405 F.2d at 1015. When the jurisdiction of the Commission is challenged, the Commission bears the burden of establishing its jurisdiction. *Id.* Respondent has challenged jurisdiction in this case. Respondent's Post Trial

Brief ("RPTB") at 33. To establish jurisdiction, Complaint Counsel must demonstrate that NTSP is an association organized to carry on business for its own profit or that of its members. *California Dental Ass'n v. FTC,* 526 U.S. 756, 767 (1999). Complaint Counsel must also demonstrate that the acts of NTSP are in or affect commerce. *McLain*, 444 U.S. at 242.

1. Actions on behalf of members

NTSP is an independent practice association ("IPA") that was formed in 1995 for the purpose of allowing a group of specialist physicians to accept economic risk on medical contracts. F. 17, 37. NTSP subsequently broadened its membership to include primary care physicians ("PCPs") and broadened its functions to include entering into non-risk contracts with health insurance plans. F. 37. Physicians establish their relationship with NTSP by entering into a Physician Participation Agreement ("PPA") with NTSP and by paying a one time fee of $1,000 to NTSP. F. 21, 64. Under the PPA, NTSP negotiates non-risk contracts on behalf of its participants. F. 65-67.

NTSP is incorporated under Texas law as a non-profit entity with no members. F. 17, 19; TEX. OCC. CODE ANN. § 162.001 (Vernon 2004). Respondent asserts, that as a matter of Texas corporation law, the participating physicians of NTSP are not "members." Thus, Respondent argues, because NTSP is a memberless organization, it falls outside the definition of a "corporation" under the FTC Act and outside the jurisdiction of the Federal Trade Commission. RPTB at 33.

However, courts and the Commission look to the substance, rather than the form of incorporation, in determining jurisdiction under the FTC Act. *See California Dental,* 526 U.S. at 767; *American Med. Ass'n v. FTC*, 638 F.2d 443, 448 (2nd Cir. 1980), *aff'd by an equally divided court, without op.*, 455 U.S. 676 (1982). "[T]he mere form of incorporation does not put [an entity] outside the jurisdiction of the Commission." *Community Blood Bank*, 405 F.2d at 1019.

The substance here, as shown by the evidence, is that NTSP's participating physicians are "members," as that word is used in the FTC Act's definition of corporation. The physicians pay dues, participate in association activities, and elect the Board of Directors. F. 21, 24, 33. They

meet periodically in "general membership meetings" to discuss matters in the common interest of all physicians, which sometimes includes the negotiation of health plan contracts. F. 33, 42. NTSP refers to its physicians as "members" in its internal communications. For example, the Board or administrative staff of NTSP routinely sends communications to its member physicians called "Fax Alerts," which report on matters, including matters relating to the business interests of the physicians, and are directed to "NTSP members." *E.g.*, F. 86, 160, 282, 326 ("NTSP is pleased to present two new NTSP contract offerings to all NTSP Members . . .").

These facts demonstrate that NTSP's participating physicians are "members" of NTSP. *Cf. Fed. Election Comm'n v. Nat'l Right to Work Comm.*, 459 U.S. 197, 205-06 (1982) (In construing the term "member" as that term is used in the Federal Election Campaign Act, the Supreme Court held that solicitations to individuals who had previously donated to a non-profit corporation did not constitute solicitation to "members," where the alleged members did not play any part in the operation or administration of the corporation and did not elect corporate officials; where there were no membership meetings; and where alleged members did not exercise any control over the expenditures of their contributions.).

The evidence also shows that NTSP acts for the pecuniary benefit of its "members." As NTSP described in a Fax Alert to "NTSP members," under the Physician Participation Agreement, "NTSP will have the exclusive right, on behalf of its members, to receive all payor offers delivered to NTSP or its members." F. 65. As set forth in the PPA entered into between NTSP and its participating physicians, "NTSP is in the business of contracting with health maintenance organizations, health care networks and other payors to provide health care services through physicians and physician groups who have contracted with NTSP to provide such health care services" and "shall use its best efforts to market itself and its Participating Physicians to Payors and solicit Payor Offers for the provision of Covered Services by Participating Physicians." F. 20, 43. *See also* F. 44 ("NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups to hopefully be able to secure contracts. . . . [I]t was to represent physicians . . . in obtaining contracts from businesses or insurance companies or in dealing with hospitals."). NTSP's analysis of contract language, from both operational and legal perspectives, and communications with payors about

the terms of contracts constitutes benefits undertaken on behalf of NTSP's member physicians. F. 45.

Further illustrating pecuniary benefits, in communications to its member physicians, NTSP has expressed satisfaction about its success in negotiating the fees to be paid to its member physicians. For example, an October 9, 2000 "Open Letter to the Membership" from Dr. Vance (then President of NTSP) notes that NTSP "started in an attempt to provide a seat at the table of medical business for the individual specialty physicians in Fort Worth," and reports that "NTSP has provided a consistent premium fee-for-service reimbursement to the members." F. 44.

The evidence shows that NTSP has negotiated fees on behalf of its member physicians under non-risk contracts with health plans, in the course of which it sought increased reimbursement rates or more favorable coverage terms for its member physicians. *Infra* III.D.2. Negotiation of the level of fees that member physicians of NTSP receive for services provided by their own profit-making physician practices has an effect on the revenues and incomes of the member physicians and thus inures an economic benefit to NTSP's member physicians.

The jurisdiction of the Federal Trade Commission extends to non-profit entities when a substantial part of the entity's total activities provides economic benefits for its members. *California Dental*, 526 U.S. at 767; *In re American Med. Ass'n*, 94 F.T.C. 701, 994 (1979). As summarized above, NTSP's activities provide pecuniary benefits for its member physicians.

2. Interstate commerce

In addition, NTSP's activities are in or affect commerce, as required by the FTC Act. 15 U.S.C. § 45 (prohibiting unfair methods of competition "in or affecting commerce"). The jurisdiction of the Commission encompasses acts and practices constituting a violation of the Sherman Act. *FTC v. Cement Instit.*, 333 U.S. 683, 690 (1948). The Commission utilizes cases interpreting jurisdiction under the Sherman Act – which regulates agreements "in restraint of trade or commerce among the several States" – in analyzing its own jurisdiction. *E.g.*, *In re Indiana Fed'n of Dentists*, 101 F.T.C. 57, 161 (1983), *rev'd on other grounds*, 745 F.2d 1124 (7th Cir. 1984), *rev'd*, 476 U.S. 447 (1986).

The jurisdictional reach of the Sherman Act (and, thus, the FTC Act), "is coextensive

with the broad-ranging power of Congress under the Commerce Clause." *Chatham Condo. Ass'n v. Century Village, Inc.*, 597 F.2d 1002, 1007 (5th Cir. 1979) (citing *Burke v. Ford*, 389 U.S. 320, 321-22 (1967) ("When competition is reduced, prices increase and unit sales decrease . . . . Thus, the state-wide wholesalers' market division inevitably affected interstate commerce.")).

For purposes of establishing antitrust jurisdiction, actions are in or affect commerce if the government demonstrates "a substantial effect on interstate commerce generated by respondents' . . . activity. Petitioners need not make the more particularized showing of an effect on interstate commerce to fix . . . rates, or by those other aspects of respondents' activities that are alleged to be unlawful." *McLain*, 444 U.S. at 242-43. Alternatively, the Supreme Court has stated that to establish federal jurisdiction, "there remains only the requirement that respondents' activities which allegedly have been infected by a price-fixing conspiracy be shown 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved." *Id.* at 246 (quoting *Rex Hosp.*, 425 U.S. at 745).

Although the term used in evaluating the effect on interstate commerce is "substantial" or "not insubstantial," Supreme Court precedent makes clear that an effect on commerce can be viewed as "substantial" even though "its impact on interstate commerce falls short of causing enterprises to fold or affecting market price." *Rex Hosp.*, 425 U.S. at 745. Further, "[w]holly local business restraints can produce the effects condemned by the Sherman Act." *Id.* at 743 (citations omitted).

For example, in *Rex Hospital*, a small proprietary hospital, Mary Elizabeth, brought suit against another hospital, Rex, under Sections 1 and 2 of the Sherman Act, alleging that Rex had conspired with others to block the expansion and relocation of Mary Elizabeth within Raleigh, North Carolina. The Court found an effect on interstate commerce based upon the allegations in the complaint that the blocked expansion of Mary Elizabeth would cause the following reverberations in commerce: a reduction in the amount of medicine and supplies purchased from out-of-state sellers; diminished revenues from out-of-state insurance companies or the federal government; a decrease in the management service fee paid to its parent company, an out-of-state corporation; and lost revenues to out-of-state lenders who were expected to finance the planned expansion. 425 U.S. at 744.

In *McLain*, the Supreme Court considered the effects on commerce of an alleged conspiracy by real estate brokers to fix brokerage rates in New Orleans. The Supreme Court held that the jurisdictional requirement was satisfied by allegations that the conspiracy affected both the sale of real estate to interstate buyers and the financing of those sales by interstate lenders. 444 U.S. at 245. Although noting that such a conspiracy would probably have an effect on "the frequency and terms of residential sales transactions," *id.* at 246, the Supreme Court did not require the plaintiff to demonstrate or allege any particular effect on the overall flow of realty-related commerce into the state. Instead, the Supreme Court explained that jurisdiction would not be defeated "by plaintiff's failure to quantify the adverse impact of defendant's conduct." *Id.* at 243. *See also Goldfarb v. Virginia State Bar*, 421 U.S. 773, 785 (1975) ("once an effect is shown, no specific magnitude need be proved").

Furthermore, "[i]n cases involving horizontal agreements to fix prices or allocate territories within a single State, [the Supreme Court has] based jurisdiction on a general conclusion that the defendants' agreement 'almost surely' had a marketwide impact and therefore an effect on interstate commerce." *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 331 (1991) (quoting *Burke*, 389 U.S. at 322). In *Summit Health*, the market that was impacted was "the Los Angeles market." *Id.* "In *Burke*, the Supreme Court was willing to assume an effect on interstate commerce where the conduct in question, horizontal market divisions, typically has an anticompetitive effect on interstate commerce." *Chatham Condo.*, 597 F.2d at 1007 (citation omitted).

In addition, the government "need not allege, or prove an actual effect on interstate commerce to support federal jurisdiction." *Summit Health*, 500 U.S. at 331. Though not required to prove an actual effect on interstate commerce to support federal jurisdiction, in this case, as summarized in Section III.D.2., *infra*, Complaint Counsel has demonstrated that NTSP negotiated economic terms of non-risk contracts with health insurance payors. These health insurance payors, United Healthcare ("United"), Cigna Healthcare ("Cigna"), and Aetna Health, Inc. ("Aetna"), are all national health plans, headquartered outside of Texas, that sell health care products throughout the United States. F. 101-03, 195, 197, 259, 262. As such, the health insurance providers' businesses are in interstate commerce. *Indiana Fed'n of Dentists*, 101

F.T.C. at 161.[1] Any increase in fees for physician services paid to physicians, on whose behalf NTSP negotiated increased rates, affects these multi-state companies. F. 102, 104, 196-98, 263-64.

"When determining whether interstate commerce is affected by an alleged violation courts will often examine both the defendant's relationship with interstate markets and the plaintiff's." *Construction Aggregate Transport, Inc. v. Florida Rock Indus., Inc.*, 710 F.2d 752 (11th Cir. 1983) (citing *Rex Hosp.*, 425 U.S. at 741 (local actions by defendants to block relocation of hospital adversely affects interstate commerce with regard to medicines and supplies purchased by plaintiff hospital)); *Lehrman v. Gulf Oil Corp.*, 464 F.2d 26, 34-35 (5th Cir. 1972) (demise of plaintiff's business had impact on interstate flow of goods he would have sold) (alternative holding); *Heille v. City of St. Paul*, 671 F.2d 1134, 1137 (8th Cir. 1982) (examining both plaintiff's and defendant's use of goods manufactured out-of-state) (other citations omitted)).

The Complaint in this case was brought by the Federal Trade Commission, and not by the insurance companies. However, the allegations of the Complaint focused on, and the evidence demonstrated, higher rates paid by the insurance companies. Higher rates and more favorable contract terms directly affect these multi-state companies. *See* F. 102, 104, 196-98, 263-64.

Purchases by a defendant of out-of-state goods are also a factor in determining whether an activity substantially affects interstate commerce. *E.g.*, *Rex Hosp.*, 425 U.S. at 744 (petitioner's purchases of out-of-state medicines and supplies considered in determining "substantial effect" on interstate commerce); *Miller v. Indiana Hosp.*, 843 F.2d 139, 144 n.5 (3rd Cir. 1988) (defendant hospital's treatment of out-of-state patients, purchase of medical supplies from out-of-state, and receipt of money from out-of-state, including federal funds, satisfies the requirement of affecting interstate commerce); *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696 (4th Cir. 1991) (same). *See also United States v. Robertson*, 514 U.S. 669, 672 (1995) ("[A] corporation is

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[1] The Commission's holding that the respondent's anticompetitive activity had a substantial effect upon interstate commerce and, thus, that the Commission had jurisdiction over the complaint was not appealed by the respondent. *Indiana Federation of Dentists v. FTC*, 745 F.2d 1124, 1132 (7th Cir. 1984).

generally 'engaged "in commerce"' when it is itself 'directly engaged in the production, distribution, or acquisition of goods or services in interstate commerce.'") (*per curiam*) (quoting *United States v. Am. Bldg. Maint. Indust.*, 422 U.S. 271, 283 (1975)).

From January 1, 1999 to December 22, 2003, NTSP purchased $1,047,819.86 from vendors with billing addresses outside of Texas. F. 22. For example, NTSP purchased $457,373.09 of stop loss insurance from a California insurance broker. F. 22. These purchases from out-of-state sources illustrate that NTSP is directly engaged in the acquisition of goods or services in interstate commerce. This factor, together with the impact of NTSP's negotiation of rates and economic terms paid by multi-state insurance companies, demonstrates that NTSP's activities substantially affect commerce.

Under the broad jurisdictional scope of "a substantial effect on interstate commerce," the activities of Respondent are in or affect commerce. Thus, the Commission has jurisdiction over NTSP, and the conduct challenged in the Complaint, under Sections 4 and 5 of the FTC Act. 15 U.S.C. §§ 44, 45.

B. Burden of Proof

Under Commission Rule of Practice 3.51(c)(1), "[a]n initial decision shall be based on a consideration of the whole record relevant to the issues decided, and shall be supported by reliable and probative evidence." 16 C.F.R. § 3.51(c)(1). The Commission amended its Rules of Practice, effective May 18, 2001. FTC Rules of Practice, Interim rules with request for comments, 66 Fed. Reg. 17,622 (April 3, 2001). Through the amendments, the Commission removed the requirement of Rule 3.51(c)(3) that the initial decision of an Administrative Law Judge ("ALJ") be supported by "substantial" evidence. 66 Fed. Reg. at 17,626. The Administrative Procedure Act, however, requires that an ALJ may not issue an order "except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence." Administrative Procedure Act ("APA") 5 U.S.C. § 556(d). According to Black's Law Dictionary, "probative evidence" means having the effect of proof; tending to prove, or actually proving an issue. "Substantial evidence" is defined in Black's Law Dictionary as such evidence that a reasonable mind might accept as

adequate to support a conclusion. At the adjudicative level of these proceedings, any difference between "probative" evidence and "substantial" evidence is not dispositive under these standards. Therefore, all findings of fact in this Initial Decision are supported by reliable, probative, *and* substantial evidence.

The parties' burdens of proof are governed by Commission Rule 3.43(a), Section 556(d) of the APA, and case law. FTC Rules of Practice, Interim rules with request for comments, 66 Fed. Reg. 17,622, 17,626 (April 3, 2001). Pursuant to Commission Rule 3.43(a), "[c]ounsel representing the Commission . . . shall have the burden of proof, but the proponent of any factual proposition shall be required to sustain the burden of proof with respect thereto." 16 C.F.R. § 3.43(a). Under the APA, "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." 5 U.S.C. § 556(d). *See also Steadman v. SEC*, 450 U.S. 91, 102 (1981) (APA establishes preponderance of the evidence standard of proof for formal administrative adjudicatory proceedings).

The government bears the burden of establishing a violation of antitrust law. *United States v. E.I. duPont de Nemours & Co.,* 366 U.S. 316, 334 (1961). "[T]he antitrust plaintiff must present evidence sufficient to carry its burden of proving that there was [an anticompetitive] agreement." *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 763 (1984). Accordingly, Complaint Counsel bears the burden of demonstrating that Respondent's actions in this case are anticompetitive.

C. Relevant Market

The relevant market has two components, a geographic market and a product market. *H.J., Inc. v. Int'l Tel. & Tel.*, 867 F.2d 1531, 1537 (8th Cir. 1989). Even in a horizontal price fixing case analyzed under the *per se* rule, the relevant market must be defined. *Bogan v. Hodgkins*, 166 F.3d 509, 515 (2d Cir. 1999) ("[I]t is an element of a *per se* case to describe the relevant market in which we may presume the anticompetitive effect would occur."); *Double D Spotting Serv., Inc. v. Supervalu, Inc.*, 136 F.3d 554, 558-59 (8th Cir. 1998) ("[A] plaintiff alleging a horizontal restraint must at least define the market and its participants.").

The relevant geographic market is the region "in which the seller operates, and to which the purchaser can practicably turn for supplies." *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961). The relevant product or service market is "composed of products that have reasonable interchangeability for the purposes for which they are produced – price, use and qualities considered." *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 404 (1956); *Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 481-82 (1992) (relevant market determined by the choices of products or services available to consumers).

Complaint Counsel argues "that it is unnecessary to define markets or assess market power when conduct is clearly anticompetitive, especially if (as here) there is direct evidence of actual anticompetitive effects (higher prices) as a result of the conduct." Complaint Counsel's Post Trial Reply Brief ("CCPTRB") at 13-14. Cases relied upon by Complaint Counsel hold that market *power* need not be demonstrated or that anticompetitive *effects in* the market need not be proved. However, these cases do not hold that the market need not be *defined. E.g.*, *Todd v. Exxon Corp.*, 275 F.3d 191, 206 (2d Cir. 2001) (finding first that plaintiff has adequately *defined* the market before holding that "actual adverse effect on competition . . . arguably is more direct evidence of *market power* than calculations of elusive market share figures") (emphasis added); *Re/Max Int'l, Inc. v. Realty One, Inc.*, 173 F.3d 995, 1018 (6th Cir. 1999) ("an antitrust plaintiff is not required to rely on indirect evidence of a defendant's monopoly power, such as high market share within a *defined* market, when there is direct evidence that the defendant has actually set prices or excluded competition") (emphasis added). As Complaint Counsel stated in its brief, "[i]n *Polygram Holding*, the Commission held that it was not necessary to examine evidence of respondent's market power, such as a high market share within a *defined* market, where there is direct evidence of price-fixing among competitors." CCPTRB at 14 (citing *In re Polygram Holding, Inc.*, 2003 FTC LEXIS 120, at *45 n.26 (July 24, 2003) (emphasis added). Market definition and market power are different issues. No one can dispute, with any credibility, that the necessity to first *define* a market is the same thing as a requirement to demonstrate *power* within that already defined market.

Complaint Counsel's expert, Dr. Harry Edward Frech, did not attempt to prove a relevant market. Dr. Frech's testimony on this point could not be more clear:

> Q. And by the way, you're not positing any relevant market in this case, isn't that correct?
>
> A. That's correct.

Frech, Tr. 1393-94. Fortuitously for Complaint Counsel, despite its misguided belief that the market need not be defined, evidence introduced at trial demonstrates that the relevant market in this case is physician services available to patients in Fort Worth, Texas (the "Fort Worth area"). *See* F. 52-63.

The evidence shows that primary care physicians and specialists from the Fort Worth area are important to health insurers, employers, and consumers. F. 52-62. In contracting for health plan services, Fort Worth employers demand significant coverage by physicians who practice in Fort Worth and who admit patients to Fort Worth hospitals. F. 52, 54.

Representatives from health insurance plans testified that they would not be able to effectively market their products to Fort Worth employers without a sufficient number of Fort Worth physicians covering various fields of practice in their network. F. 53. One health insurance plan conducted an independent analysis of the importance of NTSP physicians to its Fort Worth area health plan. This analysis revealed that, without NTSP physicians, there would be substantial coverage holes in the Fort Worth area in several areas of specialization. F. 62.

Health plans would not substitute physicians whose services are available in other areas such as Dallas County or the Mid-Cities area to avoid a small but significant Fort Worth area price increase. F. 58. Representatives from health insurance plans also testified that, even if the price of Fort Worth area physician services increased by five percent or greater, they would still need to have various kinds of Fort Worth area physicians included in their health plans to serve Fort Worth employers and consumers. F. 60.

NTSP has approximately 480 participating member physicians, the majority of whom are specialists. F. 32. The vast majority of NTSP physicians are located in the Fort Worth area of Tarrant County, Texas. F. 31. NTSP physicians are a significant presence in the Fort Worth area. F. 61. NTSP physicians make up a large percentage of Tarrant County practitioners in

many medical specialties: pulmonary disease (80 percent); cardiovascular disease (59 percent); and urology (69 percent). F. 61. NTSP has stated that a health plan attempting to serve the employees of the City of Forth Worth "would not be able to satisfy employer/employee match or network access standards without NTSP [p]hysicians [p]articipating in the [n]etwork." F. 63.

Accordingly, the evidence establishes that the relevant market is physician services available to patients in the Fort Worth area.

D. Horizontal Agreement

The FTC Act's prohibition of unfair methods of competition encompasses violations of Section 1 of the Sherman Act, which prohibits agreements in restraint of trade. *California Dental*, 526 U.S. at 762 n.3. The Commission relies on Sherman Act law in adjudicating cases alleging unfair competition. *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 451-52 (1986); *In re California Dental Ass'n*, 121 F.T.C. 190, 292 n.5 (1996).

Section 1 of the Sherman Act prohibits "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations . . . ." 15 U.S.C. § 1. The ban on contracts in restraint of trade extends only to unreasonable restraints of trade, i.e., restraints that impair competition. *State Oil Co. v. Khan*, 522 U.S. 3, 10 (1997); *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918).

To determine whether Complaint Counsel has established that Respondent's actions violate Section 5 of the FTC Act or Section 1 of the Sherman Act, the critical questions are: (1) whether there was a contract, combination, or conspiracy; and, if so, (2) whether the contract, combination, or conspiracy unreasonably restrained trade.

1. Whether there was a contract, combination, or conspiracy

a. Summary of facts

One of NTSP's functions is to messenger to its member physicians the offers that NTSP receives from health insurance providers of fee-for-service, non-risk contracts ("non-risk contracts"). F. 44. NTSP enters into a Physician Participation Agreement ("PPA") with its member physicians. F. 64. The PPA grants NTSP the right to receive all payor offers and

imposes on the member physicians a duty to promptly forward those offers to NTSP. F. 65. The PPA also grants NTSP a right of first negotiation with health care payors, with each physician agreeing that he or she will refrain from pursuing offers from a health plan until NTSP notifies him or her that NTSP is discontinuing negotiations with the health plan. F. 65-66. (CX 275 at 24 ("NTSP shall have the right to receive all Payor Offers made to NTSP or Physician . . . If Physician receives a Payor Offer, . . . Physician will promptly forward such Payor Offer to NTSP for further handling in accordance with the provisions of this Agreement.")).

The Board of Directors of NTSP ("Board") decides whether to send non-risk contract offers to its member physicians based on "Board minimums." F. 83. Board minimums are minimum rates established through NTSP's polling of its member physicians to determine what each physician believes are acceptable fees for non-risk contracts. F. 84, 87. (*E.g.*, CX 1196 ("Every year the Board asks the members to tell them what they consider to be appropriate reimbursement. . . . Once a year we poll the members and get that information from them."). NTSP's polling form asks each physician to disclose the minimum price that he or she would accept to provide medical services pursuant to a fee-for-service HMO or PPO agreement. F. 89. NTSP collects the results and calculates the mean, median, and mode ("averages") of the minimum acceptable fees. F. 93. NTSP then sends to its member physicians "Fax Alerts," that communicate to NTSP physicians the minimally acceptable fee schedules for non-risk health plan contracts. F. 94, 98, 84 (Fax Alert from NTSP to its member physicians informing them of the results of that year's poll and stating that NTSP "utilizes these minimums when negotiating managed care contracts on behalf of its participants"). If a non-risk contract offer falls below the minimally acceptable fee schedule, NTSP, on behalf of its member physicians, rejects the offer by determining to not messenger the offer to its member physicians. F. 68, 83.

NTSP cannot and does not bind any member physician to non-risk contracts. F. 71. The PPA gives NTSP no authority to bind physicians. F. 67. Any non-risk contracts which NTSP has decided to accept are messengered by NTSP to NTSP's physicians for their individual decisions on whether or not to join. *See* F. 71, 72. *E.g.*, F. 189, 326-27.

In the process of negotiations for the provision of physician services under health plans with United Healthcare ("United") and with Aetna Health, Inc. ("Aetna"), NTSP has solicited

and obtained powers of attorney from its member physicians, giving NTSP the legal authority to negotiate non-risk contracts with those health plans on behalf of NTSP's member physicians. F. 76-77, 160-61, 302-04. In the process of negotiations with Cigna Healthcare ("Cigna"), NTSP requested that its member physicians sign an authorization form to allow NTSP to serve as its physicians' agent. F. 80, 205.

NTSP has encouraged its physicians to abstain from negotiating direct contracts with health plans and to refer any health plans' offers to NTSP staff in accordance with their participation agreements. F. 78, 168. NTSP's physicians have referred health plans attempting to contract directly with them back to NTSP, with the knowledge that NTSP would reject offers below Board minimum rates. F. 81. Cigna, for example, received forty virtually identical letters from physicians directing Cigna to contact NTSP, rather than the physicians, because NTSP was acting as the physicians' agent in negotiating the non-risk sharing contract in question. F. 206. When United approached individual physicians to offer direct contracts, United was also referred to NTSP. F. 173.

b. Summary of parties' positions

Complaint Counsel argues that the mere existence of NTSP is a combination that satisfies the combination requirement of Section 1 of the Sherman Act. Complaint Counsel's Post Trial Brief ("CCPTB") at 51 (citing *Alvord-Polk, Inc. v. Schumacher & Co.*, 37 F.3d 996, 1009 n.11 (3d Cir. 1994) ("There is . . . authority for the proposition that a trade association, in and of itself, is a unit of joint action sufficient to constitute a section 1 combination."). Complaint Counsel further asserts that the evidence – that NTSP polled and disseminated averaged data on future prices; that NTSP set minimum rates for contracting with health plans based on this data; and that NTSP collected powers of attorney from member physicians – demonstrates that NTSP entered into a "contract, combination or conspiracy" to implement and enforce price and related agreements. CCPTB at 59-60.

Respondent argues that NTSP, as a single entity, is incapable of colluding with itself. Respondent's Post Trial Reply Brief ("RPTRB") at 7-8. Respondent further asserts that, under

the *Colgate* doctrine, NTSP has the legal right to refuse to sign and messenger to its member physicians contractual offers that are outside NTSP's business model. RPTB at 18, 22 (citing *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919)).

c. Analysis

(i) Concerted action must be demonstrated

To establish a violation of Section 1 of the Sherman Act, a plaintiff must demonstrate concerted action. *Viazis v. Am. Ass'n of Orthodontists*, 314 F.3d 758, 761 (5th Cir. 2002). "The term 'concerted action' is often used as shorthand for any form of activity meeting the section 1 'contract, combination or conspiracy' requirement." *Alvord-Polk*, 37 F.3d at 999 n.1.

In *Viazis*, the Court of Appeals for the Fifth Circuit held, "[d]espite the fact that 'a trade association by its nature involves collective action by competitors, it is not by its nature a 'walking conspiracy', its every denial of some benefit amounting to an unreasonable restraint of trade.'" 314 F.3d at 764 (quoting *Consolidated Metal Prod., Inc. v. Am. Petroleum Inst.*, 846 F.2d 284, 293-94 (5th Cir. 1988)). Simply because NTSP is an organization of otherwise competing physicians does not mean that the concerted action requirement of Section 1 of the Sherman Act has automatically been satisfied. Indeed, in *Alvord-Polk,* the case relied upon by Complaint Counsel, the Court of Appeals for the Third Circuit held, "concerted action does not exist every time a trade association member speaks or acts. Instead, in assessing whether a trade association (or any other group of competitors) has taken concerted action, a court must examine all the facts and circumstances to determine whether the action taken was the result of some agreement, tacit or otherwise, among members of the association." 37 F.3d at 1007-08.

(ii) Agreement under *Maricopa*

In *Arizona v. Maricopa Co. Med. Soc'y*, 457 U.S. 332, 356-57 (1982), the complaint challenged agreements among competing physicians, who were members of medical societies or medical foundations, that set, by majority vote, the maximum fees that the physicians could claim in full payment for services to policyholders of specific health insurance plans approved by the foundations. While the Supreme Court's opinion provides little detail on the challenged

agreements, more detail is available in the lower court decisions. As described by the Court of Appeals, "[t]he challenged conduct is the setting by majority vote of maximum fees that physician members may claim in full payment for health services they provide to policyholders of [certain] approved insurance plans." *Arizona v. Maricopa Co. Med. Soc'y*, 643 F.2d 553, 554 (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982). Further, the Court of Appeals noted that the foundations' "activities include polling their members from time to time to set upper limits on fees they may charge patients covered by insurance plans the [medical societies] approve." *Id.* at 554-55. At the district court level, the court found, "[i]t is undisputed that the foundations set the maximum amount to be paid [to] physicians who agree to provide services to patients who are enrolled in insurance plans approved by the foundations. It is further undisputed that the doctors who agree to participate in the foundation-approved plans are free to set the prices they charge their patients." *Arizona v. Maricopa Co. Med. Soc'y*, 1979 U.S. Dist. LEXIS 11918, at *2 (D. Az. 1979), *aff'd*, 643 F.2d 553 (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982). As described by the Courts of Appeals for the Fourth Circuit and for the Ninth Circuit, the illegal agreements in *Maricopa* were the agreements by the participating physicians to accept set amounts that had been determined by the foundations as fees in payment for physician services to policyholders. *Ratino v. Med. Serv.*, 718 F.2d 1260, 1270 (4th Cir. 1983); *Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022, 1027 (9th Cir. 1988).

The Supreme Court in *Maricopa* found these agreements to be a "combination . . . [that] permitted [the physicians] to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care." 457 U.S. at 356. Thus, the Supreme Court found concerted action without finding that the competing physicians agreed directly with each other to set prices and even where the participating physicians were free to set their own prices. *See id.* In so holding, the Supreme Court noted that the rule against price fixing "is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases." *Id.* at 348.

In this case, there is no evidence that one or more of the member physicians agreed with each other to reject a non-risk payor offer; there is no evidence that one or more of the member

physicians consulted with each other when responding to polls or making decisions on non-risk payor contracts; and, there is no evidence that any member physician knew what another physician was going to do in response to a non-risk payor offer. F. 73-75. However, *Maricopa* does not require such evidence.

The evidence in this case does establish that Respondent entered into agreements with physicians to negotiate non-risk contracts on behalf of those physicians and that physicians agreed to accept the rates of the non-risk contracts entered into between NTSP and health care payors. F. 44, 51, 64, 191, 326. Respondent argues that NTSP physicians at times signed contracts with certain health plans, individually or through other physician groups, at rates different than those agreed to by NTSP. RPTB at 19. However, a price fixing conspiracy need not be perfect or complete in order to be unlawful. *In re High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d 651, 656 (7th Cir. 2002) ("An agreement to fix list prices is . . . a per se violation of the Sherman Act even if most or for that matter all transactions occur at lower prices.").

The evidence further establishes that the physicians, who are otherwise competitors of each other (F. 35-36), provided to NTSP the minimum prices that each physician or physician group would be willing to accept on a non-risk contract specifically for NTSP's use in negotiating the economic terms of non-risk contracts. F. 87-90, 96-98, 155-59, 308-16. *E.g.*, F. 88 ("NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants."). And, the evidence establishes that NTSP used this price information to obtain more favorable rates or contract terms from health insurance payors than the payors initially offered. F. 44, 170-90, 317-30. This behavior satisfies the concerted action requirement under *Maricopa.*

In addition, the evidence establishes that NTSP sought a uniform rate for all of its specialties, regardless of the supply or demand for specific specialty services in the market. F. 291, 293, 340. This behavior is contrary to the Supreme Court's finding in *Maricopa* that the rule against price fixing was violated by a price restraint that tended to provide the same economic rewards to all practitioners, regardless of skill or experience. *Maricopa*, 457 U.S. at 348.

The challenged concerted action in this case is similar to the agreement challenged in *Hassan v. Indep. Practice Assoc., P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988). In *Hassan,* an organization of physicians and osteopaths set a maximum fee schedule that was initially based on schedules submitted by members, as well as information about fees in areas in which the organization did not operate. *Id.* at 681-82. The court concluded that, where the association and the board of directors which set the fees were made up of physicians or osteopaths, health care providers set the fee reimbursement and that, under *Maricopa*, there was an agreement between competitors. *Id.* at 687.

If, as in *Maricopa*, it is unlawful for competing physicians to set *maximum* prices, then, for even stronger reason, it is unlawful for competing physicians to set, through NTSP, *minimum* prices. *See United States v. Socony-Vacuum Oil Co., Inc.*, 310 U.S. 150, 223 (1940) ("Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*.").

(iii) Actions on behalf of members

Respondent asserts that NTSP is a single entity, incapable of colluding with itself. RPTRB at 7-8. "It is not sufficient to assert, as defendants do, that a corporation cannot conspire with itself. We must look at substance rather than form." *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476, 480, 481 (4th Cir. 1980) (finding action in concert where "in a real and legal sense, [defendants] are agents of their member physicians"). The substance here is that NTSP, in negotiating economic terms of non-risk contracts, did so for the pecuniary benefit of its member physicians. *Supra* III.A.1. *E.g.,* F. 84 (NTSP utilizes these minimums determined by polls "when negotiating managed care contracts *on behalf of its participants*.") (emphasis added).

Respondent is an association of individual competing physicians who have not integrated their medical practices and who have separate and distinct economic interests. F. 18, 35. Where "[e]ach doctor practices medicine in his or her own individual capacity[,] each is a 'separate economic entity potentially in competition with other physicians.'" *Capital Imaging Associates,*

P.C. v. Mohawk Valley Med. Ass'n, Inc., 996 F.2d 537, 544 (2nd Cir. 1993) (quoting *Bolt v. Halifax Hosp. Med. Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990). *See also Oregon Physicians' Serv.*, 868 F.2d at 1024, 1030 (denying summary judgment where plaintiff produced sufficient evidence to permit a trier of fact to conclude that an organization founded by physicians that offered and administered a prepaid health care plan was an organization of physicians or an agent of its member physicians and may have acted for the anticompetitive interests of its member physicians).

Respondent not only is an entity composed of physicians, it is managed by a Board composed of eight physicians, elected by physicians. F. 23-24. Physician control of NTSP further undermines Respondent's argument that NTSP is a single entity with a unity of purpose. *Virginia Academy of Clinical Psychologists*, 624 F.2d at 481 (physician control of prepaid health care plans sufficient to bring its actions within the purview of Section 1 of the Sherman Act). *See also Addino v. Genesee Valley Med. Care, Inc.*, 593 F. Supp. 892, 894, 896-97 (W.D.N.Y. 1984) (where board of non-profit corporation composed of half physicians and half laypersons approved all proposed rates for physician services, plaintiffs' allegation that defendant was merely a vehicle for the member physicians to fix prices was held to be more than sufficient to state a claim of conspiracy between and among defendant's member physicians); *cf. Barry v. Blue Cross of California*, 805 F.2d 866, 869 (9th Cir. 1986) (where plaintiffs failed to produce any evidence of physician control of the price-setting entity, court upheld the agreement as to prices and reimbursement).

Accordingly, NTSP is not a single entity with a "complete unity of purpose," incapable of conspiring with itself. *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 772 (1984) (no concerted action where a parent company and wholly owned subsidiary had a "'unity of purpose or a common design'") (citation omitted).

(iv) Respondent's authority

Relying on *Viazis*, Respondent argues that Complaint Counsel has failed to establish concerted action. RPTB at 16. In *Viazis*, plaintiff, an orthodontist, claimed that the action taken by an association of orthodontists to suspend plaintiff's membership in the association was

concerted action, in violation of Section 1 of the Sherman Act. 314 F.3d at 761. After a hearing and appeal, the association's ethics committee found that plaintiff had violated the association's prohibition of false and misleading advertising and determined to suspend plaintiff's membership in the organization for one year. *Id.* at 761, 764. The Court of Appeals for the Fifth Circuit held that the suspension of plaintiff could "constitute action pursuant to a conspiracy only if the members of [the association] were conspiring among themselves." *Id.* at 764. Plaintiff "was unable to demonstrate that the ethics proceedings against him were a sham or that the standards applied were pretextual, so he failed to establish the existence of an unlawful conspiracy." *Id.* at 764-65.

In *Viazis*, the plaintiff presented no evidence that the proceedings against him were in any way designed to limit competition. *Id.* In this case, the evidence demonstrates that NTSP engaged in conduct that had the purpose and effect of limiting price competition among NTSP physicians and raising rates above those initially offered to NTSP on non-risk contracts. *E.g.*, F. 187, 327. Accordingly, *Viazis* does not compel a finding that NTSP did not engage in a contract, combination, or conspiracy.

Respondent also asserts that, under *Colgate*, 250 U.S. at 307 (establishing manufacturer's right to refuse to deal) and *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP,* 124 S. Ct. 872, 880-81 (2004) (establishing network's right to refuse to make itself available), NTSP has a right to follow its own business model and to refuse to sign and messenger contractual offers that fall below Board minimums. RPTB at 22. Respondent further asserts that the Court of Appeals for the Fifth Circuit recently reiterated the right of an association to refuse to deal in its *Viazis* decision. RPTB at 22.

In *Colgate*, the United States Supreme Court held that a manufacturer has a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently. 250 U.S. at 307. *Colgate* involved the unilateral decision by a single corporation, Colgate, not to sell its products to dealers who would resell them at prices below the suggested prices set by Colgate. *Id.* at 302-03. As a single corporation, in fact and in form – unlike NTSP – Colgate could not conspire with itself. But here, where NTSP is not an entity with unity of purpose, *Colgate* is inapplicable. *See St. Bernard General Hosp., Inc. v. Hosp. Serv. Ass'n, Inc.*, 712 F.2d 978, 986-87 (5th Cir. 1983)

(*Colgate* doctrine inapplicable to an association comprised of nine local hospitals).

Trinko is likewise inapplicable to the facts of this case. In *Trinko*, the Supreme Court addressed conduct by a single firm charged with monopolization under § 2 of the Sherman Act, not with "contract, combination or conspiracy" under § 1 of the Sherman Act. *Trinko*, 124 S. Ct. at 878. There was no allegation that the defendant had agreed with any other person on prices or on a refusal to deal. *See id.* The Court in *Trinko* held that the defendant was not required to make its communication network available to competitors. *Id.* at 880. The Court's holding reflects the reluctance of courts to use the antitrust laws to force competitors to cooperate with one another, recognizing that such cooperation may instead lead to collusion or reduce incentives to innovate. *Id.* at 879. Thus, *Trinko* is inapposite to a case such as this, involving an agreement on prices and concerted action.

Viazis also does not compel a conclusion that NTSP has a right to refuse to sign and messenger contractual offers that fall outside NTSP's business model. In *Viazis*, the Fifth Circuit held that a plaintiff cannot show competitive harm "merely by demonstrating that the defendant 'refused without justification to promote, approve, or buy the plaintiff's product.'" 314 F.3d at 766 (quoting *Consolidated Metal Products*, 846 F.2d at 297). Respondent asserts that this case is similar to *Viazis* in that NTSP is making a decision on whether or not it wants to be involved in (i.e., "approve") a payor's offer. RPTB at 22. What makes this case different, however, is that the court in *Viazis* found that there was no evidence that the association had influence over its members' purchasing decisions or that it coerced them into rejecting plaintiff's product. 314 F.3d at 766. Here, there is evidence that NTSP influenced its member physicians to allow NTSP to negotiate economic terms of non-risk contracts on their behalf and that NTSP rejected offers that fell below Board minimum rates which NTSP had set based upon polling the member physicians. *E.g.*, F. 65-67, 70, 83-89, 127, 155-57, 300, 311-16.

(v) Summary

Complaint Counsel has presented evidence "that tends to exclude the possibility that the alleged conspirators acted independently." *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986) (quotation omitted). The evidence, as detailed in the Findings

of Fact and summarized above, establishes that NTSP and its member physicians entered into agreements to allow NTSP to negotiate on behalf of its member physicians; that NTSP established Board minimum rates by polling its member physicians to determine the minimally acceptable rate that its member physicians would accept for physician services; that NTSP used these Board minimum rates in negotiating the economic terms of non-risk contracts with health insurance plans; and that NTSP obtained for its member physicians more favorable rates or contract terms from health insurance payors than the payors initially offered. Accordingly, Complaint Counsel has demonstrated concerted action. The next required inquiry is whether Respondent's actions unreasonably restrained trade.

2. Whether there was an unreasonable restraint of trade

a. Summary of facts

A review of the actions NTSP took in its negotiation of economic terms of non-risk contracts with three health insurance payors – United, Cigna, and Aetna – demonstrates that the concerted action taken by NTSP was an unreasonable restraint of trade. As detailed in the Findings of Fact and summarized below, NTSP, on behalf of its member physicians, negotiated economic terms on non-risk contracts and entered into agreements with health care payors through which NTSP obtained higher rates or more beneficial economic terms than the health care payors initially offered to NTSP. NTSP has not demonstrated valid procompetitive justifications for this conduct. Thus, as set forth below, Complaint Counsel has demonstrated an unreasonable restraint of trade.

(i) Negotiations of economic terms with health plans

The Medicare RBRVS fee schedule is Medicare's Resource Based Relative Value System ("RBRVS"), a system developed by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for each service rendered to Medicare patients. F. 10. Health plans that contract with physicians on a fee-for-service basis often do so based on a stated percentage of the Medicare RBRVS fee schedule, which provides reimbursement rates for a large number of specific procedures. F. 11. The Medicare RBRVS

establishes weighted values for each medical procedure, such that the application of a percentage multiplier enables one to determine the fees for thousands of different services simultaneously. F. 12.

NTSP's polling form, which asks each physician to disclose the minimum price that he or she would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement, asks member physicians to indicate their price selection by placing a check mark next to one of several pre-printed Medicare RBRVS ranges. F. 89-90. On October 15, 2001, the NTSP Board received annual poll results. F. 96. Based on the poll results, NTSP established minimum prices of 125% of 2001 Medicare RBRVS for HMO products and 140% of 2001 Medicare RBRVS for PPO products as minimally acceptable fee schedules. F. 96. On November 11, 2002, NTSP conducted another annual poll to determine minimum reimbursement rates for use in negotiation of HMO and PPO products and anesthesia contracts with health plans. F. 97. On its 2002 polling form sent to physicians, NTSP included the 2001 poll results, reported by mean, median, and mode. F. 97. The results of the 2002 annual poll by mean, median, and mode, for HMO were 131%, 135%, and 135%; for PPO, 146%, 145%, and 145%. F. 98. As summarized below, these minimum rates were used by NTSP in its negotiation of economic terms of non-risk contracts on behalf of its member physicians.

- **United**

In June 1998, NTSP sought to negotiate a non-risk contract with United, a health care payor that had been identified by NTSP as a potential major player in the market place. F. 107-08. To that end, NTSP solicited powers of attorney from its member physicians and recommended that the physicians "refrain from responding to United Healthcare while NTSP's request for agency status is being tabulated." F. 108, 110. In the course of its negotiations with United, NTSP made fee proposals to United and instructed its member physicians not to take any actions with respect to a United contract because NTSP was engaged in negotiations with United on behalf of NTSP's member physicians. F. 112-13. In the fall of 1998, United made an offer to NTSP on a non-risk contract containing rates that were below the rates available to physicians through another IPA, Health Texas Provider Network ("HTPN"). F. 116. NTSP and HTPN had

an arrangement whereby NTSP physicians would be allowed to access HTPN's payor offers. F. 117. NTSP proposed to United that NTSP's member physicians contract with United through HTPN, which allowed higher rates than those offered to NTSP by United. F. 118-19. A significant number of NTSP physicians did access United through HTPN. F. 120.

In March 2001, NTSP approached United to negotiate a direct NTSP-United non-risk contract. F. 121. At that time, United already had contracts with approximately two-thirds of NTSP's member physicians, either directly or through other physician organizations such as HTPN. F. 124. Therefore, United concluded that there was no real need to enter into a contract with the remainder of NTSP physicians through an NTSP group contract. F. 124. Nevertheless, United offered NTSP its then standard rate in the Fort Worth area of 110% of 2001 Dallas RBRVS, which was the equivalent of 115% of 2001 Tarrant County RBRVS. F. 126. Without presenting the offer to its member physicians, NTSP informed United that the offer was unacceptable because it fell below NTSP's Board minimums and because it offered a single rate for both HMO and PPO products, instead of different rates for the two products. F. 127, 129, 147. In a Fax Alert to the member physicians, NTSP's Board informed its member physicians that NTSP and United had agreed to fundamental non-economic terms, but that NTSP believed that United's rate offer was lower than NTSP's minimum price level. F. 149.

Following its rejection of the United offer, NTSP contacted a large employer, the City of Fort Worth, which was engaged in contract negotiations with United to provide health care coverage to the employees of the City of Fort Worth. F. 140, 141, 144. In July 2001, NTSP sent a letter to the Mayor of Fort Worth notifying him that United's reimbursement rates are "well below market benchmarks" and that "NTSP simply has not and will not accept United's request for our participation in their provider network for your employees." F. 138. The letter also stated that "the City may experience significant network disruption once United officially begins their duties (up to 588 doctors no longer available)." F. 138. NTSP encouraged its Board members to "contact any city council members they know to let them know that United's panel is not adequate." F. 135. NTSP also urged its primary care physicians to contact the Mayor and city council members to educate them about the situation with United and ask for assistance. F. 136.

These actions created concern among United's client, the City of Fort Worth, that NTSP physicians might drop out of United's network, leaving an inadequate network of physicians to serve its Fort Worth-based employees. F. 143. Based on these concerns, the City of Fort Worth urged United to do what was necessary to preserve its provider network. F. 143.

United, because it had a majority of NTSP physicians already under contract through HTPN, did not initially increase its offer to NTSP in the summer of 2001. NTSP, in July 2001, informed United that NTSP intended to terminate the contract that NTSP had with HTPN for the provision of physician services to United. F. 153. *See also* F. 150 (Fax Alert informing NTSP member physicians that "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."). Subsequently, on July 23, 2001, the NTSP Board approved termination of NTSP's participation in the United-HTPN contract, effective October 20, 2001. F. 151.

In addition, NTSP solicited powers of attorney from its member physicians to enable NTSP to negotiate contracts between the physicians and United on the physicians' behalf. F. 160. Under the broad language of the power of attorney, NTSP was authorized to negotiate price terms on behalf of the member physicians: "[t]his power of attorney grants the authority to the agent to act on the undersigned's behalf regarding the foregoing described agreements in all respects, including the authority to negotiate the terms of, enter into, execute, amend, modify, extend or terminate any such agreements." F. 161.

United learned about NTSP's efforts to solicit powers of attorney from NTSP's member physicians. F. 162. This effort, in conjunction with NTSP's termination of 108 physicians participating in United via HTPN and the concerns expressed by the City of Fort Worth to United about losing NTSP physicians from United's provider network, induced United to change its network strategy for Tarrant County. F. 162. Initially, United tried to recruit the terminated NTSP member physicians individually. F. 163. United directly offered those physicians the opportunity to return to a United contract at the same reimbursement rates that they had received under the HTPN-United agreement prior to their termination by NTSP. F. 164.

NTSP sent another Fax Alert to its member physicians in August 2001. In it, NTSP explained that it had been receiving calls from member physicians regarding direct offers that

they had received from United; repeated NTSP's assessment that the United offer fell below Board minimums; noted that NTSP had already received 107 executed powers of attorney from its member physicians "to act on their behalf in regard to all contracting activity between themselves and United Healthcare"; invited the submission of executed powers of attorney by other member physicians; and advised member physicians who had already signed powers of attorney to inform United representatives that NTSP was their contracting agent and to instruct United "to contact NTSP directly." F. 165-68. NTSP promised its member physicians that it would continue to pursue a direct contract with United that "meets or exceeds" the fee schedule minimum rates set by NTSP membership. F. 166.

United was not successful in signing contracts directly with NTSP physicians. United's initial direct contract invitation attracted only a few physicians, even though the physicians were offered the same rates that they previously received through HTPN. F. 171-72. Some of these physicians who rejected United's offer explicitly referred United back to NTSP as their negotiating agent. F. 173.

After receiving little interest in its initial direct offer to the terminated NTSP physicians, United tried to work through other Fort Worth IPAs or large medical groups. United offered 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO to two other IPAs, All Saints Affiliates and Medical Clinic of North Texas. F. 170. Next, United offered NTSP a rate of 125% of 2001 Tarrant RBRVS for HMO and 130% Tarrant RBRVS for PPO. F. 185.

NTSP and United signed a contract for 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO, effective November 1, 2001. F. 186. On November 1, 2001, NTSP sent the contract to its member physicians to opt in or opt out, indicating that the contract was a result of negotiations and that the 125% of the 2001 Tarrant County RBRVS for the HMO was "at the average level of acceptable reimbursement," but that the PPO rate of 130% was below the acceptable average reimbursement levels determined by the NTSP Board based on the poll results. F. 189. Of NTSP's member physicians, for HMO, 24% accepted, and for PPO, 23% accepted the NTSP-United contract. F. 191.

• **Cigna**

Cigna purchased Healthsource, Inc. ("Healthsource") in late 1997 and informed physicians in Healthsource's network that their contracts with Healthsource would be assigned to Cigna. F. 201-02. NTSP physicians who had contracts with Healthsource, at NTSP's direction, sent Cigna forty virtually identical letters, representing fifty-two doctors in separate practice groups, refusing assignment and stating that NTSP would be their representative and agent in negotiations with Cigna. F. 204-06.

Cigna and NTSP entered into a Letter of Agreement ("LOA") in October 1999, through which Cigna agreed to reimburse NTSP specialists, with the exception of cardiologists/CV [cardiovascular] surgeons, gastroenterologists, urologists, oncologists, and podiatrists, on a fee schedule equal to 125% of the 1998 Dallas County RBRVS. F. 212-13. Subsequently, NTSP requested, and Cigna agreed to, an amendment to the contract that insured that the rate would be adjusted annually to maintain 125% of current year RBRVS. F. 220.

Under the October 1999 LOA, Cigna entered into a non-risk contract for "NTSP specialists." F. 213, 237. Subsequently, NTSP asked Cigna to allow primary care physicians to "opt in" to the NTSP-Cigna contract. F. 238. Cigna already had an adequate number of primary care physicians in its network and determined that if NTSP's primary care physicians were allowed into Cigna's network, Cigna's overall costs would increase without any benefit to Cigna. F. 239. At times during the negotiations, in late 2000, regarding the inclusion of primary care physicians, NTSP threatened to terminate the NTSP-Cigna contract. F. 244. Cigna eventually agreed to allow NTSP's primary care physicians to opt in to the existing contract. F. 246.

In preparation for its negotiations with NTSP, Cigna analyzed the importance of having NTSP's physicians in its Fort Worth area network. F. 235. Cigna determined that NTSP's physicians made up a high percentage of many specialty practices. F. 235. Cigna also performed disruption analyses to determine the effect of losing access to NTSP's physicians. F. 235. Based on these analyses, Cigna concluded that a loss of NTSP physicians would have a significant negative impact on Cigna's network in several crucial specialties, and that, therefore, it must have those physicians in its Fort Worth area network. F. 235. Cigna also concluded, based on the identical letters it received from NTSP's member physicians designating NTSP as their agent

and the threats by NTSP to terminate its contracts with Cigna, that NTSP's physicians would only contract through NTSP and would not agree to contract individually with Cigna. F. 206, 208.

Under the contract between Cigna and NTSP that was current at the time of trial, April 2004, PPO reimbursement is at a rate of {

} and HMO reimbursement is at a rate of {

}. F. 250 (*in camera*). Cigna agreed to allow NTSP's primary care physicians to opt in to the contract on a fixed amount per patient basis and to provide for the future inclusion of specialists who had previously been carved out of the Cigna HMO contract. F. 246. There is insufficient evidence to determine if NTSP's demand of these rates was based on Board minimums or poll results.

- **Aetna**

Prior to 2000, many NTSP physicians served Aetna patients in the Fort Worth area through contracts that NTSP's physicians had with Medical Select Management ("MSM"), an IPA to which Aetna had delegated almost all medical risk for HMO care. F. 267, 269, 273-74. In 1999 and again in 2000, NTSP approached Aetna to obtain a direct NTSP-Aetna contract that would not involve MSM. F. 276-77. Initially, NTSP and Aetna tried to negotiate a risk contract, but after those negotiations reached a dead end, in October 2000, their negotiations shifted to non-risk, fee-for-service HMO and PPO products. F. 286.

In their negotiations on the terms of a non-risk contract, Aetna initially offered to NTSP rates that were based on a reference schedule that uses the same relative value units from the RBRVS schedule, but places a different multiplier on different specialties' services, based on supply and demand. F. 288. Aetna's initial offer aggregated to about 111% to 112% RBRVS for HMO and about 123% to 125% RBRVS for PPO, with some specialities being offered more or less than the aggregate. NTSP rejected this offer and proposed, instead, uniform rates for all specialities of 125% RBRVS for HMO and 140% RBRVS for PPO. F. 288. In November 2000, Aetna, in response to NTSP's demands, agreed to raise its PPO offer to 140% and offered a

higher HMO reimbursement rate of 116%. F. 298. NTSP accepted the offered PPO rates, but continued to insist on the higher rate of 125% for its HMO contract. F. 299, 300.

In the midst of negotiating the HMO rates with Aetna, NTSP decided to re-poll its member physicians "on the acceptability of the present Aetna offering." F. 311. Shortly thereafter, NTSP informed its member physicians that "[t]he membership's message that a 125% of current Medicare HMO fee schedule is required has been transmitted to Aetna and a response on this final contractual item is expected within the next 24 to 36 hours." F. 316. NTSP further informed its member physicians that NTSP continued to act as their agent and instructed its member physicians to refer all contacts and materials received from Aetna to NTSP directly. F. 316.

During these negotiations, Aetna was subjected to pressure to reach an agreement with NTSP. In June 2000, NTSP threatened that its member physicians might immediately end their participation in the Aetna-MSM arrangement. F. 278. NTSP also sought and received approximately 180 powers of attorney from its member physicians, authorizing NTSP to act for those physicians in all transactions relating to MSM and to represent its member physicians in any negotiations with Aetna, regarding any term. F. 304. Using the authority provided by the powers of attorney, in November 2000, as previously threatened, NTSP terminated its member physicians' participation in the Aetna-MSM arrangement, citing breach of contract by MSM. F. 297. Based on the language of the powers of attorney and other NTSP statements to Aetna, Aetna believed that it could not negotiate directly with NTSP physicians. F. 306.

Ultimately, Aetna agreed to NTSP's terms. On December 19, 2000, Aetna wrote to NTSP and proposed for PPO, 140% of current Medicare RBRVS, anesthesia at $45.00; for HMO, 125% of current Medicare RBRVS, anesthesia at $43.00. F. 323. NTSP responded, stating that NTSP would send out a notice to its member physicians notifying them that the PPO and HMO offers were within the messenger minimums. F. 324. NTSP forwarded the NTSP-Aetna agreement to its member physicians. F. 326. One hundred and eighty-eight member physicians agreed to the NTSP-Aetna contract. F. 326.

In 2001, Aetna attempted to reduce the rates it paid to NTSP. F. 331. Aetna offered NTSP rates that Aetna believed were more in line with the market, but in some aspects were

higher than Aetna's general fee schedule. F. 338-39. NTSP did not present Aetna's rate proposal to its member physicians because NTSP did not have Board authority to do so. F. 341. The Aetna-NTSP contract was terminated at the beginning of 2002. F. 332.

(ii) Effects on prices

The evidence establishes that NTSP, through its coordinated efforts, was able to demand higher prices from United and Aetna and more favorable terms in its contract with Cigna, than those health insurance payors initially offered. However, there is insufficient evidence to establish that the rates that United, Cigna, and Aetna agreed to with NTSP are uniformly higher than rates health insurance payors offered to other IPAs or directly to other physicians.

Several health plans estimated that they had paid increased prices as a result of NTSP's negotiation of economic terms of non-risk contracts. United agreed to a contract with rates that were an increase of 10% from their initial HMO offer and an increase of 15% from their initial PPO offer. F. 187. However, the rate that United offered to NTSP was the same rate that United had offered other IPAs. F. 188. Cigna estimated that it would cost { } to shift some of its direct-contracted physicians from market compensation to NTSP compensation. F. 248 (*in camera*). Cigna's representative testified that the reimbursement rate of 125% of RBRVS on HMO and 130% of RBRVS on PPO was somewhere between 15 and 20 percent higher than Cigna's standard rates. F. 217. However, Cigna's representative also testified that the rates that Cigna paid to NTSP were in the "general ballpark" of the rates Cigna paid to other IPAs { } F. 217 (*in camera*). Aetna agreed to contract rates for 2000 (uniform rates of 140% RBRVS for PPO and 125% RBRVS for HMO) that were higher than the rates Aetna initially offered (aggregated to about 123% to 125% RBRVS for PPO and to about 111% to 112% RBRVS for HMO). F. 327. Although Aetna's representative testified that the rates in the 2000 Aetna-NTSP contract were higher than other IPAs for similar services, those rates were identical to the rates in the Aetna-MSM contract. F. 328-29.

Complaint Counsel, in its post trial brief, argues that NTSP had compared the rates that its physicians were offered directly by the health plans to the rates that NTSP had succeeded in

obtaining from those health plans, and concluded that: NTSP's contract rates with Aetna were at least 15 percent higher for both HMO and PPO arrangements; its contract rates with Cigna were at least 12 percent higher for HMO arrangements and 20 percent higher for PPO arrangements; and its contract rates with United were 15 percent higher for HMO arrangements. CCPTB at 21-22. However, the evidence cited by Complaint Counsel does not support these conclusions.

(iii) Procompetitive justifications

Respondent asserts that its conduct and business model have strong procompetitive effects and efficiencies, for both risk and non-risk contracts. The evidence presented at trial demonstrates that, with respect to non-risk contracts, NTSP's business model does not generate strong efficiencies, and that any efficiencies generated from NTSP's risk contract business do not, to a significant degree, spillover into NTSP's non-risk contract business. The evidence further establishes that any efficiencies that NTSP has achieved from its risk contract business that may spillover to NTSP's non-risk contract business are not dependent upon and do not require NTSP's negotiation of economic terms in non-risk contracts.

NTSP is not clinically integrated for patients under NTSP's non-risk contracts. F. 246. For patients covered under NTSP's non-risk contracts, NTSP does not: engage in case management; provide feedback to physicians concerning patient care; require adherence to its clinical guidelines and protocols; operate or refer patients to any disease management programs or patient registries; or engage in meaningful patient education. F. 365, 370, 372-73, 375. NTSP's medical director has no responsibility for controlling costs for patients under NTSP's non-risk contracts and NTSP's medical management committee does not evaluate the care of patients under NTSP's non-risk contracts. F. 366-67. NTSP's hospital utilization management program does not apply to patients under NTSP's non-risk contracts and NTSP's information systems do not include data for patients under NTSP's non-risk contracts. F. 368-69.

Sixty percent of NTSP's physicians participate in non-risk contracts. Roughly half of those physicians participate in risk-sharing contracts. F. 51. NTSP physicians who do not participate in NTSP's shared risk contract are unlikely to learn and apply techniques to control costs and to improve quality that are developed or learned in the context of that risk-sharing

arrangement. F. 379. Further, NTSP has not achieved significant spillover benefits from its risk business to its non-risk business because it lacks data for patients seen under non-risk contracts and thus is hindered in implementing organized processes for these patients. F. 378. Finally, NTSP does not need to set minimum contract rates in its non-risk contracts in order for any efficiencies achieved through NTSP's risk contract business to spillover to NTSP's non-risk contract business. F. 380.

b. Summary of parties' positions

Complaint Counsel asserts that because NTSP's acts and practices fit squarely within the conduct traditionally condemned as *per se* illegal, there is no need to engage in an extensive or elaborate analysis of market definition and competitive effects. CCPTB at 60. Complaint Counsel further asserts that irrespective of the standard of analysis applied, indirect evidence of Respondent's market power is unnecessary where there is direct evidence of price fixing among competitors. CCPTB at 60.

Respondent asserts that the rule of reason analysis should be applied in this case since the conduct at issue might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition. RPTB at 4. Respondent further asserts that because Complaint Counsel has not demonstrated that the challenged conduct has a net anticompetitive effect and has not proven NTSP's market power, Complaint Counsel has not proven an unreasonable restraint of trade. RPTB at 9, 11.

c. Analysis

Section 1 of the Sherman Act provides that "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1. Despite its broad language, Section 1 has long been interpreted to outlaw only those restraints that are "unreasonable." *Maricopa*, 457 U.S. at 343. The Supreme Court has set forth three methods for analyzing the reasonableness of a restraint on trade: (1) *per se* analysis, for obviously anticompetitive restraints; (2) quick look analysis, for those with some procompetitive justification; and (3) the

full "rule of reason," analysis for restraints whose net impact on competition is particularly difficult to determine. *Continental Airlines, Inc. v. United Airlines, Inc.*, 277 F.3d 499, 508-09 (4th Cir. 2002). In *California Dental*, the Supreme Court held, as demonstrated by the circumstances before it, "there is generally no categorical line to be drawn between restraints that give rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment." *Id.* at 780-81. Instead, what is required is to look to "the circumstances, details, and logic of a restraint." *Id.* at 781. The three methods are best viewed as a continuum, on which the "amount and range of information needed" to evaluate a restraint varies, depending on how "highly suspicious" and how "unique" the restraint is. *Continental Airlines*, 277 F.3d at 509 (citing 11 Herbert Hovenkamp, Antitrust Law P 1911a (1998); *California Dental*, 526 U.S. at 779-81) .

In *California Dental*, the challenged restraint of trade – restrictions on both discount and nondiscount advertising – "fail[ed] to present a situation in which the likelihood of anticompetitive effects [was] comparably obvious." *Id.* at 771. The Supreme Court held that, where competing claims about the effects of the professional advertising restrictions were plausible, the obvious anticompetitive effect that triggers abbreviated analysis had not been shown. *Id.* at 778. Thus, the Supreme Court remanded the case for a more thorough inquiry into the consequence of the challenged restraints. *Id.* at 759, 781. However, where the effects of an agreement are "intuitively obvious" and "easily ascertained," *California Dental*, 526 U.S. at 759, 770, no elaborate study of the industry is needed to establish the illegality of the agreement. *Dagher v. Saudi Refining Inc.*, 369 F.3d 1108, 1116 (9th Cir. 2004).

Agreements among competitors to fix or set prices have been historically condemned as *per se* illegal. *Socony-Vacuum*, 310 U.S. at 218; *Maricopa*, 457 U.S. at 344 ("The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some."); *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 647 (1980) ("It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable.") (citations omitted); *Nat'l Soc'y of Prof'l Engineers v. United States*, 435 U.S. 679, 692 (1978) (noting that "price is the

'central nervous system of the economy'" and holding that "an agreement that 'interferes with the setting of price by free market forces' is illegal on its face") (citation and alteration omitted).

Courts, after *California Dental*, have applied the *per se* analysis to horizontal price fixing. *E.g.*, *Dagher*, 369 F.3d at 1116 n.7 ("Because we hold that the plaintiffs have made a sufficient showing with respect to the illegality of the alliance's price fixing system under the *per se* rule, we need not decide whether that scheme would survive 'quick look' review."); *Freedom Holdings Inc. v. Spitzer,* 357 F.3d 205, 226 (2nd Cir. 2004); *Freeman v. San Diego Ass'n of Realtors*, 322 F.3d 1133, 1150-54 (9th Cir. 2003). "Traditional 'hard-core' price fixing remains *per se* unlawful under the seminal case *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-24 (1940), and its progeny." *Todd*, 275 F.3d at 198.

Courts employ the quick look approach when a restraint of trade is not illegal *per se*, but nevertheless has such obvious anticompetitive effects that a "full scale" rule of reason analysis is not necessary. *California Dental*, 526 U.S. at 770. "[W]hen there is an agreement not to compete in terms of price or output, 'no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement.'" *NCAA v. Bd. of Regents*, 468 U.S. 85, 109 (1984).

Regardless of what method of analysis is used, "the criterion to be used in judging the validity of a restraint on trade is its impact on competition." *NCAA*, 468 U.S. at 104. "'Whether the ultimate finding is the product of a presumption or actual market analysis, the essential inquiry remains the same – whether or not the challenged restraint enhances competition.'" *California Dental* (quoting *NCAA,* 468 U.S. at 104). The analytical focus is on what conclusions regarding the competitive impact of a challenged restraint can confidently be drawn from the facts demonstrated by the parties. *See California Dental*, 526 U.S. at 779-81; *NCAA*, 468 U.S. at 103-04.

In *California Dental*, the complaint alleged that an association of dentists had unreasonably restricted two types of advertising: price advertising, particularly discounted fees, and advertising relating to the quality of dental services. 526 U.S. at 762. Here, the challenged restraint is a horizontal price fixing agreement: an agreement on the minimum reimbursement level that NTSP will accept on behalf of its member physicians for those physicians' services

pursuant to non-risk contracts with health insurance payors. Whereas in *California Dental*, the anticompetitive effects of the restrictions on advertising were not obvious, in this case, the effects of agreements to set minimum price levels are "intuitively obvious." Thus, no elaborate study of the industry is needed to establish the illegality of NTSP's actions. *See California Dental*, 526 U.S. at 759; *Dagher*, 369 F.3d at 1116.

To the extent that an examination of effects is required, in this case, the effects of NTSP's concerted action have been to cause health insurance payors to increase their offers or agree to better terms of coverage than the payors otherwise would have, but for NTSP's collective actions. Although the evidence is not conclusive that NTSP's actions resulted in supracompetitive prices, such evidence does not defeat a finding of liability in this case. *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 424 (1990) (It "is no excuse that the prices fixed are themselves reasonable.") (citations omitted).

Also, in *California Dental*, the restrictions on advertising, at least on their face, were designed to avoid false or deceptive advertising and thus "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition." 526 U.S. at 771. Respondent asserts that NTSP's conduct might plausibly be thought to have a net procompetitive effect because NTSP's conduct and business model have strong procompetitive effects and efficiencies. RPTB at 1. Where a defendant asserts that the challenged conduct has procompetitive effects, the defendant bears the burden of establishing those procompetitive effects. *California Dental*, 526 U.S. 775 n.12. Courts evaluate whether claimed efficiencies are plausible, *NCAA*, 468 U.S. at 114; *Maricopa*, 457 U.S. at 353, and whether the challenged conduct is reasonably necessary to achieve the legitimate objective identified by a defendant. *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 19-21 (1979); *United States v. Brown Univ.*, 5 F.3d 658, 678-79 (3rd Cir. 1993).

In this case, as found in F. 364-80, and summarized above, there is no plausible and valid efficiency justification for collectively setting the prices in non-risk contracts, nor is such conduct reasonably necessary to achieve the claimed procompetitive benefits. Because the challenged restraint of trade does not have a net procompetitive effect on competition, a more thorough

inquiry into the consequences of the challenged restraints is not necessary. *See California Dental,* 526 U.S. at 759, 781.

Complaint Counsel has demonstrated that the actions taken by NTSP to coerce health insurance payors to increase their offers of rate reimbursement or offer more favorable economic terms to NTSP's physicians constitute an unreasonable restraint of trade in violation of Section 1 of the Sherman Act and Section 5 of the FTC Act.

E. Remedy

1. Standards

Pursuant to Section 5 of the Federal Trade Commission Act, upon determination that the challenged practice is an unfair method of competition, the Commission "shall issue . . . an order requiring such . . . corporation to cease and desist from using such method of competition or such act or practice." 15 U.S.C. § 45(b); *FTC v. Nat'l Lead Co.*, 352 U.S. 419, 428 (1957) (Commission is authorized "to enter an order requiring the offender to 'cease and desist' from using such unfair method."). The remedy selected must have a "reasonable relation to the unlawful practices found to exist." *Nat'l Lead Co.*, 352 U.S. at 428.

In this case, Complaint Counsel has proven that Respondent engaged in horizontal price fixing through its negotiation, on behalf of its member physicians, of economic terms of non-risk contracts with health plan payors for the provision of physician services. The remedy necessary to bring an end to this unfair method of competition is an order requiring Respondent to cease and desist from collective price fixing in its negotiation of non-risk contracts. In addition, to the extent that there are any existing, current non-risk contracts between NTSP, negotiated on behalf of its member physicians, and any health care payor, Respondent must take actions, as set forth in the Order, to allow termination of any such existing contracts.

2. Provisions

Complaint Counsel's proposed order seeks a provision requiring Respondent to cease and desist from entering into an agreement among physicians "to deal, refuse to deal, or threaten to refuse to deal with any payor" and "not to deal individually with any payor, or not to deal with

any payor through any arrangement other than Respondent." Complaint Counsel's Proposed Order, Sections II.A.2, 4. Complaint Counsel explains that this provision is "intentionally broad so as to preclude respondents from engaging both in the precise conduct found unlawful in this action and 'like and related' conduct." CCPTB at 77. *See also* Complaint Counsel's Opening Statement, Tr. at 60 (Complaint Counsel seeks an order "broadly requiring NTSP to messenger contracts.").

This broad request could have the effect of compelling Respondent to messenger contracts or become a party to contracts sent to it by payors, regardless of potential risks to Respondent, its member physicians, and its patients. A mandatory injunction, which compels a party to act, is an extraordinary remedy that should be granted only in compelling circumstances. *Citizens Concerned for Separation of Church and State v. City and County of Denver*, 628 F.2d 1289, 1299 (10th Cir. 1980); *Justin Indus., Inc. v. Choctaw Sec., L.P.*, 747 F. Supp. 1218, 1220 (N.D. Tex. 1990), *aff'd*, 920 F.2d 262 (5th Cir. 1990). Sufficient compelling circumstances have not been demonstrated in this case.

Moreover, Complaint Counsel's authority cited in support of its proposed relief is based only on consent decrees. CCPTB at 76. "[T]he circumstances surrounding . . . negotiated [consent decrees] are so different that they cannot be persuasively cited in a litigation context." *United States v. E.I. du Pont de Nemours*, 366 U.S. 316, 330 n.12 (1961). Sections II.A.2 and 4 of Complaint Counsel's Proposed Order, which are not narrowly tailored to remedy the violation of law found to exist, are broader than required to remedy the unlawful conduct. A provision that could require Respondent to messenger all contracts or become a party to contracts sent to it by payors will not be ordered. Such overreaching is unnecessary. Accordingly, Sections II.A.2, 4 of Complaint Counsel's proposed order are not ordered.

In addition, any remedy must not contravene Texas health care laws, other Texas law, or federal law. *E.g.,* 28 TEX. ADMIN. CODE § 3.3703 (laying out contracting requirements for PPOs concerning exclusivity, savings inducements, hold-harmless clauses, prompt payment, continuity of care, disclosure of opinions to patients, disclosure of economic profiling criteria, disclosure of quality assessment criteria, and termination); 29 TEX. ADMIN. CODE § 21.2817 (relating to clean claims and prompt payment); TEX. INS. CODE art. 3.70-3C (same issues as TEX. ADMIN. CODE §

3.3703). The Supreme Court recently limited an agency's remedies to those that did not conflict with other laws, statutes, and policies unrelated to the agency. *Hoffman Plastic Compounds, Inc. v. NLRB*, 535 U.S. 137, 144-45 (2002). The Order issued herewith provides that nothing in this Order shall require NTSP violate state or federal law. Further, the Order is narrowly tailored and reasonably related to the violation of law found to exist.

3. Duration

Complaint Counsel has requested that the order issued in this case remain in effect for a period of twenty years. CCPTB at 79. Pursuant to the Policy Statement Regarding Duration of Competition and Consumer Protection Orders, 60 Fed. Reg. 42,569 (August 16, 1995), the Commission's stated policy is for administrative cease and desist orders to terminate after twenty years. The Order entered in this case shall remain in effect for a period of twenty years.

IV. SUMMARY OF CONCLUSIONS OF LAW

1. Respondent North Texas Specialty Physicians ("NTSP") is a corporation, as "corporation" is defined by Section 4 of the Federal Trade Commission Act, ("FTC Act"), 15 U.S.C. § 44.

2. The participating physicians of NTSP are "members" of NTSP, as that term is used in the definition of "corporation" in Section 4 of the FTC Act, 15 U.S.C. § 44.

3. The jurisdiction of the Federal Trade Commission ("FTC") extends to non-profit entities when a substantial part of the entity's total activities provides economic benefits for its members.

4. A substantial part of Respondent's activities provides economic benefits for its members.

5. The acts and practices charged in the Complaint are in or affect commerce, as "commerce" is defined in Section 4 of the FTC Act, 15 U.S.C. § 44.

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

7. The relevant market is physician services available to patients in the Fort Worth, Texas area.

8. Complaint Counsel has met its burden of proof of demonstrating that Respondent engaged in an agreement in restraint of trade.

9. Respondent has engaged in a contract, combination, or conspiracy to fix prices in non-risk contracts to be charged by physicians for providing medical services to health plans' patients.

10. Respondent's contract, combination, or conspiracy unreasonably restrained trade.

11. Respondent has not met its burden of proof of demonstrating that the challenged conduct has a net procompetitive effect on competition.

12. Respondent's fixing prices in non-risk contracts does not have a plausible and valid efficiency justification.

13. Respondent's fixing prices in non-risk contracts is not reasonably necessary to create any efficiencies.

14. The acts and practices of Respondent, as set forth in paragraphs 9 and 10 above, constitute unfair methods of competition in violation of Section 5 of the FTC Act, 45 U.S.C. § 45.

15. Relief designed to remedy Respondent's unlawful activities and to require Respondent to cease and desist from collective price fixing is appropriate.

16. The Order entered herein is necessary and appropriate to remedy the violation of law found to exist.

ORDER

I.

IT IS ORDERED that, as used in this Order, the following definitions shall apply:

A. "Respondent" means North Texas Specialty Physicians ("NTSP"), its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by North Texas Specialty Physicians, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.

B. "Medical group practice" means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, members, or employees, or in which only one physician practices medicine.

C. "Participate" in an entity means: (1) to be a partner, shareholder, owner, member, or employee of such entity; or (2) to provide services, agree to provide services, or offer to provide services, to a payor through such entity. This definition also applies to all tenses and forms of the word "participate," including, but not limited to, "participating," "participated," and "participation."

D. "Payor" means any person that pays, or arranges for the payment, for all or any part of any physician services for itself or for any other person. Payor includes any person that develops, leases, or sells access to networks of physicians.

E. "Person" means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.

F. "Physician" means a doctor of allopathic medicine ("M.D.") or a doctor of osteopathic medicine ("D.O.").

G. "Preexisting contract" means a contract that was in effect on the date of receipt by a payor that is a party to such contract of notice sent by Respondent, pursuant to Paragraph IV.A.3 of this Order, of such payor's right to terminate such contract.

H. "Principal address" means either (1) primary business address, if there is a business address, or (2) primary residential address, if there is no business address.

I. "Qualified clinically-integrated joint arrangement" means an arrangement to provide physician services in which:

1. all physicians that participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the physicians who participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and

2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

J. "Qualified risk-sharing joint arrangement" means an arrangement to provide physician services in which:

1. all physicians who participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the physicians who participate jointly to control costs and improve quality by managing the provision of physician services, such as risk-sharing involving:

   a. the provision of physician services for a fixed amount per patient, per month paid by payors;

   b. the provision of physician services for a predetermined percentage of premium or revenue from payors;

   c. the use of significant financial incentives for physicians who participate to achieve, as a group, specified cost-containment goals; or

   d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; and

2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

II.

IT IS FURTHER ORDERED that Respondent, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting

commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

A. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians to negotiate on behalf of any physician with any payor, regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms;

B. Exchanging or facilitating in any manner the exchange or transfer of information among physicians concerning the terms or conditions, including price terms, on which any physician is willing to deal with a payor;

C. Attempting to engage in any action prohibited by Paragraph II.A or II.B, above; and

D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C above.

PROVIDED, HOWEVER, that nothing in this Order shall prohibit any agreement involving or conduct by Respondent that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or qualified clinically-integrated joint arrangement.

PROVIDED, FURTHER, that nothing contained in this Order shall prohibit Respondent from communicating purely factual information describing the terms and conditions of any payor offer, including objective comparisons with terms offered by other payors, or from expressing views relevant to various health plans. "Objective information" or "objective comparison" constitutes empirical data that is capable of being verified or a comparison of such data.

PROVIDED, FURTHER, that nothing contained in this Order shall require Respondent to violate state or federal law.

III.

IT IS FURTHER ORDERED that, for three (3) years from the date this Order becomes final, Respondent shall notify the Secretary of the Commission in writing ("Notification") at least sixty (60) days prior to entering into any arrangement with any physician under which Respondent would act as a messenger, or as an agent on behalf of the physician, with payors regarding contracts.

The Notification shall include the identity of each proposed physician participant; the proposed geographic area in which the proposed arrangement will operate; a copy of any

proposed physician participation agreement; a description of the proposed arrangement's purpose and function; a description of any resulting efficiencies expected to be obtained through the arrangement; and a description of procedures to be implemented to limit possible anticompetitive effects, such as those prohibited by this Order.

Notification is not required for Respondent's subsequent acts as a messenger pursuant to an arrangement for which this Notification has been given.

Receipt by the Commission from Respondent of any Notification, pursuant to this Paragraph III, is not to be construed as a determination by the Commission that any action described in such Notification does or does not violate this Order or any law enforced by the Commission.

IV.

IT IS FURTHER ORDERED that Respondent shall:

A. Within thirty (30) days after the date on which this Order becomes final, send by first-class mail, return receipt requested, a copy of this Order to:

1. each physician who participates, or has participated, in Respondent since January 1, 2000;

2. each officer, director, manager, and employee of Respondent; and

3. the chief executive officer of each payor with which Respondent has a record of having been in contact since January 1, 2000, regarding contracting for the provision of physician services.

B. Terminate, without penalty or charge, and in compliance with any applicable laws, any preexisting contract with any payor for the provision of physician services, pursuant to a fee-for-service agreement at the earlier of:

1. receipt by Respondent of a written request from a payor to terminate such contract; or

2. the earliest termination or renewal date (including any automatic renewal date) of such contract.

Provided, however, a preexisting contract may extend beyond any such termination or renewal date no later than one (1) year after the date on which the Order becomes final, if prior to such termination or renewal date, (a) the payor submits to Respondent a written request to extend such contract to a specific date no later than one (1) year after the date

this Order becomes final, and (b) Respondent has determined not to exercise any right to terminate; *provided further*, that any payor making such request to extend a contract retains the right, pursuant to Paragraph IV.B.1 of this Order, to terminate the contract at any time.

C. Within ten (10) days after receiving a written request from a payor, pursuant to Paragraph IV.B.1 of this Order, distribute, by first-class mail, return receipt requested, a copy of that request to each physician participating in Respondent as of the date Respondent receives such request.

D. For a period of three (3) years after the date this Order becomes final:

1. distribute by first-class mail, return receipt requested, a copy of this Order to:

   a. each physician who begins participating in Respondent, and who did not previously receive a copy of this Order from Respondent, within thirty (30) days of the time that such participation begins;

   b. each payor who contracts with Respondent for the provision of physician services, and who did not previously receive a copy of this Order from Respondent, within thirty (30) days of the time that such payor enters into such contract;

   c. each person who becomes an officer, director, manager, or employee of Respondent and who did not previously receive a copy of this Order from Respondent, within thirty (30) days of the time that he or she assumes such responsibility with Respondent;

2. annually publish a copy of this Order in an official annual report or newsletter sent to all physicians who participate in Respondent, with such prominence as is given to regularly featured articles.

E. File a verified written report within sixty (60) days after the date this Order becomes final, and annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each such report shall include:

1. a detailed description of the manner and form in which Respondent has complied and is complying with this Order; and

2. copies of the return receipts required by Paragraphs IV.A, IV.C, and IV.D of this Order.

F. Notify the Commission at least thirty (30) days prior to any proposed change in Respondent, such as dissolution, assignment, sale resulting in the emergence of a successor company or corporation, the creation or dissolution of subsidiaries, or any other change in Respondent that may affect compliance obligations arising out of this Order.

V.

IT IS FURTHER ORDERED that Respondent shall notify the Commission of any change in its principal address within twenty (20) days of such change in address.

VI.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, Respondent shall permit any duly authorized representative of the Commission:

A. Upon written request and two (2) days' notice to Respondent, access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in its possession, or under its control, relating to any matter contained in this Order; and

B. Upon written request and five (5) days' notice to Respondent, and in the presence of counsel, and without restraint or interference from it, to interview Respondent or employees of Respondent, relating to any matter contained in this Order.

VII.

IT IS FURTHER ORDERED that this Order shall terminate twenty (20) years from the date it is issued.

ORDERED:

D. Michael Chappell
Administrative Law Judge

Date: November 15, 2004