UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

DOCKET NO. 9312

IN THE MATTER OF

NORTH TEXAS SPECIALTY PHYSICIANS,
a corporation

ANSWERING AND CROSS-APPEAL BRIEF OF COUNSEL SUPPORTING THE COMPLAINT

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The following abbreviations and citation forms are used:

ID	Initial Decision
IDF	Initial Decision Finding of Fact
CX	Complaint Counsel Exhibit
CCPTPF	Complaint Counsel's Post-Trial Proposed Findings of Fact, filed June 16, 2004
CCPTRB	Complaint Counsel's Post-Trial Reply Brief
RAB	Respondent's Appeal Brief, filed Jan. 14, 2005
RPTRB	Respondent's Post-Trial Reply Brief, filed July 6, 2004

Citations to the trial transcripts include the witness name and page number: Quirk, Tr. 1420.

Pages of exhibits are referenced by page number: CX 212 at 2.

References to investigational hearing or deposition transcripts that have been included in the trial record as exhibits include the exhibit number, the transcript page(s), the witness name, and the designation "IH" or "dep": CX 1178 (Hollander, Dep. at 68).

STATEMENT OF THE CASE

Introduction and Summary of Argument

This case challenges collective action by competing physicians to raise the level of physician fees offered by health plans, by acting through Respondent North Texas Specialty Physicians (NTSP), an organization that the physicians created and control. Stripped to its essentials, the record shows, as the ALJ found, that NTSP orchestrated an agreement among its participating physicians: to set a collectively-determined minimum price; to have NTSP negotiate with health plans to secure their agreement to offer the doctors that minimum price; and to take various other collective actions, including departicipation and threats of departicipation from payor networks, to increase pressure on payors to agree to the collective price demand.

Over two decades ago, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Supreme Court confirmed that traditional antitrust rules apply to price fixing undertaken in the context of physician contracting with health plans. The Court held that when a physician organization composed of competing doctors set a maximum fee to offer health insurers for providing medical services to patients, they engaged in horizontal price fixing. It declared the Society's conduct *per se* illegal after concluding that the price fixing was not reasonably necessary to the joint arrangement offered by the group–that is, it was not merely an "ancillary restraint."

Thus, the two central questions raised by NTSP's appeal are:

- Does the challenged conduct constitute an agreement to fix prices?
- If so, should it be treated as a *per se* violation–or can it be said that the price fixing is merely ancillary to some legitimate, potentially efficiency-enhancing collaboration among the physicians, thus warranting a deeper inquiry into its competitive effects?

These two questions are relatively easy to answer in this case, because the material facts are essentially undisputed, and the legal principles are well-established. NTSP concedes that it set a minimum fee for payor offers to its members. It attempts to claim that its interactions with payors over prices were not "negotiations." Instead, it suggests they were merely the expression of NTSP's "opinion" about what its members wanted to see in a payor offer (and an informed one at that, because since 2001 NTSP has asked its members to vote for the lowest price they thought acceptable in upcoming contracts). As the ALJ recognized, however, NTSP's own documents contradict any suggestion that NTSP did not seek agreements with payors on the fees to be offered to its physicians. Moreover, as the record shows, when necessary to obtain such agreements, NTSP resorted to other types of collective action, including actual and threatened refusals to deal.

The question whether NTSP engaged in price fixing thus boils down to a legal argument. But NTSP comes up short here too, because antitrust law's definition of "price fixing" is not nearly as narrow as NTSP would like to believe. And its suggestion that it should be treated as a "single entity," even though it admittedly is controlled by competing physicians, is likewise contradicted by decades of Supreme Court law.

Deciding whether NTSP's price setting is an ancillary restraint is similarly straightforward. NTSP does a small amount of contracting on a "risk-sharing" basis, a type of arrangement to which joint price setting is likely to be ancillary. NTSP's price setting for those contracts is not challenged here. But, try as it might, NTSP cannot offer any plausible and cognizable argument as to why setting prices for its non-risk contracting served to promote anything other than giving it bargaining power over payors. It makes vague claims about "spillover" and "teamwork" from its risk contracting, but the claims fail because NTSP simply cannot make a logical connection

between price fixing and the purported spillover claim. The facts get in NTSP's way as well, because only half of the NTSP doctors do any risk-contracting through NTSP. As for NTSP's argument that it "conserved resources" by refusing to convey certain offers, that argument applies to any cartel that fixes prices, and does not raise a cognizable antitrust defense to price fixing.

Thus, the Commission should not hesitate to invoke the *per se* rule here. Contrary to NTSP's wishful thinking, *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999), did not overrule well-established antitrust rules on price fixing. Moreover, the evidence shows that the purpose and effect of NTSP's conduct was to protect doctors' incomes, not increase competition.

We can also grant that NTSP has tried to make a go of its risk-contracting product. The problem is that, increasingly, this risk product was not what the market was demanding. If the organization's product fails the test of the marketplace, it may not try to compensate by price fixing on another product. The federal antitrust agencies have emphasized that doctors can lawfully join together to create new ventures that may offer efficiencies, and can set prices if reasonably necessary to their venture. But recognition of the flimsy justification offered here would not only sanction conduct that would be *per se* unlawful in any other industry, it would also threaten to discourage innovative actions by physicians who seek to offer a true competitive alternative in the marketplace and are willing to do the sometimes difficult work involved in such an undertaking.

Finally, the remedy aspect of the case has important implications for the use of antitrust law as a tool to promote the interests of consumers in high-quality, cost-effective health care. As the Supreme Court has observed, "if the Government proves a violation but fails to secure a

remedy adequate to redress it," then it has "'won a lawsuit and lost a cause.'"[1] As is discussed below, the ALJ's narrow order fails to provide essential relief. The evidence of NTSP's blatant disregard for antitrust limits on its conduct, and its disingenuous invocation of the antitrust agencies' "messenger model" terminology, demonstrate the need for an order that will effectively eradicate the effects of that conduct and prevent its recurrence.

Complaint Counsel therefore ask that the Commission affirm the ALJ's finding of liability, expressly, hold that the challenged conduct is *per se* unlawful price fixing, and modify the ALJ's order to provide an adequate remedy for NTSP's unlawful conduct.

Statement of Facts

A. Background

Since the demise of indemnity insurance because of its contribution to spiraling health care costs, private health insurance in the United States has been provided largely through arrangements in which health plans contract with health care providers to treat the plans' subscribers on pre-determined price terms. In such arrangements, the health plan typically creates incentives for subscribers to select providers who have agreed to participate in the network. These arrangements are often referred to as preferred provider organizations (PPOs), in which the consumer pays more out of pocket if he or she selects a provider outside the network; or health maintenance organizations (HMOs), in which the consumer may have to bear the full cost of treatment by an out-of-network provider.[2]

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[1] *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 323-24 (1961) (*quoting International Salt Co., Inc. v. United States,* 332 U.S. 392, 401 (1947)).

[2] For background on physician contracting with health plans, see Frech, Tr. 1281-97; Jagmin, Tr. 976-80.

Absent some agreement among them, competing providers decide independently whether to accept the contract terms offered by the health plan. The plan, in turn, may adjust its terms, based on provider competition in the marketplace, to obtain the extent of provider participation it wishes to achieve. It then markets its products, in competition with other health plans, to employers who offer health benefits to their employees, and to other buyers. Competition among physicians, and among health plans, benefits consumers in various ways. *See* Frech, Tr. 1289-92.

A health plan's payment arrangements with providers may be based on a "fee-for-service" approach, a set, periodic fee per subscriber to cover all needed services ("capitation"), or may involve some variation or combination of payment systems. What is relevant for this case is that some payment systems involve providers' collectively assuming and sharing the risk (in whole or in part) that the costs of providing care will exceed the payments from the plan–sometimes referred to as "risk sharing." Antitrust analysis recognizes that such risk sharing potentially creates an interdependence among the competing participants to provide care within the financial constraints of the risk arrangement, which, in turn, may yield substantial efficiencies that may ultimately benefit consumers. Consequently, any price agreements among competing providers that are reasonably necessary to operate the risk-sharing arrangement are examined in greater detail under the rule of reason to assess their competitive effects, instead of being subject to the rule of *per se* illegality that is applied to price agreements that are "naked," *i.e.*, not ancillary to some potentially procompetitive undertaking. For convenience, in this brief, risk-sharing contracts

between a provider and a health plan are referred to simply as "risk contracts," and all others as "non-risk contracts."[3]

B. NTSP

North Texas Specialty Physicians is an organization of independent physicians and physician groups practicing in and around Fort Worth, Texas. IDF 31 (nearly 90% practice in Fort Worth and its surrounding county; majority in Fort Worth), 35-36. As its name implies, NTSP is composed largely of medical specialists. In 2001, it represented approximately 650 doctors, of whom 528 were specialists; at the time of trial in 2004, its membership stood at roughly 500. IDF 32. NTSP represents a substantial portion of the physicians practicing in certain specialty areas in Tarrant County, including approximately 80% of pulmonologists, 70% of urologists, and 60% of physicians specializing in cardiovascular disease. IDF 61. In many specialities, NTSP doctors account for the vast majority of admissions at Fort Worth's leading hospital, Harris Methodist Fort Worth Hospital. Frech, Tr. 1303-1305; *see also* IDF 52-63.

NTSP's primary activity is representing its participating physicians in obtaining contracts with health plans. IDF 43. It solicits offers from payors, evaluates those offers, and advises members on a variety of contracting issues. IDF 20, 43-45. When founded in 1995, it originally

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[3] We offer some points of clarification to IDF 13 and 15: Regarding risk-sharing and capitation (IDF 13), individual capitation involves risk assumption, but not risk-sharing; in addition, group capitation is only one type of risk-sharing arrangement. Regarding IDF 15 (non-risk-sharing arrangements), fee-for-service arrangements can involve risk sharing, whereas individual (as opposed to group) capitation arrangements do not involve the sharing of risk among providers. For a more complete discussion, see U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, 67-70 *available at* http://www.ftc.gov/reports/hlth3s.pdf (Aug. 28, 1996) (*Health Care Statements*). Accordingly, although these clarifications do not undermine the ALJ's conclusion on liability, the Commission should not adopt IDF 13 and 15 in their current form.

focused on contracting with payors under arrangements in which NTSP accepted group capitation payments from plans ("risk contracts"). But the initial interest of employers and other purchasers in NTSP's risk arrangement declined. IDF 46-50. By 2001, NTSP's Board acknowledged that risk contracting was such a small part of its business that its "focus should center on how to benefit members on fee-for-service contracts as well." CX 83 at 3. As of the time of trial, NTSP had only one risk contract, and upwards of 20 non-risk contracts. IDF 49, 50. Only about half of NTSP's physicians participate in NTSP's risk contracts. Van Wagner, Tr. 1830; Frech, Tr. 1353-54.

To join NTSP, physicians sign a participation agreement and pay a $1,000 fee. IDF 64; Van Wagner, Tr. 1552. NTSP's participating member physicians elect representatives from their ranks to serve on the eight-member Board of Directors and set NTSP policy. IDF 23, 24, 38.

Under the participation agreement that doctors sign when joining, NTSP physicians agree that NTSP shall have a right of first refusal on payor offers for non-risk contracts–that is, physicians agree to refrain from pursuing a non-risk payor offer individually until notified that NTSP is terminating its consideration of the offer. IDF 66. CX 275 at 25-26 Section 2.5 ("Non Risk Payor Offers Other Than Tied Payor Offers"); Section 2.6 ("Payor Offers Rejected by NTSP"); CX 276; CX 311 at 8.[4] Under the agreement, if NTSP declines to represent its members

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[4] NTSP disputes this ALJ finding, claiming that the Provider Participation Agreement (PPA) employs a narrow definition of "Payor," so that a reference to "Payor Offer" in the PPA refers only to offers from payors with which NTSP already has an active contract. RAB 19 & n.63; 29-30. NTSP's narrow reading of "Payor Offer" is implausible. For example, if the PPA's use of "Payor Offer" were so limited, then the PPA, which states "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," grants no authority for NTSP to obtain new contracts for its members. *See* CX 275 at 30-31. In addition, other evidence supports the finding that NTSP physicians agree to refrain from individual dealings to give NTSP

with respect to any payor, or if fewer than 50% of participating physicians approve a non-risk offer, "then . . . any Participating Physician shall have the right to pursue such Payor Offer on its own behalf." CX 275 at 26; *see also* IDF 64-67, 69.

C. NTSP's Activities to Raise Payor Price Offers to Members on Non-Risk Contracts

NTSP's representation of members in non-risk contracting involves: setting a minimum fee schedule; negotiating with payors to secure their agreement to offer NTSP members fees at least at the NTSP-set minimum; and taking actions to reinforce NTSP's price demands in particular negotiations, such as collective termination of NTSP physicians' participation in existing payor contracts and using agency agreements to orchestrate refusals to deal with specific payors outside of NTSP.

NTSP bylaws provide that it will seek both risk and non-risk contracts from payors. CX 275 at 24-26. From the outset, NTSP had a mechanism for handling payor offers for non-risk contracts, including the requirement that members defer to NTSP's right of first refusal. In

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time to seek an agreement with the payor on behalf of the group. CX 1178 (Hollander, Dep. at 68) ("And there were various criteria like time limits that the participating physician generally agreed that they would just wait and after that time limit was expired, then they were free to negotiate on their own."); *see also* CX 173, 174, 276.

The ALJ properly did not credit trial testimony that the PPA does not limit members' freedom to deal directly with non-risk payor offers. *See, e.g.,* Van Wagner, Tr. 1855-58 (acknowledging that her trial testimony was inconsistent with her prior sworn testimony at a 2002 investigational hearing, when she conceded that NTSP members could "not act upon an offer that is received from a payor if that payor has also presented NTSP with an offer that NTSP is currently considering."). The ALJ's conclusion that NTSP's PPA gave the organization a right of first refusal was well-supported in the record, and his rejection of contrary trial testimony was proper, since this self-serving testimony was contradicted by the contemporaneous documents cited above and prior sworn statements of the NTSP officials. *See, e.g., Adolph Coors Co.*, 83 F.T.C. 32, 177 (1973), *aff'd,* 497 F.2d 1178 (10th Cir. 1974), *cert. denied,* 419 U.S. 1105 (1974).

addition, although the participation agreement provides that NTSP will "promptly" transmit payor offers (but only proceed to execute those offers that satisfy at least 50% of its members), in practice the process worked differently. NTSP refused to convey to its physicians any offer that it decided most members would not find attractive.[5] The NTSP Board established minimum prices for payor offers ("Board minimums") and assessed the attractiveness of price offers based on those minimum fee levels.

In 2001, NTSP began to conduct annual polls to set the Board's minimum price screen for payor offers. CX 387. NTSP asked each participating physician to indicate the minimum price that he or she would find acceptable for the coming year for non-risk payor contracts, including both fee-for-service HMO and PPO contracts. Van Wagner, Tr. 1818 (poll results reflect minimum rates physicians want to receive in the future); IDF 89. The polling forms ask physicians to select one of several designated price ranges, expressed in terms of a range of percentages of Medicare's Resource-Based Relative Value Scale (RBRVS).[6] For example, the September 14, 2001 poll begins:

> Each year and as a function of the messenger model IPA structure, 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.

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[5] *See, e.g.*, Vance, Tr. 595-96 (policy not to messenger contracts that Board "felt would not be acceptable or would not be accepted by our members"); Vance, Tr. 613-16 (Board didn't pursue contracts if it thought the economic terms were unlikely to be acceptable to "a significant portion of the membership").

[6] RBRVS is a payment methodology established by the federal government to govern Medicare payments for physician services. It uses three components: a relative value for each procedure; a geographic adjustment factor; and a dollar conversion factor. *See* IDF 10-12.

CX 387. It then offers a choice of one of seven percentage ranges (e.g., "125-129% of Current Medicare").

NTSP consistently reported the results of its annual polls back to its members in Fax Alerts. *See, e.g.*, CX 393 (Oct. 29, 2001, Fax Alert reporting a mean of 142% of RBRVS, median and mode of 144.5% of RBRVS, and stating that the percentages represent what "the 'average' NTSP physician would find acceptable for the next twelve months on HMO and PPO products."). NTSP witnesses said they could not recall the reason for giving poll results to members. *See, e.g.*, Palmisano, Tr. 1249. NTSP did, however, expressly urge members to use the poll results when evaluating offers from payors on an occasion when it deviated from its general policy not to convey any price offers below its minimum fee schedule. CX 1097 at 2; Vance, Tr. 1215-8.

As it had promised its members, NTSP used poll results in seeking to secure payor agreement to meet NTSP's collectively-determined minimum fee demands. The ALJ's findings detailed NTSP's negotiations on terms of non-risk contracts with three payors: United Healthcare (IDF 101-191); CIGNA Healthcare (IDF 195-255); and Aetna (IDF 259-356); *see also* ID 76-82.[7]

Although NTSP insists that it did not "negotiate" price terms with payors, but merely offered information and opinion to payors about what members would likely do in response to a

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[7] NTSP's broad claim that "Complaint Counsel and the ALJ fail to distinguish between comments about risk and non-risk contract terms" (RAB 24) is unavailing. In instances where there were references to negotiations relating to "risk" contracting as that term has been used in this proceeding (*i.e.*, contracts involving sharing of financial risk among NTSP physicians), the ALJ's findings reflect the distinction. *See, e.g.*, IDF 286 (negotiations between NTSP and Aetna on a risk contract ended in October 2000; parties thereafter negotiated only for a non-risk contract). Moreover, health plans testifying at trial explained that their negotiations with NTSP involved non-risk contracts. *See, e.g.*, Quirk, Tr. 293-94 (United) (never discussed risk contract with NTSP); Roberts, Tr. 481-87 (Aetna) (negotiations over price concerned non-risk contract); Grizzle, Tr. 808-09 (CIGNA) (never discussed risk product concerning PPO product).

price offer, the evidence belies the claim. NTSP actively sought out payors, initiated discussions about fees, and sought agreements from payors to accede to the minimum fee schedule.[8] And when advocacy failed to produce the desired result, NTSP took sterner measures. For example, while attempting in 2001 to extract an agreement from United to raise its offer to meet NTSP's minimum fee schedule, NTSP: solicited from members and obtained 107 powers of attorney appointing NTSP as the contracting agent for members' dealings with the payor, (IDF 160–69); terminated participation by NTSP physicians in a United contract that individual members had elected to access through NTSP's arrangement with another IPA (IDF 149-54); and threatened United, both directly and through communications with United customers, with mass network disruption if it did not accede to the NTSP fee demands (IDF 135-46).[9]

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[8] *See, e.g.*, IDF 108-109; CX 1014 at 1 (explaining that United's attempt to change fee schedules prompted NTSP to seek negotiations with United in 1998); IDF 122; CX 210 at 3 ("NTSP has identified United Health Care as a re-negotiation target"); CX 1043 at 1 (reporting to members that NTSP and United were "far apart in agreeing to a market reimbursement fee schedule"); CX 578 (urging Aetna to "reconsider their position on not accepting the members' poll results on compensation"); CX 1010 at 1 ("NTSP has utilized the [Healthsource to CIGNA] assignment opportunity to begin discussions with CIGNA on the adequacy of their overall fee schedules").

When Blue Cross Blue Shield simply refused to negotiate rates with NTSP, NTSP responded with an April 2000 fax alert to its physicians, informing members that it deemed the rates offered to be "below market," that it had declined to pursue a group contract because "HMO Blue *is not willing* [to] negotiate the rate proposal," and that, while BCBS was seeking direct contracts with physicians, "*NTSP does not recommend participation.*" CX 704 (emphasis in original).

[9] *See, e.g.*, CX 1043 (announcing to members that United and NTSP are far apart on a market fee schedule, that the Board has authorized termination of the existing contract, and urging members to contact the City of Fort Worth about low rates and potential network disruption); CX 1062 (soliciting powers of attorney to negotiate with United).

NTSP used powers of attorney to solidify its power as a bargaining agent in similar situations with other payors. For example, in late 2000, when bargaining with Aetna over fee levels for a non-risk contract failed to yield an offer with rates meeting NTSP's minimum price, NTSP sent Aetna a list of 180 physicians and medical groups who had executed powers of attorney appointing NTSP as their bargaining agent for any direct contracting with Aetna. IDF 302-307.[10] Aetna officials understood this as a clear message that these individuals would not deal through direct contracts, and concluded that they had no practical alternative to dealing with NTSP as the collective bargaining agent of its members. Jagmin, Tr. 1058-60; *see also* IDF 205-08 (NTSP collection and use of agency agreements from member physicians in connection with 1998 negotiations with CIGNA).

And, in fact, when United was faced with NTSP's collection of powers of attorney from members, it attempted to make offers directly to NTSP members who had signed powers of attorney. Physician groups largely stonewalled, and numerous physicians responded that NTSP was negotiating on their behalf. Beaty, Tr. 459-60.

NTSP also used the threat of contract termination as a bargaining tool in dealing with CIGNA. In 2001, it sought to get CIGNA to compensate NTSP primary care physicians at the

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[10] NTSP attempts to dismiss its use of Powers of attorney to increase its negotiating leverage with Aetna by stating that Aetna itself required IPAs to obtain grants of power of attorney before engaging in contract discussions. RAB 20 n.69. But, as Dr. Jagmin of Aetna testified, what Aetna required to negotiate a group contract with an IPA was a provision to guarantee that patients would continue to receive care from NTSP physicians in case the IPA ceased to exist. Jagmin, Tr. 1054-55. The ALJ correctly found that the Powers of attorney collected by NTSP were intended and were used to negotiate more favorable compensation on behalf of NTSP members. Dr. Jagmin testified that receiving notice that NTSP had collected 180 Powers of attorney from members meant to Aetna that, absent a group contract through NTSP, these 180 individuals would all use NTSP as their agent for purposes of individual direct contracting. Jagmin, Tr. 1058-59.

same rate CIGNA paid NTSP specialists. To obtain higher fees for its non-specialist physicians, NTSP threatened CIGNA with termination of its existing agreement covering NTSP's specialists' participation in CIGNA's network. IDF 237-45.

In sum, it is apparent that NTSP negotiated with payors in an effort to increase, and reach agreements on, fee offers, and it organized collective action of various types to increase its bargaining leverage.

NTSP negotiations were highly successful in achieving their intended result. They repeatedly induced payors to raise their price offers to NTSP's participating physicians. IDF 185-87 (United); IDF 323-25, 327 (Aetna); Grizzle, Tr. 732-38; *see also* IDF 237-45, 247-48 (CIGNA). For example, NTSP's actions caused United to raise its offer from 115% of Tarrant County RBRVS for both HMO and PPO contracts to 125% for HMO and 130% for PPO. IDF 187. In addition, the ALJ found that NTSP's threatened departicipation by its specialists forced CIGNA to increase the fees it paid to NTSP primary care physicians above the "market rates" they had been receiving under their individual contracts with CIGNA. (IDF 248); *see also* IDF 237-45, 247; Grizzle, Tr. 732-38.

NTSP's leaders have acknowledged their success. For example, in July 2001, Dr. William Vance noted that "NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term[inate] the entire NTSP network last year." CX 256 at 2; Vance, Tr. 1225-26. He concluded, "Without NTSP's influence this last two years, our market level of reimbursement would be significantly below its present level." CX 256 at 2; Vance, Tr. 1225-26; *see also* CX 350 (NTSP has provided a "consistent premium fee-for-service reimbursement" to its members "compared with any other contracting source.").

D. NTSP's Misuse of the "Messenger Model" Label

Throughout its efforts to get payors to raise their price offers to NTSP's minimum fee schedule, NTSP repeatedly invoked the term "messenger model" to describe its activities. That term came into widespread use following the federal antitrust agencies' 1996 publication of revisions to the *Statements of Antitrust Enforcement Policy in Health Care* (hereinafter *"Health Care Statements"*).[11] The *Health Care Statements* discuss the application of general antitrust principles established by the Supreme Court to particular types of activities involving health care providers. The term "messenger model" was used by the agencies as a way to describe arrangements that are designed to reduce costs associated between contracting physicians and health plans, but do not involve horizontal agreements among network providers on prices or price-related terms.

In the *Health Care Statements,* the agencies elaborated on the "messenger model" concept through an example, explaining that an agent who negotiates prices on behalf of competing providers and then relays the resulting offer to the providers for acceptance or rejection is engaged in *per se* unlawful price fixing. *Id.* at 140 (noting that "[t]he participants' joint negotiation through a common agent confronts the payer with the combined bargaining power of the [network's] participants, even though they ultimately have to agree individually to the contract negotiated on their behalf"). The agencies also advised providers that even if competing physicians "have not directly agreed among themselves on the prices to be charged, their use of an agent subject to the control [of the group] to establish fees and to negotiate and execute contracts on behalf of the venture would amount to a price agreement among competitors." *Id.* at 131 n.66.

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[11] *See Health Care Statements* at 125-27.

Additionally, the agencies noted that the mere fact that the physicians' agent transmits contract offers for final acceptance or rejection after collective negotiation does not make an arrangement a "messenger model:"

> Use of an intermediary or "independent" third party to convey collectively determined price offers to purchasers or to negotiate agreements with purchasers, or giving to individual providers an opportunity to "opt" into, or out of, such agreements does not negate the existence of an agreement.

Id. at 126 n.65. Finally, the agencies identified certain activities that, if undertaken by an agent of competing providers, create a risk that the arrangement constitutes *per se* illegal price fixing rather than a "messenger model" arrangement. These actions include: "coordinat[ing] the providers' responses to a particular proposal"; "disseminat[ing] to network providers the views or intentions of other network providers as to the proposal"; "express[ing] an opinion on the terms offered"; or "decid[ing] whether or not to convey an offer based on the agent's judgment about the attractiveness of the prices or price-related terms." *Id.* at 127. The limits on messenger behavior under messenger model arrangements have been disseminated among the physician community and the health care and antitrust bars.[12]

Nonetheless, NTSP repeatedly invoked the agencies' "messenger model" terminology in connection with its collective bargaining activities on behalf of its members. For example, when asking members to vote on the acceptable minimum price that the Board should demand for the

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[12] For example, in 1997, the American Medical Association's Associate General Counsel advised that a messenger: "may develop a schedule showing what percentage of physicians in the network would accept offers at various fee levels" but that "the messenger may not share this information with the physicians"; may not negotiate with a payor over fees to be offered to network participants; and "may not decide to forgo an offer because it is too low." Edward Hirshfeld, *Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks*, 6 ANNALS HEALTH L. 1, 29 (1997).

coming year's negotiations with payors, NTSP asserted that it was undertaking to establish minimum fee levels "as a function of the messenger model IPA structure." CX 387 at 1. And when it provided the poll results (which it characterized as the fee level "that the 'average NTSP physician' would find acceptable for the next twelve months on HMO and PPO products") to its members, it described its provision of this information to members as being "[i]n keeping with the messenger model approach." CX 393 at 1; *see also* CX 186, 1075 at 2. In addition, after United CEO Thomas Quirk wrote to NTSP stating that "there may be serious antitrust issues raised by the manner in which North Texas Specialty Physicians ("NTSP") is representing its physician members in their contractual arrangements with UnitedHealthcare" and detailing those concerns (CX 1067 at 1), NTSP responded with a brief letter stating that "NTSP is fully aware of the antitrust issues surrounding an IPA's use of the messenger model and at all times complies with antitrust regulations and practices." CX 1122.[13]

Proceedings Below

The complaint in this case, issued September 16, 2003, charges NTSP with restraining competition among its participating physicians by orchestrating and implementing unlawful agreements among its members to obtain more favorable non-risk contract offers from payors. In particular, the complaint alleges that NTSP, among other things, negotiated payor contracts on the physicians' collective behalf, collected the physicians' price requirements and used their averages as a floor in negotiating contracts, reported the group's prospective price information back to the physicians, and organized collective refusals to deal with payors to extract higher prices.

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[13] NTSP's counsel at the time was Thompson & Knight, the same law firm that represents NTSP in this proceeding. *See* Van Wagner, Tr. 1815-16; CCPTPF 64-66.

¶¶ 16-21. The complaint further alleges that NTSP's challenged conduct was "not reasonably related to any efficiency-enhancing integration" (¶ 22), and that it deprived "health plans, employers, and individual consumers" of "the benefits of competition" among NTSP's participating physicians (¶ 23).

After a four-week trial, Administrative Law Judge D. Michael Chappell issued an initial decision on November 15, 2004, holding NTSP's conduct unlawful. The ALJ made extensive factual findings detailing NTSP's policies and conduct, including its setting of minimum fees, its negotiations with payors on behalf of its physicians, and its numerous acts to increase its bargaining leverage with payors, including agreements to refrain from individual dealings with payors, and threatened and actual contract terminations. Finding that NTSP is controlled by its participating physicians and had organized collective action to establish and extract fee concessions from payors, the ALJ concluded that NTSP's conduct amounted to "a horizontal price fixing agreement." ID 86. He held that evidence of direct agreements among physicians was not needed (ID 68-69), and rejected Respondent's claim to be a single entity, incapable of conspiring with its members. ID 70-71. He also found that NTSP had offered no plausible claim that its collective price setting was ancillary to any procompetitive undertaking. ID 87. Accordingly, he concluded that "the actions taken by NTSP to coerce health insurance payors to increase their offers of rate reimbursement or to offer more favorable economic terms to NTSP's physicians constitute an unreasonable restraint of trade." ID 88. In addition, he concluded that "[t]o the extent that an examination of effects is required," the finding that NTSP's actions had caused payors to increase their offers was sufficient. ID 87.

Despite his extensive findings regarding the various methods that NTSP used to violate the law, the ALJ issued a narrow cease-and-desist order. Apparently believing that the law requires a Commission remedy to be "narrowly tailored" to the violation found (ID 89, 90), he determined that what was needed was a prohibition on NTSP's involvement in agreements "to negotiate" on behalf of physicians regarding terms of dealing with payors. He rejected broader relief proposed by Complaint Counsel, including a ban on orchestrating agreements among physicians to refuse to deal with payors, stating that such relief was not narrowly tailored to the violation and might deprive NTSP of any ability to decline to enter into a contract with a payor. In addition, he further limited the scope of the order by adding two provisos: one protecting NTSP actions "communicating purely factual information" about payor offers and "expressing views relevant to various health plans"; the other stating that nothing in the order compels NTSP to violate state or federal law. ID 94. He created these exceptions notwithstanding NTSP's assertions throughout the litigation that its conduct merely amounted to either the communication of information or legitimate efforts to avoid contracts that it deemed to be legally risky.

Respondent has appealed the ALJ's rulings on liability and jurisdiction, as well as his order. Complaint Counsel's cross appeal seeks modifications to the ALJ's order.

QUESTIONS PRESENTED

Questions Presented by Respondent's Appeal

1. Whether NTSP's conduct constitutes a horizontal price-fixing agreement.

2. Whether NTSP's conduct is an unreasonable restraint of trade, and in particular:

   (A) whether the conduct can be condemned as *per se* unlawful unless it is reasonably necessary to further a legitimate joint arrangement;

   (B) whether NTSP offered any plausible claim that its price-fixing was ancillary to some procompetitive undertaking;

   (C) whether a more detailed inquiry into the effects of NTSP's conduct under the rule of reason is satisfied by the abundant evidence that NTSP succeeded in achieving its goal of increasing the prices that health plans offered to NTSP physicians to NTSP's desired minimum.

3. Whether NTSP is a "corporation" under the FTC Act.

4. Whether the interstate commerce requirement is satisfied.

5. Whether the ALJ's order–in ordering termination of NTSP's non-risk contracts with payors, and prohibiting conduct beyond negotiation of price terms– is within the Commission's remedial authority.

Question Presented by Complaint Counsel's Cross Appeal

1. Whether the Commission should modify and supplement the ALJ order to:

   (A) broaden the core prohibitions beyond the narrow relief recommended by the ALJ;

   (B) delete provisos added by the ALJ that would allow NTSP to continue conduct that the ALJ found was used to carry out the unlawful conspiracy;

   (C) make other modifications to provide effective relief.

ARGUMENT

I. NTSP'S CONDUCT CONSTITUTES A HORIZONTAL AGREEMENT TO FIX PRICES

The violation charged here requires proof of: (1) an agreement (2) that restrains trade (3) unreasonably. When an organization is controlled by competitors, its actions are analyzed under the antitrust laws as the concerted action of those competitors.[14] The conclusion that an entity's conduct constitutes concerted action is only the first step in the antitrust analysis. Next, one must ask: "an agreement to do what?" Put another way, as Judge Easterbrook stated in *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397 (7th Cir. 1989): "There can be no restraint of trade without a restraint." Thus, for example, an agreement among competitors to express an opinion is concerted action, but absent other evidence, mere collective expression of opinion by competitors, without any agreement on their behavior in the marketplace, does not establish an agreement in restraint of trade. *See id.* at 398.

In this case, there is unquestionably concerted action, because NTSP is a combination of competing doctors, and its challenged conduct concerns the sale of their medical services. NTSP's attempt to assert a single entity defense based on *Viazis v. American Ass'n of Orthodontists,* 314 F.3d 758 (5th Cir. 2002), simply misreads the decision. And it is equally clear that the concerted action here–an agreement among physicians to jointly negotiate agreements with payors on minimum fees for their medical services–is a restraint that, as a matter of law, amounts to a horizontal agreement to fix prices, as the ALJ correctly held. NTSP's numerous and

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[14] *See, e.g., National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978); *National Collegiate Athletic Ass'n v. Board of Regents of the University of Oklahoma*, 468 U.S. 85, 99 (1984) (NCAA).

various attacks on this conclusion simply ignore well-established principles regarding the scope of the concept of price fixing in antitrust law.

A. Antitrust Law Treats Actions by Competitor-Controlled Entities as Concerted Action by their Members

A long line of Supreme Court cases establishes that, when an organization is controlled by a group of competitors, antitrust law treats the entity as the agent of the group and the entity's conduct as that of a combination or conspiracy of its members. An early case, *American Column & Lumber Co. v. United States*, 257 U.S. 377, 399-400 (1921), observed: "Obviously the organization of the defendants [an association of hardwood manufacturers] constitutes a combination . . . so that there remains for decision only the question whether the system of doing business adopted resulted in that direct and undue restraint of interstate commerce which is condemned by [the Sherman Act]." Later cases involving competitor-controlled entities, including *Associated Press v. United States*, 326 U.S. 1 (1945); *United States v. Sealy, Inc.*, 388 U.S. 350 (1967); *National Society of Professional Engineers*, 435 U.S. 679; *National Collegiate Athletic Ass'n v. Board of Regents of the University of Oklahoma*, 468 U.S. 85 (1984) (NCAA); and *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492 (1988), likewise treat the entity's conduct as concerted, rather than unilateral, action. In *Sealy*, for example, the Court held that Sealy's exclusive territory arrangements for licensing its trademark were the product of a horizontal combination of its licensees. It reached this conclusion because Sealy's board of directors was composed of licensees. The Court stressed that, in assessing the existence of a horizontal combination, substance prevails over form, and the fact that competitors act through a

corporation should not obscure the analysis. *Sealy,* 388 U.S 352-54 (*cited with approval in NCAA*, 468 U.S. at 99 n.18).

Lower courts have applied the Supreme Court's teachings in numerous cases. For example, in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476, 479-81 (4th Cir. 1980), the court ruled that, because the defendant Blue Shield plan was controlled by its physician members, the plan's refusal to pay psychologists amounted to collective action by physicians rather than unilateral action.[15] The court did so without finding that the plan's individual physicians had met and agreed directly with each other to adopt the challenged policy. That is because, as Professors Areeda and Hovenkamp explain, when participants in a joint venture remain competing economic actors apart from their cooperative undertaking, and they control the venture, then it is appropriate to treat the conduct by the venture as the product of a horizontal conspiracy among its members, without any need to find a direct agreement, express or implied, among individual members.[16]

NTSP's suggestion that no violation can be established in this case, absent evidence that any individual physician directly agreed with another to collude over price (RAB 12-14), is thus without merit. Likewise, its claim that "there is no collusion among physicians in this case" (RAB

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[15] *See also Hahn v. Oregon Physicians' Service*, 868 F.2d 1022, 1028-30 (9th Cir. 1988) (applying *Virginia Academy* analysis to provider-controlled health plan); *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.,* 792 F.2d 210, 215 (D.C. Cir. 1986) (Bork, J.) (defendant's board of directors was controlled by competitors, taking the case "out of the *Copperweld* rule" and bringing it "within the rule of *Sealy*"); *St. Bernard General Hospital, Inc. v. Hospital Service Ass'n of New Orleans, Inc.*, 712 F.2d 978, 981, 987 (5th Cir. 1983) (by virtue of power to elect Board members, "the participating hospitals enjoyed effective control of the Blue Cross board"; as a result, defendant plan "is not a single trader").

[16] *See* VII PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW, ¶¶ 1475a, 1477, 1478a (2d ed. 2003).

3) should be rejected, given the undisputed facts establishing that NTSP is controlled by practicing physicians.[17]

Two additional points should be noted. First, attributing the entity's actions to the group means that the entity's conduct is concerted action; but it does not mean that individual members are necessarily subject to personal liability. Such liability depends on facts that show a degree of personal involvement in the challenged conduct beyond mere membership.[18] No questions of personal liability are raised here, however.

Second, the fact that competitors control an organization does not mean that every action the entity takes has antitrust significance. When a competitor-controlled venture takes action that is unrelated to competition by or with the individual competitors, then the separate economic identities of the participants should have no relevance. In those circumstances, it makes no difference whether one characterizes the organization as a single entity with respect to such conduct or simply concludes that in those cases the competitors have not created any horizontal restraint of trade.[19] It is apparent that NTSP's challenged actions, which concern competition

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[17] We note that IDFs 73, 74, 75, and 92 are stated more broadly than is, or could be, warranted based on the trial record, because they are stated in absolute terms. *E.g.*, IDF 73 ("There are no agreements between one or more NTSP member physicians to not participate in or reject a non-risk payor offer."). In his discussion of these findings, however, the ALJ in less sweeping language, stated (ID 68) that "there is no evidence" of direct agreements between "member physicians" (something Complaint Counsel did not attempt to prove, as the discussion above explains). We urge the Commission not to adopt these findings in their current form, as we believe they misstate the ALJ's intent and serve to add confusion to the concerted action element of the case.

[18] *See, e.g., Vandervelde v. Put & Call Brokers & Dealers Ass'n*, 344 F. Supp. 118, 155 (S.D.N.Y. 1972).

[19] Areeda and Hovenkamp suggest treating joint ventures as a single firm for activities not involving competition among or with venture participants, and treating the venture

among or with its participating physicians, are not the conduct of a single entity. Thus, Respondent cannot defend those actions as the mere exercise of rights recognized under the *Colgate* doctrine[20] to engage in unilateral refusals to deal. *See* RAB 14-15.

B. NTSP's Reliance on *Viazis* Is Misplaced

NTSP's response to well-established Supreme Court antitrust conspiracy principles is to assert that the Fifth Circuit's decision in *Viazis* "governs" this case and establishes that NTSP is not a "walking conspiracy." RAB 12. NTSP misreads the decision. What the *Viazis* court actually said is:

> Despite 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 Products, Inc. v. American Petroleum Institute*, 846 F.2d 284, 293-94 (5th Cir. 1988)).[21] In other words, the Fifth Circuit acknowledged that a trade association involves concerted action, but equated "conspiracy" with "an unreasonable restraint of trade."[22] Of course, NTSP is not a "walking conspiracy" in the *Viazis* sense. As we have already

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as a "continuing conspiracy" when it engages in activities that control or affect individual market behavior of the members. *See* VII PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW, ¶ 1475a, ¶ 1478a, at 319 (2d ed. 2003).

[20] *United States v. Colgate & Co.*, 250 U.S. 300 (1919).

[21] *Consolidated Metal Products* held that a trade association of competitors was not a "walking conspiracy" because the action in question–a product certification program–did not unreasonably restrain trade.

[22] *Viazis* involved a claim by an orthodontist who was disciplined by his professional association for using what the trade association found to be deceptive advertising claims about the superior efficacy of an orthodontic bracket. Dr. Viazis filed an antitrust action alleging a broad conspiracy involving the association (AAO), the manufacturer of his device (GAC), and others to exclude his brackets from the market. Most of the opinion discussed the

noted, some things NTSP might do are not illegal. But this does not mean that NTSP is a single entity under the antitrust laws, and *Viazis* did not intend to immunize all trade association activities from antitrust scrutiny.

C. The Concerted Conduct Here Is Horizontal Price Fixing

Antitrust law treats a wide variety of arrangements as horizontal price fixing, beyond simply agreements to charge a specific or uniform price. Since *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940), it has been clear that "a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging or stabilizing the price of a commodity" is price-fixing. The essence of the concept is "an interference with the market forces freely setting the prices of goods."[23]

The record here makes clear that NTSP, acting as a combination of competing physicians, engaged in concerted bargaining over fees. That alone would be sufficient proof of an agreement to restrain price competition, because concerted bargaining inherently joins together competitors who would otherwise make independent decisions on price and other terms of dealing with payors. But, as discussed above, in this case there is also direct proof of: (1) agreements between individual doctors and NTSP to set a collective minimum price, as evidenced by physicians'

Fifth Circuit's conclusion that Viazis had failed to provide evidence that GAC's termination of its marketing agreement with him was anything other than an independent business decision. With respect to the complaint about the AAO's disciplinary action, the court found Viazis had not demonstrated "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." 314 F.3d at 764-65.

[23] *National Electrical Contractors Ass'n, Inc. v. National Constructors Ass'n,* 678 F.2d 492, 500 (4th Cir. 1982) (*citing Yarn Processing Patent Validity Litigation*, 541 F.2d 1127, 1137 (5th Cir. 1977), *cert. denied,* 435 U.S. 910 (1977)).

participation in NTSP's future price polls; (2) agreements between individual doctors and NTSP to have NTSP undertake concerted bargaining on their behalf (the right of first refusal in the participation agreement and the solicitation and submission of powers of attorney); and (3) concerted actual and threatened network departicipation by NTSP physicians in order to increase pressure on payors to yield to NTSP's price demands. Such tactics to increase pressure on health plans to adopt payment policies preferred by health care providers have been found unlawful in cases such as *Michigan State Medical Society*, 101 F.T.C. 191 (1983) (collection of proxies authorizing plan departicipation to force private health plans and state Medicaid agency to change payment policies), and *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania*, 815 F.2d 270 (3d Cir. 1987) (departicipation campaign to force health plan to abandon cost-containment program).

We note, however, that evidence of such coercive tactics is not required to prove a price-fixing agreement. As the Commission observed in *Michigan State*: "[C]ollective efforts by providers to enter into agreements with third parties may be coercive even absent a direct threat of a boycott, since the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained." 101 F.T.C. at 296 n.32. In this case, however, the evidence shows not only negotiations aimed at obtaining an agreement to the minimum fee schedule, but also use of enforcement mechanisms, such as the powers of attorney and collective departicipation from payor networks, to coerce agreement from payors who had refused to yield. The ALJ thus was assuredly correct in concluding that NTSP's conduct amounted to horizontal price fixing. ID 86-87.

NTSP's numerous and varied efforts to defend or explain away these agreements are uniformly without merit. NTSP's principal contention is that it lacked any power to bind members to payor contracts. But this argument, even if literally true,[24] does not disprove the conspiracy. First, to the extent that NTSP merely asserts that its members were free to demand higher fees than NTSP's minimum, this contention, like its assertion that it "does not negotiate to raise rates *above* this threshold" (RAB 22 (emphasis added)), is irrelevant.[25] This case involves use of a *minimum* fee schedule. Fixing minimum fees, as the bar associations did in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), is still price fixing.

But more fundamentally, NTSP's "no power to bind" contention (meaning doctors were free to reject contract offers for any reason at all) rests on the erroneous premise that joint price

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[24] The powers of attorney authorized NTSP to "enter into, execute, amend, modify, extend, or terminate" the relevant contracts. IDF 77 (*quoting* CX 1061-110[2]; 347-404). Thus, on their face, they granted NTSP authority to accept payor contracts on behalf of the physicians who executed them. NTSP's contrary assertion rests on its claim that the powers granted were subject to the phrase "in any lawful manner," which NTSP says means that "NTSP used the powers of attorney only in conjunction with the messenger model." RAB 20-21. But, even leaving aside NTSP's distorted and opportunistic use of the term "messenger model" to describe its unlawful behavior, this reading of the powers does not advance NTSP's argument. The evidence shows that, by communicating to payors that it had obtained the powers of attorney, it effectively conveyed a message that attempts by payors to deal directly with the physicians would be futile. *See, e.g.*, Jagmin, Tr. 1050-51, 1058-60. Indeed, when United tried to go around the powers of attorney and contract directly with physicians, more often than not the physicians told United to deal with NTSP. Beatty, Tr. 459-60. The primary purpose of the powers of attorney was in their value as a negotiating tool, regardless of whether NTSP intended to exercise any authority to execute individual contracts on behalf of physicians.

The ALJ's broadly worded finding, IDF 71, that "NTSP cannot and does not bind any member physician or physician group to non-risk contracts" thus seems to conflict with his findings about the powers of attorney. IDF 76-82, 160, 161, 167-69.

[25] Moreover, in the case of its negotiations with Blue Cross Blue Shield, NTSP did seek rates above its minimum price floor. Haddock, Tr. 2742-43; CX 710.

negotiations are unlawful only if there is proof of an agreement to adhere to the minimum fee schedule in dealings outside of NTSP, whether individually or through other networks. In this, NTSP simply ignores the scope of the antitrust concept of price fixing.

Plymouth Dealers Ass'n of Northern California v. United States, 279 F.2d 128 (9th Cir. 1960), is instructive. Competing sellers of Plymouth brand automobiles agreed on list prices for the vehicles they sold. They were not bound by those list prices, and the court did not find that they had agreed to adhere to the list prices. Instead, the evidence showed an agreement to use the list prices as a starting point for negotiations with consumers. Individual dealers were free to and did apply their own discounts, trade-in allowances, etc., to arrive at a final selling price. But the court had little difficulty concluding that the agreement would tend to affect or tamper with the prices paid for Plymouth cars:

> The competition between the Plymouth dealers and the fact that the dealers used the fixed uniform list price in most instances only as a starting point, is of no consequence. It was an agreed starting point; it had been agreed upon between competitors; it was in some instances in the record respected and followed; it had to do with, and had its effect upon, price.

Id. at 132. The court rested its conclusion squarely on the principles set forth in *Socony-Vacuum* and other Supreme Court price-fixing cases. It noted in particular *Socony-Vacuum's* broad definition of price fixing, and observed, "When the term 'fix prices' is used, that term is used in its larger sense." *Id.* And the Supreme Court has continued to emphasize that price fixing encompasses a broad range of actions affecting price.[26]

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[26] *See, e.g., Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 648 (1980) (agreement to eliminate short-term credit was tantamount to agreement to eliminate discounts and was *per se* illegal price fixing).

More recently, Judge Posner observed in *High Fructose Corn Syrup Antitrust Litigation*, 295 F.3d 651, 655 (7th Cir. 2002), that "[a]n 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." As he explained, "the list price is usually the starting point for the bargaining and the higher it is (within reason) the higher the ultimately bargained price is likely to be." *Id.*

And so it is in this case. Indeed, the record evidence establishes that NTSP's use of a minimum schedule had the very effects identified in *Plymouth Dealers, Socony-Vacuum*, and *High Fructose Corn Syrup*. As Complaint Counsel's expert, Professor H. E. Frech, explained, NTSP's minimum fee schedule coupled with its right of first negotiation would hinder health plans in their ability to contract directly with physicians. Frech, Tr. 1315-17. United's representative, Mr. Quirk, confirmed that this was in fact the case. Quirk, Tr. 316-17. In addition, Professor Frech explained, the Board minimum rates were higher than what physicians were actually willing to accept. Frech, Tr. 1321-22. That is not surprising since, acting as a group, the physicians would be expected to seek a higher price than they could get when competing for individual contracts. Frech, Tr. 1322. Furthermore, Professor Frech explained that negotiating a minimum price offer has the effect of raising the prices that "low end" physicians would otherwise earn, without reducing the price that "high end" physicians would receive; "low end" physicians will accept the Board minimum because it is higher than they can negotiate on their own, and "high end" physicians (who can opt out of the NTSP-negotiated offer) will simply negotiate through other IPAs or individually for a rate higher than the NTSP minimum. Frech, Tr. 1322-24.

Mr. Jagmin of Aetna testified as to how this phenomenon played out in practice. In October 2000, Aetna offered NTSP its "reasonable equitable fee" (REF) schedule. Jagmin, Tr.

1012, 1014-15. The REF accounts for the intensity of competition by paying lower prices to physicians that are in low demand relative to the higher prices paid to physicians in high demand. Jagmin, Tr. 1012-13. NTSP rejected this offer, stating it did not want to be involved in an offer where physicians were being played off against each other. NTSP instead demanded a rate that applied uniformly to all physicians, which translated to an across-the-board rate of 111-112% of RBRVS. Jagmin, Tr. 1030-31, 1076-77, 1165; CX 540. As Jagmin explained, the net result was an inflation in the entire fee schedule, because physicians that normally would have been paid 100% of RBRVS under Aetna's REF would accept the 112% of RBRVS offer that NTSP was demanding, and physicians who Aetna normally paid 135% of RBRVS under its REF schedule would still have to be paid 135% of RBRVS under a direct contract. Jagmin, Tr. 1031-33. Although this was not desirable to Aetna, Jagmin (Tr. 1031-32) Aetna ultimately agreed to NTSP's demand–and at rates well above 112% of RBRVS. CX 585 (125% of RBRVS for HMO product; 140% of RBRVS for PPO product). *See generally* IDF 286-323.

In sum, the agreement among NTSP physicians was formed with the purpose and effect of raising the prices payors would offer to pay them for their medical services, and is therefore price fixing. The participating physicians' ability to opt in or out of a contract negotiated by NTSP–i.e., NTSP's inability to "bind" its members to a contract–does not eliminate the existence of a price fixing agreement when providers collectively negotiate with health plans over what contract terms will be offered.[27]

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[27] Indeed, the Commission and the Department of Justice have taken steps to inform health care providers and their attorneys of this fundamental antitrust law principle. *See, e.g.*, *Health Care Statements* at 126 n.65.

Aside from this fundamental error in NTSP's defense, there are a variety of other misstatements and misunderstandings. First, NTSP makes various flawed arguments relating to its polling activities. It asserts, for example, that the poll results reflected "independent decisions" (RAB 26). But in fact, doctors knew that NTSP would use individual members' poll responses to create group "averages" to be used by their organization in the coming year's negotiations with payors. *See, e.g.*, CX 387. In effect, by indicating their intentions about future pricing, they were casting a vote on the desired minimum price for the group (not simply reporting past or current prices). They assuredly were aware that any individual response would help to raise or lower the average fee for the group (an average that NTSP would then use in negotiating with payors). Frech, Tr. 1321-22. Thus, the individual decisions of responders to the polls were distinctly *interdependent*–not independent.

Additionally, NTSP appears to misunderstand the significance of its disclosure of poll results to members. This conduct is an act in furtherance of NTSP's collective bargaining with payors. It reinforces the conclusion that the purpose and likely effect of NTSP's actions were to affect market prices. The dissemination of the price averages calculated from the polls had two likely effects. First, as Professor Frech explained, reporting statistics to members about their rivals' future pricing plans was a way to encourage the physicians not to accept prices below the group's minimum fees. Frech, Tr. 1326-27. Second, the information could cause members to inflate their poll responses in subsequent years. *See* CX 430 (2002 annual polling form reminded physicians of prior year's averages); IDF 99-100.

NTSP's inability to offer an alternative explanation for making sure all members were kept informed about what [price] "the average NTSP physician would find acceptable" (CX 393) is

further evidence that the purpose was to achieve precisely those results. Even standing alone, without the collective bargaining, the dissemination of the poll results would raise antitrust concerns, because of the risk that the information would be used to facilitate a tacit conspiracy among members on pricing. But the complaint did not plead the polling activities as an independent violation, the ALJ did not treat them as such, and finding them to be an independent violation is unnecessary to establish liability here.

Finally, NTSP makes a variety of assertions in an effort to suggest that some of its conduct was also directed at issues other than price, such as contract disputes with particular payors, "non-economic terms" of payor contracts, or possible violations of state regulations governing matters such as prompt payment of claims.[28] RAB 24-25, 55-57. But even assuming NTSP had other issues on the table as well, that is ultimately irrelevant, because of the abundant evidence that NTSP's collective negotiations and related conduct were designed to raise the level of price offers

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[28] These claims are essentially *post hoc* efforts to explain away NTSP's illegal price fixing. For example, NTSP claims that its communications with physicians, the City of Fort Worth, and United "were related to United's attempts to undercut a NTSP risk contract to treat the employees of the City of Fort Worth." RAB 54. The evidence, however, demonstrates that NTSP's efforts were aimed at achieving a higher price under the non-risk contract that the City had decided it wanted. Mosley, Tr. 185-92 (describing meeting between City of Fort Worth and NTSP and complaints about rates made by NTSP); Quirk, Tr. 339-46 (describing meeting between United and NTSP where Board complained about United's offer of a single rate for both HMO and PPO); Vance, Tr. 857 (Vance told mayor that NTSP did not think City would have adequate panel "because they [United] apparently were not going to pay at the current rates that most of the other payors were going to pay and we didn't think most of our network would sign up for it"); CX 1043 (urging NTSP members to contact City of Fort Worth because of United's low rates); CX 1062 at 1 (announcing that United contract was terminated because of low rates and single rate for both HMO and PPO products); CX 1029 (letters from NTSP physicians to City of Fort Worth complaining about rates).

to its otherwise competing physicians from health plans.[29] Moreover, competitors may not collectively withhold their services from customers or engage in boycotts in order to enforce their view of the proper interpretation of state law or to achieve their preferred approach on purportedly "non-price" contract terms.[30]

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[29] Although the ALJ adopted findings relating to certain penalties imposed on health plans that were targets of NTSP's collective price negotiations (IDF 192-94; 256-58; 357-63), it is unclear why he made those findings. His failure to cite them in his opinion, or discuss their significance, if any, suggests that he did not deem them relevant to any issue in the case.

[30] *See, e.g., FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 465 (1986) ("That a particular practice may be unlawful is not, in itself, sufficient justification for collusion among competitors to prevent it.") (*citing Fashion Originators' Guild of America, Inc. v. FTC,* 312 U.S. 457, 468 (1941)).

NTSP is in error when it states that the agencies' *Health Care Statements* "encourage" IPAs to negotiate non-price terms (RAB 24). Statement 4, which concerns the collective provision of non-fee-related information to purchasers, states: "Providers who collectively threaten to or actually refuse to deal with a purchaser because they object to the purchaser's administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk." *Health Care Statements* at 42. NTSP's reliance on Example 7 to Statement 8 is misplaced, because that example describes an arrangement in which the purchaser wished to engage the IPA to provide utilization review services. *Id.* at 102-05. The analysis explains that the negotiation of non-price terms was reasonably necessary to the operation of this arrangement. *Id.*

II. NTSP'S PRICE FIXING IS *PER SE* UNLAWFUL

Price fixing is one of the most suspect forms of horizontal conduct under the antitrust laws. Because NTSP's conduct constitutes horizontal price fixing, the only remaining question is whether, under the principles of *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) (*BMI*), discussed recently by the Commission in *Polygram,*[31] that conduct should escape summary condemnation under the *per se* rule by virtue of its contribution to some significant productive collaboration among the physicians. There is, however, no plausible and cognizable claim that NTSP's price fixing is merely an "ancillary restraint."

The only purported justifications offered by NTSP that even address the finding of horizontal price fixing are: (1) a claim that price fixing is necessary to achieve spillover benefits from its risk contracting; and (2) a desire to conserve resources by refusing to convey payor contract offers with prices that NTSP believes are not sufficiently high to attract a majority of its participating physicians. As we discuss below, the first contention is implausible, and the second is not a cognizable justification for price fixing.[32] The rest of NTSP's proffered justifications are merely denials that it engaged in the price-fixing agreement that the evidence establishes and the ALJ found. RAB 45-56.

Since NTSP's conduct constitutes *per se* illegal price fixing, its assertions about the need for proof of a relevant market and market power are plainly incorrect. Nonetheless, even a more searching inquiry under the rule of reason to examine the effects of NTSP's conduct confirms that

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[31] *See Polygram Holding, Inc.*, FTC Dkt. No. 9298 (July 24, 2003), Slip Op. at 18-19, *appeal pending*, No. 03-1293 (D.C. Cir. Sept. 22, 2003).

[32] *Id.* at 29-32 (regarding the need for a cognizable and plausible justification).

NTSP had sufficient power to achieve its intended goal of raising the level of fees offered by payors to its members. NTSP's actions caused precisely the type of injury to competition that the antitrust laws were designed to prevent, and they should be declared unlawful.

Before turning to these points, however, we find it necessary to point out the ALJ's confusion about the distinction between *identifying* a market in which anticompetitive effects are presumed to occur, and *defining* a relevant market in order to measure market share and draw inferences about market power. As he did in *Kentucky Household Goods Carriers Ass'n, Inc.*, FTC Dkt. No. 9309 (initial decision filed June 21, 2004), in this case the ALJ again expressed his belief that establishing a *per se* unlawful price fixing agreement requires proof of a relevant market. ID 61. Chiding Complaint Counsel for its contention that the *per se* rule requires no such proof, he cited two cases, neither of which remotely supports his view that proof of market definition (though, oddly, not market power) is an essential element of a *per se* price fixing violation.[33] (He then concluded that the record nevertheless established that the provision of physician services in the Fort Worth area was a relevant market (ID 64)). We request that the Commission not only correct the ALJ's error in the present case, but also reiterate the following principles for guidance in future cases:

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[33] The first, *Bogan v. Hodgkins,* 166 F.3d 509, 515 (2d Cir. 1999), merely stated that "it is an element of a *per se* case to *describe* the relevant market in which we may presume the anticompetitive effect would occur" (emphasis added). The *Bogan* court went on to conclude that the challenged agreement among agents of an insurer not to recruit each others' sales personnel did not amount to a *per se* illegal group boycott. *Bogan*, 166 F.3d at 511-12, 515. The other case, *Double D Spotting Service, Inc. v. Supervalu, Inc.,* 136 F.3d 554 (8th Cir. 1998), held that the plaintiff did not establish that the defendant's grant of an exclusive license to another firm was a *per se* violation, and that an assessment of its competitive effect required an inquiry into market power.

- No proof of market definition or market power is required to establish a *per se* violation. Any naked price agreement among competitors (actual or potential) is conclusively presumed unreasonable, and deemed *per se* unlawful. *See, e.g.*, *Socony-Vacuum Oil Co.*, 310 U.S. at 221-22.

- Antitrust law condemns naked price fixing without regard to market power because even an agreement between two small competitors poses a potential threat to the free market. *Per se* rules also avoid the need for a burdensome inquiry into market conditions when the nature of the conduct itself poses such a threat. *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 433-36 (1990).

- The *per se* rule *requires* courts to condemn price fixing without proof of market power. The rule has "the same force and effect as any other statutory command[]." *Id.* at 433.

A. Horizontal Price Fixing Is Condemned as *Per Se* Unlawful Unless It Is an Ancillary Restraint

In *BMI,* the Supreme Court held that setting a price for a blanket license to perform copyrighted musical composition was not *per se* unlawful price fixing, because fixing a fee for the blanket license was necessary if the product was to be sold at all. 441 U.S. at 22. As the Commission observed in *Polygram*, this ruling reflected the principle first articulated in *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899), that price restraints that are ancillary to the operation of a legitimate joint venture are subject to a more detailed antitrust inquiry under the rule of reason. On the other hand, as Judge Posner observed in *General Leaseways, Inc. v. National Truck Leasing Ass'n*, 744 F.2d 588, 595 (7th Cir. 1984), *per se* treatment is warranted where "the organic connection between the restraint and the cooperative needs of the enterprise that would allow us to call the restraint a merely ancillary one is missing."

Accordingly, the question is whether NTSP's price fixing is an ancillary restraint. As we discuss below, it is not, and it is *per se* unlawful. This ends the analysis.

NTSP's insistence that *California Dental Ass'n* requires proof of market definition and market power here plainly misses the mark. The Supreme Court's decision in that case did not overrule decades of price-fixing law.[34] Instead, the Court's decision turned on its observation that the advertising restrictions in question were "very far from a total ban on price or discount advertising" and its concern that "the particular restrictions on professional advertising could have different effects from those 'normally' found in the commercial world." *California Dental Ass'n*, 526 U.S. at 773. The Court has already rejected any suggestion that price fixing in the professions is subject to special antitrust rules.[35] The *California Dental Ass'n* majority simply was not prepared to conclude, on the limited record before it, that the dental association's disclosure requirements applicable to advertising of discounted price offers were sufficiently comparable to more extensive restrictions on price advertising to make abbreviated analysis under the rule of reason appropriate.

B. NTSP Has No Plausible Argument that Its Price Fixing Was Ancillary to any Significant Productive Collaboration Among Its Participating Physicians

As Judge Posner observed in *General Leaseways, Inc.*, 744 F.2d at 595, "[t]he per se rule would collapse if every claim of economies from restricting competition, however implausible, could be used to move a horizontal agreement not to compete from the per se to the Rule of Reason category." The Supreme Court rejected *per se* treatment in *BMI* and *NCAA* because there

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[34] The courts continue to apply traditional antitrust rules to price fixing. *See, e.g., Freeman v. San Diego Ass'n of Realtors*, 322 F.3d 1133, 1150-54 (9th Cir. 2003) (Kozinski, J.) (holding *per se* rule applied to defendants' price fixing).

[35] *See, e.g., Maricopa County Medical Society*, 457 U.S 332; *National Society of Professional Engineers*, 435 U.S. 679; *Goldfarb*, 421 U.S. 773.

was "a plausible connection between the specific restriction and the essential character of the product." *Id.* at 594. NTSP can make no such showing here.

1. NTSP's Spillover Argument Is Not Plausible

To understand NTSP's spillover argument, it is helpful first to review the facts concerning its risk-contracting arrangements and its activities relating to non-risk contracts.

- The vast majority of NTSP's business involves non-risk contracts. In the past five years, NTSP has had only two risk contracts, and at present it has only one. IDF 49 (current contract with Pacificare; previously also had risk contract with AmCare). It has approximately 20 non-risk, fee-for-service contracts. IDF 50. Its risk business, which has been declining (IDF 48), covered approximately 32,000 lives in 2001. IDF 47.

- NTSP employs certain processes to monitor and control the quality and utilization of services provided under its risk contracts, but it does not apply these processes to patient care provided under non-risk contracts. IDF 364-78.

- Only half of NTSP's participating physicians participate in NTSP's risk-contracting business. Frech, Tr. 1353; Van Wagner, Tr. 1830.

Not surprisingly, NTSP does not argue that its non-risk contracts by themselves involve any significant integration among participating physicians.[36] Nor does it contend that price fixing for non-risk contracts is necessary to market its risk product. Instead, it argues that NTSP's "business model" is designed to "extend" efficiencies it achieves in performing its risk contracts to the treatment of patients under non-risk contracts. RAB 49. NTSP suggests that this extension, or "spillover," of efficiencies will necessarily occur if the physicians on its risk panel also participate

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[36] Van Wagner, Tr. 1877 (agreeing with her previous statement that "NTSP isn't 'there yet' in terms of clinical integration for the care of non-risk patients"). For comparison, see the proposed arrangement discussed in a staff advisory opinion letter from Jeffrey W. Brennan, Esq., FTC, to John J. Miles, Esq., Ober, Kaler, Grimes & Shriver, regarding MedSouth, Inc. (Feb. 19, 2002), *available at* http://www.ftc.gov/bc/adops/medsouth.htm (addressing proposed arrangement whereby IPA physicians would collaborate on information sharing, treatment coordination, practice protocols, and enforcement of standards).

in non-risk contracts. And this is where the price fixing comes in–NTSP "hopes" that these risk panel physicians will participate in non-risk contracts if it delivers a contract offer that meets the NTSP-established minimum price. RAB 49-50.

The logical flaws in each step of this theory are apparent. First, NTSP makes no attempt to explain how the 50% of NTSP's membership that does no risk contracting would learn the techniques and processes to improve quality and control cost, or what incentive these doctors would have to apply them in their practices. NTSP's price fixing, however, applies to this substantial portion of its membership.[37]

Second, even as to the risk panel doctors, who have some familiarity with such techniques, NTSP cannot explain what incentive they would have to apply them to non-risk patients. NTSP has not provided any financial incentive for its physicians to employ the quality improvement or cost control processes from its risk contracts to their non-risk contracts. Deas, Tr. 2553-54. And NTSP does nothing to promote compliance with whatever techniques have been learned under risk contracts. It does not even monitor physician practice under non-risk contracts, let alone establish any mechanism to create incentives for physicians to adhere to quality and cost control strategies. Deas, Tr. 2550-54. Both parties' experts agreed that no spillover of any significance would likely occur absent processes to reinforce behavior. NTSP's expert, Dr. Gail Wilensky, explained: "[A]s you educate physicians on adopting good quality behavior and whether or not they will continue doing that when they leave the specific event where it occurred. And the answer is they

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[37] *See* Frech, Tr. 1353-54 (spillover could not possibly happen for the 50% of NTSP physicians who do not participate in risk contracts); Van Wagner, Tr. 1881-83 (some NTSP physicians take no risk, are uncomfortable taking risk, and enjoy NTSP's rates without taking risk).

will, but there's a high recidivism rate, so it means frequent reinforcement." Wilensky, Tr. 2166-67. Complaint Counsel's expert, Dr. Lawrence Casalino, likewise testified that gaining any significant efficiencies from "spillover" would require application of the same type of organized processes when treating non-risk patients as are used when treating risk patients. Casalino, Tr. 2864-65; IDF 365-75.

The general notion that a group of doctors operating under a risk-sharing arrangement might adopt processes to achieve group-wide efficiencies, and then also adopt those same mechanisms to achieve efficiencies for non-risk contracts, is certainly plausible in theory.[38] NTSP's problem is that this theory has no application to the facts of this case. It is undisputed that it has *not* extended its mechanisms for quality improvement and cost control, developed for its risk product, to non-risk contracting. Indeed, Dr. Wilensky acknowledged at trial that she had no knowledge about whether NTSP enrolls non-risk patients in programs used under its risk product. Wilensky, Tr. 2200-01. Dr. Casalino systematically reviewed the various mechanisms that NTSP touted as improving cost or quality. Casalino, Tr. 2836-58. While finding that some of those mechanisms were likely to improve cost or quality within NTSP's few risk contracts where they were deployed, he found that none of those processes was employed in treating patients covered by non-risk contracts. Casalino, Tr. 2805-16. NTSP's own witnesses confirmed that this was the case. *See, e.g.,* Van Wagner, Tr. 1834-36; *see also* IDFs 364-75 (citing testimony). Consequently, to the extent that NTSP's claims (RAB 50 & n.212) that both Dr. Wilensky and Complaint

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[38] Indeed, the agencies have recognized as much in the *Health Care Statements*. *See* Statement 8, Ex. 2 at 88-89.

Counsel's expert endorsed the concept of spillover as a general proposition, or that Dr. Wilensky endorsed NTSP's "business model," are true, they are simply beside the point.[39]

Finally, since there is no potentially efficiency-enhancing integration of NTSP physicians regarding non-risk contracts, NTSP cannot even begin to explain why joint pricing for its physicians' services for those contracts should be treated as an ancillary restraint. It has failed to articulate any logical nexus between the price fixing and the claimed efficiencies. Any "spillover" that will occur automatically means that there is no need for joint pricing for non-risk contracts to achieve that benefit.[40] Moreover, even if NTSP applied some significant cost and quality controls to non-risk contracts (which it does not), it would not necessarily be the case that joint pricing would be reasonably necessary to achieve the benefits of such activities. But in this case, there is nothing but NTSP's vague assertions about spillover and teamwork.[41]

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[39] Though Dr. Wilensky endorsed NTSP's "business model," she had little or no knowledge about the actual nature of the organization and its activities. She believed NTSP's non-risk contracting activities were "secondary," that its "primary activities are of a risk-taking organization," and that NTSP is "a rare group that is dominated by its risk-taking activities." Wilensky, Tr. 2158-59. She was similarly uninformed about whether NTSP's various risk programs applied to non-risk patients. Wilensky, Tr. 2198-2205.

[40] Frech, Tr. 1346-51, 1450 (price setting is not necessary to achieve spillover because, to the extent it exists, it occurs absent price setting); Maness, Tr. 2262-63 (acknowledging it is not necessary "for NTSP's physicians to agree on a consensus price in order to achieve the efficiencies [Maness] believe[s] NTSP achieves"); Maness, Tr. 2359-60 (critical mass of participating physicians needed for NTSP to achieve spillover/teamwork efficiencies could be achieved without physicians participating in NTSP contract); Deas, Tr. 2460-64 (claiming improvements in practice generated by NTSP spilled over to treatment of Blue Cross (with which NTSP has no contract) patients); Deas, Tr. 2533-35 (spillover and teamwork efficiencies can occur without the same doctors contracting through NTSP as long as physicians are part of health plan's network; "most of the physicians in NTSP have several ways of participating in a health plan's offer").

[41] *See* Casalino, Tr. 2797-98 (IPAs such as NTSP are loose affiliations; many participants do not even know one another). Although NTSP asserts that Dr. Casalino admitted

Furthermore, it should be noted that even NTSP's fundamental premise–that its price fixing would ensure participation by risk panel physicians–is implausible. The prices NTSP set were not prices sought by risk panel doctors, but instead were averages reflecting price demands of the membership as a whole.[42] NTSP broadly canvassed all of its participating physicians. *See, e.g.*, CX 387, CX 611 at 2. According to NTSP's own testimony, its Board members and senior management were never informed of individual poll responses; they received only aggregated, average results. Van Wagner, Tr. 1638-43. Those aggregated, average results surely did not reveal to what extent risk panel physicians were likely to participate in non-risk contracts at any given price range. Indeed, NTSP emphasizes in its appeal brief that, given only the aggregated statistics, "it is impossible for [anyone] to determine the response of any specific physician or speciality, or even to determine whether they responded." RAB 24. The Commission can safely conclude that the assertion that the price fixing was undertaken to assure spillover benefits is merely a *post hoc* attempt to dress up naked price fixing.

In sum, even if there were a plausible claim that significant efficiencies achieved under risk-sharing arrangements would automatically "spill over" to benefit patients covered under non-

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he had no proof that "clinical integration" yields better results than "teamwork" (RAB 51), this is incorrect. He merely stated that he was not aware of any empirical studies that compare the benefits of utilization management to the benefits of organized processes. Casalino, Tr. 2894. As noted previously, NTSP uses neither for its non-risk patients; the distinction is thus irrelevant.

[42] Interestingly, elsewhere in its brief, NTSP emphasizes that "less than 34%" of its physicians responded to its poll. RAB 23. This fact would seem to further undermine the suggestion that deriving a minimum fee schedule from the polling data would ensure participation by risk panel physicians.

risk contracts, joint pricing is plainly not necessary to achieve that result.[43] And since NTSP concedes that it does not apply the processes employed under its risk-contracting product to the non-risk arrangements, NTSP can make no plausible claim that joint price setting for its physicians' services is reasonably necessary to promote such collaboration. Accordingly, NTSP has failed to offer a plausible argument that its price-fixing conduct is merely an ancillary restraint.

2. Conservation of Resources Is Not a Cognizable Justification for Price Fixing

Apart from its spillover argument, NTSP also asserts that it has "a right and a duty to avoid expending its resources on offers of interest to only a minority of NTSP's physicians." RAB 47.[44] This may be true, provided that, in so doing, it does not orchestrate or facilitate horizontal agreements on price." The problem is that this is precisely what NTSP did. It goes without saying that all price fixing agreements save negotiating costs for cartel members, but such savings are not a cognizable justification for that conduct. That is not to say that cost avoidance is not a legitimate business purpose as a general proposition. But it will not save NTSP's horizontal price fixing agreement from *per se* condemnation. A refusal to deal at less than the cartel price is not an economic efficiency or cost savings that would tend to promote competition.

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[43] Accordingly, the Commission should reject NTSP's argument (RAB 45-46) that it was deprived of due process because the ALJ denied its discovery request for data from payors that NTSP asserts would have proven its contention that spillover benefits naturally accrue to patients covered under non-risk contracts.

[44] The conserving resources argument is ironic, given the amount of time NTSP officials and staff spent in negotiating price terms on behalf of members.

NTSP's attempt to support its "conserving resources" argument by citing to a 2003 FTC staff advisory opinion letter addressing a proposal by a group of physicians known as Bay Area Preferred Physicians (BAPP), (RAB 32-33, 47) is in vain. That group's proposal to refuse to administer a contract that fewer than 50% of the physicians accepted, unless the payor agrees to bear the group's contract administration costs, raised antitrust questions about the risk of signaling and facilitating tacit price agreements among members.[45] But it did not present the type of collective price negotiations that NTSP has undertaken. Indeed, it is strange that NTSP cites the staff letter in question, since the letter itself describes the conduct alleged in the complaint in this case as an example of an "anticompetitive abuse of the messenger concept."[46]

C. Even a More Detailed Inquiry into the Effects of NTSP's Conduct under the Rule of Reason Is Satisfied by the Abundant Evidence that NTSP Successfully Limited Competition Among Its Physicians and Forced Health Plans to Raise the Prices Offered to Those Physicians

NTSP's collective bargaining achieved its purpose. By limiting individual dealings by NTSP physicians, and instead negotiating collectively, NTSP was able to force payors to raise their price offers to meet the collectively-determined price minimum. The evidence shows that NTSP orchestrated an agreement among participating physicians to bargain collectively with health plans in order to raise payors' price offers. There is no dispute that, absent the agreement, competition for patients would have caused those physicians to compete over the price and other terms they would accept as a condition of participation in health plans' provider networks.

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[45] Letter from Jeffrey W. Brennan, Esq., FTC, to Martin J. Thompson, Esq., Manatt, Phelps & Phillips, L.L.P. (Sept. 23, 2003) (BAPP letter), *available at* http://www.ftc.gov/bc/adops/bapp030923.htm.

[46] BAPP letter at nn.6 & 8.

Indeed, it was the prospect of avoiding such competition that made participation in NTSP attractive.[47]

The record evidence leaves no doubt that the agreement to jointly negotiate to secure a collectively-determined minimum price had the effect of suppressing competition among NTSP physicians with respect to their dealings with payors, and forcing payors to raise their price offers. The ALJ's findings detail NTSP's successes in this regard. *E.g.*, IDF 185-87, 323-25, 327.

Not only does the evidence demonstrate that payors increased their offers because of NTSP's tactics, it also demonstrates those tactics were designed to and did cause payors to actually pay more for physician services than they otherwise likely would have paid. As Dr. Frech explained, the likely effect of negotiating a minimum price offer was to inflate the fees paid to "low end" physicians (who would have otherwise contracted at a lower rate) without reducing the fees paid to "high end" physicians (who would opt out of the NTSP contract and negotiate higher rates through other avenues). Frech, Tr. 1322-24. The evidence demonstrates that the phenomenon was not only an economic theory, but in fact happened. For example, Aetna was forced by NTSP to use the single Board-approved rate applicable to all physicians instead of its REF schedule which would have compensated physicians based on whether they were in high or low demand. Jagmin, Tr. 1012-13, 1015-16, 1030-33, 1076-88. CIGNA likewise was forced to pay higher fees to physicians than what would have occurred absent NTSP's tactics. After being

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[47] *See, e.g.*, CX 380 at 3 (NTSP former President Vance's August 2001 letter to members stating "Unless NTSP or someone can provide a unifying voice for physicians, we will see a free fall in fees"). *See also* CX 350 (Oct. 9, 2000 letter to NTSP members from President Vance: "Our disagreements with . . . selected payors have been for the most part supported by our members. That cooperation is always at risk due to the lack of strong economic links and differences in practice. Short-term advantage and perceived best interest are always controversial and potentially divisive, weakening the strength that our numbers provide.").

threatened with the withdrawal of all NTSP specialists from its network, CIGNA was forced to contract with NTSP for NTSP primary care physicians. CIGNA had no interest in this because most of the primary care physicians were already in CIGNA's network through other contracts, at lower rates. Thus, CIGNA ultimately was forced to pay more as a result of NTSP's conduct. Grizzle, Tr. 732-38.

The statements of NTSP's own leaders corroborate this assessment of the anticompetitive impact of NTSP's actions. For example, a founder and the president of NTSP for six years, Dr. William Vance, observed, "NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term[inate] the entire NTSP network last year." CX 256; Vance, Tr. 1225-26.[48] Accordingly, as in *Indiana Federation of Dentists*, even absent application of a *per se* analysis, no more elaborate proof is needed to establish that NTSP's conduct is anticompetitive.

It is of no consequence that the price offers that NTSP succeeded in obtaining from payors may not have been "uniformly higher" (ID 82) than the fees payors offered to other IPAs. Other IPAs may have offered more value to the health plans than NTSP; or perhaps the IPAs engaged in concerted bargaining as well.[49] In any event, it does not matter. The question for the Commission

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[48] *See also* CX 350 ("NTSP, through PPO and risk contracts, has provided a consistent premium fee-for-service reimbursement to members when compared with any other contracting source."); IDF 44.

[49] *See, e.g., System Health Providers, Inc.*, FTC Dkt. No. C-4064 (consent order issued Oct. 24, 2002), *available at* http://www.ftc.gov/os/2002/11/shpdo.pdf (settling charges that Dallas-based physician organization engaged in unlawful collective bargaining); *SPA Health Organization*, Dkt. No. C-4088 (consent order issued July 17, 2003), *available at* http://www.ftc.gov/os/2003/07/spahealthdo.pdf; *see also* CX 438 at 1.

is not whether the price NTSP fixed was fair or reasonable.[50] Instead, the issue under the rule of reason inquiry is merely whether NTSP's price fixing was "likely enough to disrupt the proper functioning of the price-setting mechanism of the market" (*Indiana Federation of Dentists*, 476 U.S. at 461-62), and of that there can be no doubt.

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[50] *Superior Court Trial Lawyers Ass'n*, 493 U.S. at 424 ("it was settled shortly after the Sherman Act was passed that it 'is no excuse that the prices fixed are themselves reasonable'"); *National Society of Professional Engineers*, 435 U.S. at 689 (the law "unequivocally foreclose[s] . . . an inquiry into the reasonableness of the prices set by private agreement"); *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1927) ("The power to fix prices, whether reasonably exercised or not, involves the power to control the market and to fix arbitrary and unreasonable prices.").

III. NTSP IS A "CORPORATION"

The Commission's jurisdiction to enforce Section 5 extends to unfair methods of competition by "persons, partnerships, and corporations." Section 4 of the FTC Act defines a "corporation" as an entity that is "organized to carry on business for its own profit or that of its members." The Supreme Court's decision in *California Dental Ass'n*, 526 U.S. at 765-69, confirmed what prior appellate court decisions had held–that this language encompasses nonprofit trade and professional associations that engage in activities that confer pecuniary benefits on for-profit members.[51] As the Supreme Court stated in *California Dental Ass'n*:

> an entity organized to carry on activities that will confer greater than *de minimis* or presumed economic benefits on profit-seeking members certainly falls within the Commission's jurisdiction.

526 U.S. at 767 n.6.

There is no question that NTSP's activities provide pecuniary benefits to its participating physicians. IDF 43-45. Its primary function–marketing its physicians to health plans (CX 311 at 10-11; IDF 20)–plainly satisfies this element of the test. NTSP's protestations to the contrary are entirely without merit. NTSP seems to think that the Commission jurisdiction only exists when the challenged conduct has been shown to increase members' profits. RAB 58-59. The Supreme Court's decision in *California Dental Ass'n* squarely rejected this contention stating, "It should go without saying that the FTC Act does not require for Commission jurisdiction that members of an entity turn a profit on their membership, but only that the entity be organized to carry on business for members' profit." 526 U.S. at 767 n.6.

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[51] *See, e.g., American Medical Ass'n*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided Court,* 455 U.S. 676 (1982); *FTC v. National Commission on Egg Nutrition*, 517 F.2d 485, 487-88 (7th Cir. 1975).

NTSP's second theory, that it can escape the Commission's jurisdiction by virtue of being organized under state law as a "memberless" corporation, is equally without merit (otherwise, numerous trade associations would have long ago taken advantage of this loophole). It is so well-established that the issue of FTC jurisdiction turns on substance, not form, and that the mere form of incorporation is not controlling, that it barely bears repeating.[52] And NTSP's participating physicians plainly possess sufficient indicia of membership to qualify as "members" within the meaning of Section 4. Like members of a non-profit trade association, which Congress sought to include with the "for the profit of its members" language,[53] NTSP's physicians come together with other members of their profession to promote their common business interests (IDF 39, 42); elect representatives to the governing board to pursue those interests (CX 275 at 6-7; IDF 24); and contribute funds to finance activities of the organization. IDF 21, 33. Not surprisingly, NTSP's own documents regularly refer to its participating physicians as "members." ID 55. The ALJ was thus plainly correct in concluding that NTSP participating physicians are "members" and that NTSP is a "corporation" within the meaning of Section 4.

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[52] *See, e.g., California Dental Ass'n*, 526 U.S. at 765-69 (holding organization organized under state law as a non-profit corporation to be within the Commission's jurisdiction); *Community Blood Bank of the Kansas City Area, Inc. v. FTC*, 405 F.2d 1011, 1018-19 (8th Cir. 1969) (jurisdiction to be determined "on an ad hoc basis"; mere form of incorporation not controlling).

[53] *See Community Blood Bank*, 405 F.2d at 1016-17 (discussing legislative history and noting that Congress was "aware that corporations ostensibly organized not-for-profit, such as trade associations, were merely vehicles through which a pecuniary profit could be realized for themselves or their members").

IV. THE INTERSTATE COMMERCE REQUIREMENT IS SATISFIED

The Commission's interstate commerce jurisdiction is as broad as that conferred under the Sherman Act.[54] To demonstrate the requisite effect on interstate commerce, it is sufficient to show that, "as a matter of practical economics," the challenged agreement "could be expected to" affect the flow of interstate commerce.[55] There is no need to prove an actual effect on interstate commerce[56] or to quantify the expected effect.[57]

The ALJ identified various relevant channels of interstate commerce, such as the flow of funds across state lines from out-of-state payors to physician members of NTSP. He properly concluded that NTSP's actions to maintain physician fee levels, if successful, could be expected to affect the flow of such interstate payments. ID 58-59.[58] That is sufficient to establish jurisdiction.

NTSP's argument that its conduct is beyond the reach of federal antitrust law once again essentially ignores modern Supreme Court jurisprudence. First, its recycling of its "no collusion among physicians" refrain is not only wrong (as discussed above), but entirely inapposite here,

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[54] *American Medical Ass'n*, 94 F.T.C. at 994. The Supreme Court has repeatedly emphasized the breadth of federal antitrust jurisdiction, even in cases challenging wholly intrastate conduct of local actors. *See, e.g., Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991); *McLain v. Real Estate Board of New Orleans, Inc.*, 444 U.S. 232 (1980); *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976); *Goldfarb*, 421 U.S. 773; *see also Hammes v. AAMCO Transmissions, Inc.*, 33 F.3d 774, 778-81 (7th Cir. 1994) (Posner, J.) (discussing breadth of federal antitrust jurisdiction).

[55] *Hospital Building Co.*, 425 U.S. at 745.

[56] *Pinhas*, 500 U.S. at 330.

[57] *Goldfarb*, 421 U.S. at 785.

[58] *See, e.g., Hospital Building Co.*, 425 U.S. at 738; *FTC v. Indiana Federation of Dentists*, 101 F.T.C. 57, 77 (1983), *vacated*, 745 F.2d 1124 (7th Cir. 1984), *rev'd*, 476 U.S. 447 (1986).

because–as the Supreme Court emphasized most recently in *Summit Health, Ltd. v. Pinhas*, 500 U.S. at 330–"proper analysis focuses, not upon actual consequences, but rather upon the potential harm that would ensue if the conspiracy [alleged by the plaintiff] were successful." Second, it asserts that payor activity in commerce lacks any nexus to the challenged price fixing. But the logical impact of fixing physician fees on payments made by out-of-state third-party payors is both apparent and supported by the record,[59] and nothing offered by NTSP suggests otherwise.[60]

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[59] Jagmin, Tr. 977, 979-80 (costs in local markets affect costs of multi-state employers).

[60] NTSP also challenges the ALJ's citation to its own general business activities in interstate commerce as a basis for asserting jurisdiction. RAB 59. Since there is ample basis to find the requisite effect on interstate commerce based on the nexus to interstate payments by payors, it is unnecessary to address NTSP's arguments about the correct interpretation of the Supreme Court's decision in *McLain,* 444 U.S. at 242.

V. NTSP'S ATTACKS ON THE ALJ'S ORDER ARE WITHOUT MERIT

NTSP's objections to the order filed by the ALJ largely rest on the premise that there was no violation. In addition, however, it complains about two particular aspects of the ALJ order: the provision requiring termination of NTSP's contracts with payors for the provision of physician services on a non-risk-sharing basis; and the scope of the prohibition on collective negotiation on behalf of its physician members. As explained below, both of these provisions are "reasonably related" to NTSP's unlawful conduct and therefore are within the Commission's remedial discretion.[61]

The contract termination provision in the ALJ order (Paragraph IV.B, ID 95-96) requires NTSP to terminate any non-risk-sharing contracts for the provision of physician services in effect when the order becomes final at the earlier of: (1) a request by the payor; or (2) the contract termination or renewal date. Termination of these contracts is designed to eliminate the effects of NTSP's unlawful price-fixing. Absent termination, NTSP's physicians will continue to reap the benefits of their unlawful price fixing, achieved through NTSP's collective bargaining with payors. NTSP's complaint that the order applies to all of its non-risk contracts (rather than just ones that were specifically mentioned at trial) misconstrues the nature of the violation alleged and proved, as well as the Commission's remedial authority. That violation concerns NTSP's conduct in setting and seeking payor agreement to minimum acceptable fees for physician contracts with payors, not just certain specific instances of enforcement described at trial. The particular contracts highlighted at trial are merely examples of NTSP's implementation of the unlawful conspiracy to fix prices.

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[61] *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611-13 (1946).

NTSP also objects that its contracts with payors are already terminable at will. But requiring termination is necessary to avoid the risk that payors might fear retaliation or suffer a short-term competitive disadvantage if they voluntarily terminate a contract with NTSP.

NTSP also complains that the ban on collective bargaining with payors over terms of physician contracts is improper because it covers "non-price" terms as well as price terms. As noted above (see n.30, *supra*), NTSP is in error when it suggests that either antitrust law or the *Health Care Statements* "encourage" IPAs to negotiate non-price terms. And, in any event, the prohibition of such negotiations, a routine remedial provision in similar cases,[62] is plainly warranted in this case to ensure that NTSP does not seek to perpetuate its unlawful conduct by orchestrating agreements on contract terms that it asserts are "non-price" or "non-economic" terms. As the Supreme Court has observed, respondents found to have violated the law "must expect some fencing in."[63]

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[62] *See, e.g., Piedmont Health Alliance*, FTC Dkt. No. 9314 (consent order issued Oct. 1, 2004), *available at* http://www.ftc.gov/os/adjpro/d9314/041005do0210119.pdf; *SPA Health Organization,* FTC Dkt. No. C-4088 (consent order issued July 17, 2003), *available at* http://www.ftc.gov/os/2003/07/spahealthdo.pdf; *System Health Providers*, FTC Dkt. No. C-4064 (consent order issued Oct. 24, 2002), *available at* http://www.ftc.gov/os/2002/11/shpdo.pdf.

[63] *FTC v. National Lead Co.*, 352 U.S. 419, 431 (1957); *see also Toys "R" Us v. FTC*, 221 F.3d 928, 939-40 (7th Cir. 2000).

VI. THE COMMISSION SHOULD SUPPLEMENT AND CLARIFY THE ALJ'S ORDER

Once a violation is found, the Commission has an obligation to order effective relief to protect the public from further violations. The order filed by the ALJ, however, is inadequate in two fundamental respects. First, the core prohibitions of the order are unduly narrow and fail to provide adequate protection against further violations. Second, the ALJ added two unwarranted provisos that are likely to enable NTSP to continue certain conduct that the ALJ found was used to accomplish the unlawful price-fixing scheme.

Complaint Counsel request that the Commission issue the proposed order set forth at Appendix A and discussed below. It essentially is the order that Complaint Counsel proposed to the ALJ, with minor clarifying modifications, which are discussed below. It is designed to protect the public against further violations, while leaving NTSP free to pursue arrangements that may offer efficiencies without creating a significant risk of further anticompetitive conduct. Its core prohibitions are designed to prevent the kinds of conduct that NTSP used to carry out its unlawful price fixing. At the same time, it would permit NTSP to engage in legitimate joint arrangements and set prices for its physicians' services when such conduct is reasonably necessary to the joint arrangement. The record in this case makes it clear that the proposed prohibitions are needed. The proposed prohibitions relate directly to the conduct NTSP used to carry out its unlawful scheme.

A. The ALJ's Order Is Inadequate

1. The Limited Core Prohibitions Would Allow NTSP to Continue Orchestrating Anticompetitive Agreements Among its Members

The ALJ believed that the primary relief needed was a prohibition on NTSP participating in agreements among physicians "to negotiate on behalf of any physicians with any payor" regarding terms of dealing with payors. *See* ID 88, 94 (Paragraph II.A). He rejected provisions proposed by Complaint Counsel that would have also prohibited, in connection with the provision of physician services: agreements on terms of dealing with payors (*i.e.*, without regard to whether there is any agreement to "negotiate"); collective refusals to deal with payors; and agreements that physicians not deal individually with payors or through entities other than NTSP. Although he included a provision barring information exchanges, (Paragraph II.B, ID 94), he limited its scope both by deleting language routinely included in Commission orders and, as discussed below, by including a proviso allowing NTSP to "communicat[e] purely factual information concerning a payor offer," and to "express[] views relevant to various health plans." ID 94. As a result, the ALJ's order would permit NTSP to continue a variety of activities that it used to further its unlawful price agreements.

The ALJ action rests on a variety of errors or misconceptions. First, although he quoted the well-established standard from *FTC v. National Lead Co.*,[64] that a remedy is proper as long as it has a "reasonable relation to the unlawful practices found to exist," he then accepted NTSP's unsupported and incorrect assertion (RPTRB 45-46) that the reasonable relation standard "means that any remedy should be narrowly tailored to any violation found to exist." *See* ID 89 (rejecting

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[64] 352 U.S. 419, 428 (1957) (*quoting Jacob Siegel,* 327 U.S. at 613).

Sections II.A.2 and 4 of Complaint Counsel's Proposed Order as "not narrowly tailored to remedy the violation").

It is well established, however, that the Commission is to fashion a remedy adequate to cope with unlawful practices and it has "wide discretion" in making its decision on remedy.[65] Courts will not interfere with the Commission's choice unless the remedy has "no reasonable relationship to the violation proved."[66] The Supreme Court has emphasized that the Commission "is not limited to prohibiting the illegal practice in the precise form in which it is found to have existed in the past:"

> If the Commission is to attain the objectives Congress envisioned, it cannot be required to confine its road block to the narrow lane the transgressor has traveled; it must be allowed effectively to close all roads to the prohibited goal, so that its order may not be by-passed with impunity.

FTC v. Ruberoid Co., 343 U.S. 470, 473 (1952).[67] Thus, the Commission can prohibit conduct that would not be illegal standing alone, and ban conduct that would be permitted if engaged in by someone not found to have violated the law.[68]

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[65] *Jacob Siegel*, 327 U.S. at 611. *See also FTC v. Ruberoid* Co., 343 U.S. 470, 473 (1952).

[66] *Gibson v. FTC*, 682 F.2d 554, 572 (5th Cir. 1982) ("The Commission has wide discretion in determining what type of order is necessary to remedy the unfair practices found . . . 'The courts will not interfere except where the remedy selected has no reasonable relation to the unlawful practices.'") (*quoting National Lead Co.*, 352 U.S. at 428)).

[67] *See also Rubbermaid, Inc. v. FTC*, 575 F.2d 1169, 1172 (6th Cir. 1978) ("The Commission may be properly concerned not only with the open and formal implementation of agreements exactly like those entered into in the past, but also with the possibility that past unlawful conduct will be perpetuated in some more subtle form in the future.").

[68] *See, e.g., Toys "R" Us*, 221 F.3d at 939-40.

The ALJ was also mistaken when he accepted NTSP's assertion (RPTRB 46) that the provisions Complaint Counsel proposed prohibiting agreements to refuse to deal would impose on NTSP a broad duty to contract with all payors. The language of the order does not dictate that result, and the provisions in question–which have been included in numerous orders involving price fixing by physician organizations–have never been interpreted in this manner. What they do prohibit is conduct by NTSP–"in connection with the provision of physician services"– to orchestrate or implement an agreement among physicians to refuse to deal. Thus, for example, if NTSP offers to sell utilization review services to payors for a fee, a mere refusal to deal with a payor who declined to meet NTSP's price for those services would not violate the order, because it would not involve an agreement among physicians to refuse to deal with respect to the provision of their physician services. Nonetheless, as is discussed below, we have included some additional language in the proposed order to further clarify the scope of Paragraph II.

NTSP's activities with respect to "messengering" contracts likewise would be limited only by the prohibitions of Paragraph II of the proposed order, as Complaint Counsel's post-trial reply brief to the ALJ states. CCPTRB at 39. The proposed order neither bars NTSP from engaging in messenger arrangements, nor compels it to undertake them; it requires advance notice to the Commission if NTSP elects to engage in such activity during the three years after the order becomes final. Accordingly, a refusal by NTSP to messenger a contract would violate the proposed order only if that refusal served, or was part of a broader course of conduct, to orchestrate or facilitate an underlying agreement barred by Paragraph II, for example, an agreement among the physicians concerning the price they would accept from a payor for providing medical care to patients.

Finally, the ALJ's suggestion that prior Commission consent decrees were irrelevant to his consideration of relief (ID 89) misunderstands their relevance here. The statement he quoted from *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 330 n.12 (1961), merely makes the well-understood point that the presence of lesser relief in a negotiated consent decree does not suggest that a more extensive remedy (in that case divestiture) would be inappropriate in a litigated case. Past Commission consent orders are relevant, nonetheless, because they reflect and inform the agency's experience and expertise in crafting remedies for similar antitrust violations. In reviewing FTC orders, the courts give significant deference to the Commission's expertise because, as the Supreme Court acknowledged in *Ruberoid,* 343 U.S. at 473, "Congress expected the Commission to exercise a special competence in formulating remedies to deal with problems in the general sphere of competitive practices." The Commission has a substantial body of experience to draw upon regarding remedies for physician collective bargaining. These orders have evolved, and continue to evolve, over time as the Commission has gained greater experience with similar conduct and remedies, as markets have changed, and as provider responses to changing market dynamics have adapted. The Commission can and should draw upon this experience in deciding the appropriate scope of relief in this case.[69]

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[69] Since the time that Complaint Counsel's post-trial briefs to the ALJ were filed, the Commission's approach to relief in cases challenging physician collective bargaining has continued to evolve. *See, e.g., Piedmont Health Alliance*, FTC Dkt. No. 9314 (consent order issued Oct. 1, 2004).

2. The Provisos Added by the ALJ Are Not Necessary to Protect Legitimate Conduct and Would Undermine the Order

The ALJ included two additional provisos in his order. One states that nothing in the order bars NTSP from "communicating purely factual information" about a payor offer or "expressing views relevant to various health plans." ID 94. The other provides that nothing in the order would "require Respondent to violate state or federal law." *Id.*

Neither of these provisos is necessary to protect legitimate conduct by NTSP. Both would, at a minimum, create substantial uncertainty about the scope of the order's core prohibitions, and they are likely to immunize conduct that the order is designed to and should prohibit. Provisos are helpful when there is a need to carve out an exception for conduct that would otherwise be prohibited under the order. For example, this is the function of the proviso in Paragraph II of the proposed order concerning integrated joint arrangements. Provisos can cause mischief, however, when they seek to exempt from coverage conduct that would not be barred by the order in any event.

The provisos the ALJ added are particularly harmful in this case, because the litigated record shows that NTSP has already sought to defend its unlawful conduct by claiming that it was merely engaging in the conduct protected by the ALJ provisos: providing information to members and health plans; and acting to protect itself from what it claims to be legally risky contracts.

a. Communicating Information and Views

The antitrust laws do not prohibit a group of competitors from mere dissemination of information that does not involve any agreement on how competitors will behave in the

marketplace.[70] In the context of an order against a proven wrongdoer, however, the goal is to allow legitimate collective provision of information and opinion, while at the same time prohibiting conduct that serves to facilitate agreement among competitors with respect to their marketplace behavior. In some cases, to ensure adequate relief, the Commission and the courts find it necessary to curtail expression that would be left untouched by the law if no violation has been proved or alleged.[71]

In the Commission's earliest litigated case addressing physician collective bargaining, *Michigan State Medical Society*, 101 F.T.C. 191 (1983), and in a few subsequent consent orders,[72] the Commission included a proviso allowing the respondent to provide "information and views" to payors. *Id.* at 314. But the proviso proved to be unworkable in practice, and it is no longer used in Commission orders addressing similar conduct. The problem is that nearly anything can be termed "providing information and views." An announcement by NTSP that it and its physicians will not contract with payors at prices below a certain level can be characterized as conveying factual information or as an expression of opinion. Indeed, NTSP has sought to couch much of its illegal conduct in just this fashion. *See, e.g.*, RAB 25-26, 33-34. Since the proviso appears to protect all communication falling under its terms, it presents the real possibility the Commission

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[70] *See, e.g., Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397 (7th Cir. 1989); *see also Health Care Statements,* Statements 4 & 5.

[71] *See, e.g., National Society of Professional Engineers,* 435 U.S. at 697-99 (1979).

[72] *See, e.g., FTC v. College of Physicians-Surgeons of Puerto Rico,* Civ. No. 97-2466-HL (D.P.R.) (stipulated permanent injunction entered Oct. 2, 1997). The scope of the prohibition in *Michigan State Medical Society* is broader than those used in later orders, by virtue of its ban on collective action to "attempt to affect . . . terms of reimbursement." 101 F.T.C. at 313.

would be unable to act against conduct that took the form of communicating factual information or views to payors or physicians, even if it were an integral part of an effort to establish or carry out an agreement that violated the core prohibitions of Paragraph II.A of the order, or the ban on information exchanges in Paragraph II.B. The broad proviso adopted by the ALJ could thus effectively immunize conduct designed to carry on the unlawful conspiracy that the ALJ condemned.[73]

b. Violations of State or Federal Law

The ALJ apparently believed that a proviso was necessary to ensure that the order would not "contravene" Texas law or federal law. ID 89. The only laws he cited were the same Texas administrative regulations that NTSP claimed justified its challenged conduct in the first place–a defense the ALJ soundly rejected. Neither NTSP nor the ALJ explained how the order would otherwise require NTSP to violate these or any other laws.[74] Some of these laws might conceivably apply to NTSP in the administration of its risk contract (for example, NTSP may be subject to prompt pay regulations insofar as it is responsible for disbursing funds to its participating physicians), but the proviso on joint arrangements in Paragraph II means the order does not prohibit any conduct reasonably necessary to such arrangements. As noted above,

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[73] The ALJ did not discuss his reason for adding the proviso concerning providing information and views, but apparently adopted it in response to arguments in NTSP's post-trial brief.

[74] In discussing the proviso, the ALJ cited the Supreme Court's decision in *Hoffman Plastic Compounds, Inc. v. NLRB*, 535 U.S. 137 (2002), which held that federal immigration law foreclosed the NLRB from requiring a company to award back pay to an undocumented alien who had never been legally authorized to work in the United States. Neither the ALJ nor NTSP identified any overriding federal law that would conflict with the proposed relief in the present case, and we are not aware of one.

nothing in the order language proposed by Complaint Counsel would compel NTSP to execute all payor contracts that it is offered or to act as a "messenger" for all contracts. Finally, nothing in the order would prevent NTSP from reporting suspected violations of state or federal laws to appropriate law enforcement authorities. The proviso is thus unnecessary to protect any legitimate conduct that would otherwise be prohibited. Furthermore, as noted above, the antitrust laws do not permit competitors to engage in boycotts to enforce their view of what the law does, or should, prohibit.[75]

There is ample basis in the record, however, to conclude that the "law violation" proviso would likely be invoked by NTSP to justify continuing its unlawful practices. Indeed, NTSP has attempted to defend refusals to deal that enforce collective price demands by asserting that it was merely acting to avoid legally risky contracts. *See, e.g.*, RAB 47-48. Thus, inclusion of this proviso, like the "information and views" proviso, threatens to permit NTSP to escape the core remedial provisions of the order.

B. The Proposed Order

Paragraph I

Most of the definitions in Paragraph I of Complaint Counsel's proposed order are ones that commonly have been used in prior Commission orders relating to similar conduct by physician organizations, and were used by the ALJ in his proposed order.[76] A definition of "physician

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[75] *See* n.30, *supra, citing Indiana Federation of Dentists,* 476 U.S. at 447, 465.

[76] The ALJ made minor changes (without explanation) to the definitions of "clinically-integrated joint arrangement" and "risk-sharing joint arrangement." These definitions have been used routinely for several years in Commission orders. Complaint Counsel's proposed order uses the definitions previously used in Commission orders, in order to avoid possible confusion as to the terms' meaning in either the present order or prior orders. Complaint

services" has been added and is used in Paragraph II of the proposed order. The definition of "physician services" was added in order to clarify that the substantive prohibitions in the proposed order apply to NTSP's activities on behalf of physicians that involve the sale of physicians' professional services.

Paragraph II

Paragraph II of the proposed order contains the primary or core prohibitions. As discussed earlier, the ALJ's proposed order does not adequately prohibit even the illegal conduct in which NTSP was found to have engaged on behalf of its physician members. For example, as discussed more fully below, the ALJ's proposed order does not prohibit NTSP from orchestrating or facilitating a collective refusal to deal with payors by its physician members, in order to coerce the payors to offer more favorable price and other contract terms to the physicians through NTSP, unless that conduct falls within the undefined term "negotiate."

Core Prohibitions

Paragraph II.A of the proposed order prohibits NTSP from participating in, facilitating, or encouraging any agreement or arrangement between or among physicians concerning price or other terms on which those physicians will deal with payors for provision of their "physician services." Paragraph II.A specifically prohibits NTSP from participating in, or furthering, such agreements among physicians through involvement in any agreements to negotiate with a payor or through agreements among the physicians to refuse to deal, threaten to refuse to deal, or not deal individually with a payor.

Counsel's proposed order also eliminates one definition ("medical group"), which was included, but not elsewhere used, in the ALJ's order.

Paragraph II is designed to prohibit the various methods that NTSP used to make its negotiations with payors more effective:

- polling its physicians about desired future prices, and developing "minimally acceptable" contract terms, including price terms, for use in bargaining with payors;
- transmitting "acceptable" price offers from payors to its members, and refusing to transmit those offers that were unacceptable;
- using a right of first refusal to limit the ability of payors to deal individually with NTSP's physician members;
- using actual and threatened refusals by NTSP physicians to deal individually with payors, threats often collectively conveyed by NTSP, in order to coerce or influence the payors to agree to make favorable contract offers;
- using actual and threatened departicipation from payor networks to increase bargaining leverage; and
- engaging in other activities and arrangements with its physician members to make NTSP's negotiations with payors more effective, such as sharing with members the averages derived from its polling of physicians regarding minimally acceptable fees; and obtaining powers of attorney to represent and agree to contract offers on behalf of physicians.

All of these were part and parcel of the negotiation process engaged in by NTSP to affect the prices and contract terms offered by payors to NTSP's physicians.

Because of the ALJ's confusion about the scope of the provisions in Paragraph II.A of the proposed order, we have added additional language to further clarify that the restrictions on NTSP's activities in Paragraph II.A are limited to its involvement in agreements among physicians regarding their provision of physician services, *i.e.*, the professional medical services provided to patients by physicians. As discussed above, the ALJ's belief that these provisions would ban all actions or refusals to deal by NTSP misconstrues the language of Paragraph II.A.2, language used by the Commission in numerous other orders addressing physician price fixing. Nevertheless, to

eliminate any possible question, we propose adding the phrase "with respect to their provision of physician services," and a new definition of "physician services," in order to make absolutely clear that the prohibitions in Paragraph II.A address agreements concerning the sale by NTSP's physicians of their professional medical services. Thus, for example, the proposed order would not prohibit NTSP from offering (or refusing to offer) credentialing services, utilization review or medical management services, physician office management services, electronic medical records services, or joint purchasing of medical equipment or supplies. A refusal to deal with respect to such services would not violate the proposed order, unless it was part of a scheme to orchestrate or facilitate an underlying agreement among physicians regarding the sale of their medical services.

Paragraph II.A.1 of the proposed order includes a prohibition on NTSP's involvement regarding any agreement among physicians to negotiate with payors about their provision of physician services. Numerous prior Commission consent orders have used the term "negotiate" in describing prohibited conduct, without including a definition of that term in the orders. Complaint Counsel believes that it is not necessary to define "negotiate" in the order, but the Commission may wish instead to discuss in its opinion the scope of what the Commission intends to prohibit by this term.[77] Such a discussion would be particularly helpful in this case, because NTSP personnel insisted that they did not "negotiate" with payors, but instead merely "discussed" contracts with, and made "recommendations" to, payors concerning what was "reasonable" for "the majority of the network," and these were "just strictly opinion." Palmisano, Tr. 1240-41. Prohibiting NTSP from negotiating on behalf of physicians, however, proscribes any act or form of bargaining,

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[77] The last Commission opinion involving similar conduct was *Michigan State Medical Society*, 101 F.T.C. 191 (1983). The Commission's opinion in *Michigan State* does not contain a definition of "negotiate."

communication, or other interaction with a payor for, or on behalf of physicians, that has the intent or effect of reaching an agreement or arrangement relating to any terms of dealing, including, but not limited to, price terms, offered or accepted, or to be offered or accepted, by a payor for the professional medical services of any physician. In addition, the *Health Care Statements* discuss the distinction between lawful provision of factual information and views to payors, such as may occur in the operation of certain lawfully functioning messenger arrangements–which can help a payor unilaterally to frame its offers to physicians–and concerted efforts to affect payors' offers and to obtain acquiescence or agreement from payors on contract terms.[78]

Paragraph II.A.2 addresses NTSP's involvement in agreements among physicians to refuse to deal with payors. Effectively prohibiting price fixing and joint contract negotiations requires prohibitions of the threats that force payors to participate in such negotiations and to accede to the physicians' collective demands. In *Michigan State,* for example, the Commission noted that "threats of physician departicipation [from private payor and state Medicaid programs] if satisfactory agreements could not be worked out" "backed up" the medical society's unlawful collective negotiation of price terms and agreements with the payors.[79] Likewise, in this case, NTSP and its physician members used actual or threatened refusals to deal to make NTSP's collective negotiations with payors more effective.

Another tool NTSP used in aid of its collective negotiations is its agreement with participating doctors to grant NTSP a "right of first refusal," whereby its physician members agreed not to deal individually with payors while NTSP was conducting negotiations with the

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78 *See Health Care Statements,* Statements 4 & 5.

79 *Michigan State*, 101 F.T.C. at 289.

payors. Even this type of limited restriction on independent dealing by competing physicians can reinforce the group's collective bargaining power. It makes it difficult for payors to avoid negotiating with the physicians as a group, since failure or delay in reaching an agreement risks the loss by the payors of a substantial number of contracted physicians, and the payor cannot protect itself from this risk by contracting with the individual physicians during the negotiation process. The ALJ's proposed order, however, provides no relief regarding this type of conduct in furtherance of NTSP's price-fixing conspiracy. Paragraph II.A.4 of Complaint Counsel's proposed order addresses this conduct by barring NTSP's participation in agreements among physicians not to deal individually with any payor, a provision that includes within its scope limitations on individual dealing that are less than absolute, such as NTSP's right of first refusal.

Paragraph II.B prohibits NTSP from facilitating coordination among physicians in their dealings with payors by exchanging or facilitating the exchange of information among physicians concerning their willingness to deal with a payor, or on the terms and conditions, including price terms, on which they are willing to deal with payors for their physician services.[80] While such information exchanges, without more, may not be unlawful in all circumstances, the exchange of sensitive information about future terms of dealing (including prices) raises a substantial risk that it will facilitate coordination of prices and bargaining positions, and refusals to deal, among otherwise competing physicians.[81] This certainly was true regarding NTSP. In the present case,

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[80] The ALJ's order included a prohibition on exchange of information about the terms on which physicians were willing to deal with a payor but, without explanation, dropped the proposed prohibition on exchange of information as to the physicians' willingness to deal with a payor, which typically also is included in Commission orders.

[81] *See Health Care Statements,* Statement 5 at 46-48. ("In [certain] circumstances, the collective provision of prospective fee-related information or views may evidence or facilitate

NTSP's activities in furtherance of its members' price-fixing conspiracy in fact involved compilation, exchange, and coordination of future acceptable price information by the competing physicians through NTSP, which it used in establishing, and conveying to payors, "minimum acceptable prices" for dealing with payors on the physicians' behalf. Consequently, the prohibition on information exchanges in Paragraph II.B is appropriate and necessary in this case. This provision thus prevents NTSP from facilitating coordination of price and contracting terms–either directly, or through some other vehicle–by the numerous individual physician members of NTSP, who established and control it, and were the beneficiaries of its unlawful conduct, but who themselves are not named as respondents, and will not be covered by any remedial order.

Paragraphs II.C and II.D prohibit NTSP from attempting to engage in actions prohibited by Paragraphs II.A or II.B, and from "encouraging, facilitating, suggesting, advising, pressuring, inducing, or attempting to induce" anyone to violate those prohibitions.

Paragraph II Proviso

Paragraph II also includes, as has become customary in Commission orders addressing similar unlawful conduct by physician organizations, a proviso that excepts from the proposed order's core prohibitions activity by NTSP regarding certain integrated joint arrangements among physicians. These arrangements, which are defined in Paragraph I of the proposed order, are referred to as "qualified risk-sharing joint arrangements" and "qualified clinically-integrated joint

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an agreement on prices or other competitively significant terms by the competing providers. It also may exert a coercive effect on the purchaser by implying or threatening a collective refusal to deal on terms other than those proposed, or amount to an implied threat to boycott any [health] plan that does not follow the providers' collective proposal." *Id.* at 46.

arrangements."[82] The types of arrangements excepted by the Paragraph II order proviso are characterized by sufficient integration among the participants to be likely to achieve substantial efficiencies. Furthermore, any agreements among the participants on prices or other terms or conditions of dealing with payors that accompany the arrangements must be "reasonably necessary" (*i.e.*, "ancillary") to achieving those efficiencies.[83]

Paragraph III

Paragraph III requires, for a period of three years, that NTSP notify the Commission at least 60 days prior to entering into any messenger or agency relationship on behalf of physicians on dealings with payors that it elects to undertake. Notification is designed to permit the Commission to review any proposed messenger arrangement by NTSP to assure that NTSP's plans conform to the order's substantive prohibitions.

Paragraph IV

Paragraph IV of the proposed order includes standard provisions requiring NTSP to notify its leadership, current and new physician members, and payors about the entry of the Commission's order. Paragraph IV also requires NTSP to notify payors with which it has had any

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[82] The definitions of these arrangements are derived from types of potentially pro-competitive and lawful joint arrangements that are discussed in the *Health Care Statements*. Statements 8 & 9 differentiate such potentially pro-competitive arrangements, which are subject to rule of reason antitrust analysis, from price agreements not ancillary to significant integration, which are subject to *per se* condemnation as naked price fixing.

[83] Unlike some other recent Commission orders, the Paragraph II proviso does not require that those arrangements be non-exclusive–*i.e.*, "not restrict the ability, or facilitate the refusal, of physicians who participate in [them] to deal with payors on an individual basis or through any other arrangement." The need for requirements of non-exclusivity for integrated joint ventures permitted under order provisos, which have been included in some prior Commission orders, is determined on a case-by-case basis. In this instance, we do not believe that a requirement of non-exclusivity for integrated joint arrangements is necessary or warranted.

contact since January 1, 2000, regarding contracting for the provision of physician services, of their right to terminate any contracts with NTSP (other than NTSP's single capitation contract, with Pacificare of Texas, Inc.). Those contracts embody the price terms for physician services that were achieved through NTSP's illegal price fixing and collective negotiation activities, and under which NTSP's physician members continue to be paid. The ALJ's proposed order required NTSP to terminate the same contracts as would be required by Complaint Counsel's proposed order. However, the ALJ's approach to effecting contract termination, which referred to contracts "pursuant to a fee-for-service agreement," left some ambiguity as to precisely which contracts would or would not be subject to the termination requirement. Complaint Counsel's proposed order makes clear that all of NTSP's contracts with payors, other than its single risk-sharing/capitation contract with Pacificare of Texas, are covered by the contract termination provision.

Under the proposed order, contract termination is to occur at the earliest of: the date included in a request to terminate received by NTSP from the payor; or the earliest termination or renewal date of the contract.

Paragraphs IV through VII

Paragraphs IV.E, IV.F, V, VI, and VII contain standard provisions relating to filing compliance reports, providing the Commission with necessary updates and access to information relating to compliance with the order, and termination of the order.

Conclusion

The Supreme Court has observed that "price fixing cartels are condemned *per se* because the conduct is tempting to businessmen but very dangerous to society."[84] This is a case about a group of competing doctors who yielded to such temptation. Complaint Counsel request that the Commission hold NTSP's conduct unlawful and issue an order that provides effective relief.

Respectfully submitted,

Michael J. Bloom
Director of Litigation

Counsel Supporting the Complaint

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[84] *Superior Court Trial Lawyers*, 493 U.S. at 434 n.16 (*quoting* PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW, ¶ 1509, at 412-13 (1986)).

Appendix A

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. "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."

C. "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.

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

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

F. "Physician services" means professional services provided to patients by physicians.

G. "Preexisting contract" means a contract for the provision of physician services, other than the contract identified in Appendix B to this Order, 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 V.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 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 capitated rate;

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

   c. the use of significant financial incentives (*e.g.*, substantial withholds) 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 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 with respect to their provision of physician services:

1. to negotiate on behalf of any physician with any payor;

2. to deal, refuse to deal, or threaten to refuse to deal with any payor;

3. 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; or

4. not to deal individually with any payor, or not to deal with any payor through any arrangement other than Respondent;

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

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 Paragraph II of 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 a qualified clinically-integrated joint arrangement;

III

IT IS FURTHER ORDERED that, for three (3) years after 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 physicians under which Respondent would act as a messenger, or as an agent on behalf of those physicians, 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 and the Complaint 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, and include in such mailing the notice specified in Appendix A to this Order;

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, other than the contract identified in Appendix B to this Order, at the earliest 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; *provide, 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 part (1) of Paragraph IV.B 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 and the Complaint to:

   a. each physician who begins participating in Respondent, and who did not previously receive a copy of this Order and the Complaint 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 and the Complaint 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 and the Complaint 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 and the Complaint 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;

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

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. 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 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.

VII

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

By the Commission

Donald S. Clark
Secretary

SEAL
ISSUED:

[Date:]

APPENDIX A

Letter to payors with whom NTSP has a contract at the time the Order becomes final, other than a contract listed in Appendix B to the Order - to be sent within thirty (30) days after the Order becomes final

[letterhead of Respondent NTSP]

[name of payor's CEO]
[address]

Dear _____:

Enclosed is a copy of a complaint and a decision and order ("Order") issued by the Federal Trade Commission against North Texas Specialty Physicians ("NTSP").

Pursuant to Paragraph IV.B of the Order, NTSP must allow you to terminate, upon your written request, without any penalty or charge, any contracts with NTSP that are in effect at the time of your receipt of this letter.

Paragraph IV.B of the Order also provides that, if you do not terminate a contract currently in effect with NTSP, the contract will terminate on its termination or renewal date (including any automatic renewal date). However, if the contract terminates on a date prior to **[appropriate date one (1) year after Order became final]**, the contract may be extended at your written request to a date no later than **[appropriate date one (1) year after Order became final]**. The Order became final on **[appropriate date to be filled in]**. If you choose to extend the term of the contract, you may later terminate the contract at any time prior to **[appropriate date one (1) year after Order became final]**.

Any request either to terminate or to extend the contract should be made in writing, and sent to me at the following address: **[NTSP's address]**.

Sincerely,

APPENDIX B

Pacificare of Texas ANHC/IPA Services Agreement (Professional Capitation/Approved Nonprofit Heatlh (sic) Corporation (dated July 1, 2000), as amended September 1, 2001 and January 1, 2003 [identified as RX 18, including pages RX0018_001 through RX0018_087; also identified by Bates numbers PCT 000924 through PCT 000986 and PCT 000895 through PCT 000918; and Bates numbers FTC-NTSP-PCFC 000327 through FTC-NTSP-PCFC 000389 and FTC-NTSP-PCFC 000298 through FTC-NTSP-PCFC 000321].

Appendix B

IN THE MATTER OF NORTH TEXAS SPECIALTY PHYSICIANS, DOCKET NO. 9312
WITNESS INDEX[1]

WITNESS NAME	WITNESS IDENTIFICATION	PAGE RANGE OF TESTIMONY	STATUS
BEATY, DAVID	SENIOR NETWORK ACCOUNT MANAGER FOR UNITED HEALTHCARE, INC.	449-466	PUBLIC
CASALINO, LAWRENCE (REBUTTAL)	EXPERT FOR COMPLAINT COUNSEL	2779-2952	PUBLIC
DEAS, THOMAS, M.D.	CURRENT PRESIDENT, CHAIRMAN OF THE BOARD, AND MEDICAL DIRECTOR OF NTSP. NTSP PARTICIPATING PHYSICIAN	2386-2617	PUBLIC
FRECH, HARRY E.	EXPERT FOR COMPLAINT COUNSEL	1260-1453	PUBLIC
GRIZZLE, RICK	VICE PRESIDENT OF NETWORK DEVELOPMENT FOR CIGNA HEALTHCARE OF TEXAS, INC. - RESPONSIBLE FOR CONTRACTING AND MANAGING PROVIDER SERVICES IN TEXAS, OKLAHOMA & LOUISIANA	666-811 876-962	PUBLIC IN CAMERA

[1] Source: Parties First Joint Stipulation Regarding Witnesses Index, filed June 16, 2004.

WITNESS NAME	WITNESS IDENTIFICATION	PAGE RANGE OF TESTIMONY	STATUS
HADDOCK, RICK (REBUTTAL)	DIRECTOR OF NETWORK MANAGEMENT FOR BLUE CROSS BLUE SHIELD	2742-2762	PUBLIC
JAGMIN, CHRISTOPHER, M.D.	MEDICAL DIRECTOR FOR MEDICAL POLICY AND NATIONAL TRANSPLANT FOR AETNA, INC. FORMER MEDICAL DIRECTOR FOR PATIENT MANAGEMENT OPERATION FOR AETNA.	968-1180	PUBLIC
LONERGAN, FRANK, M.D.	NTSP PARTICIPATING PHYSICIAN	2695-2734	PUBLIC
LOVELADY, JOHN	VICE PRESIDENT OF NETWORK MANAGEMENT FOR PACIFICARE OF TEXAS	2618-2691	PUBLIC
MANESS, ROBERT	EXPERT FOR RESPONDENT	1982-2133 2210-2385	PUBLIC PUBLIC
MOSLEY, JIM	PRESIDENT OF EFFECTIVE PLAN MANAGEMENT	118-232	PUBLIC
PALMISANO, DAVID (BY VIDEO DEPOSITION)	FORMER DIRECTOR OF PROVIDER SPONSORED NETWORK BUSINESS DEVELOPMENT FOR NTSP	1237-1251	PUBLIC

CERTIFICATE OF SERVICE

I, Sarah Croake, hereby certify that on March 15, 2005, I caused a copy of the Answering and Cross-Appeal Brief of Counsel Supporting the Complaint to be served upon the following persons:

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

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

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

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

Sarah Croake

Sarah Croake