In the Matter of North Texas Specialty Physicians, a corporation
Docket No. 9312

OPINION OF THE COMMISSION

By LEARY, Commissioner, For A Unanimous Commission:

I. Introduction

This case involves the question of whether an independent physician association's contracting activities with payors amounts to unlawful horizontal price fixing, or is competitively benign activity that may enhance efficiency and innovation in the delivery of health care. The Commission has accepted numerous consent orders over the last ten years involving conduct similar to that at issue in the case at hand.[1] The common theme of these cases has been coordinated bargaining by groups of competing physicians, in order to increase their reimbursement rates. In these cases, competing physicians have often joined together in independent practice associations (IPAs, or networks) and agreed to boycott or refuse to deal with particular payors during contract negotiations. When the competing physicians are not financially or clinically integrated in a manner that is likely to produce efficiencies, the Commission has consistently maintained that this type of conduct amounts to illegal price fixing.

We recognize that physicians can join together and negotiate fees in ways that do not harm competition. Health care providers (including physicians) and those who pay for their services (*i.e.*, payors) are increasingly developing new and innovative approaches to health care delivery in order to increase quality and contain costs. It is important not only to protect health care consumers from anticompetitive activity, but also to avoid interference with this procompetitive activity.

We therefore approach this case with full recognition that innovative approaches to health care should be encouraged. We also recognize the frustration of many physicians over their

[1] *See, e.g., In the Matter of San Juan IPA, Inc.*, Docket No. C-4142 (consent order issued June 30, 2005), http://www.ftc.gov/opa/2005/07/fyi0548.htm; *In the Matter of New Millennium Orthopaedics, LLC*, Docket No. C-4140 (consent order issued June 13, 2005), http://www.ftc.gov/opa/2005/06/fyi0543.htm; *In the Matter of White Sands Health Care System, L.L.C*, Docket No. C-4130 (consent order issued Jan. 11, 2005), http://www.ftc.gov/opa/2005/01/fyi0504.htm; *In the Matter of Piedmont Health Alliance, Inc.*, Docket No. 9314 (consent order issued Oct. 1, 2004), http://www.ftc.gov/opa/2004/10/fyi0457.htm; *In the Matter of Southeastern New Mexico Physicians IPA, Inc.*, Docket No. C-4113 (consent order issued Aug. 5, 2004), http://www.ftc.gov/opa/2004/08/fyi0445.htm; *In the Matter of California Pacific Medical Group, Inc.*, Docket No. 9306 (consent order issued May 10, 2004), http://www.ftc.gov/opa/2004/05/fyi0431.htm.

perceived lack of bargaining power in negotiations with large health care payors. The Commission has already provided extensive guidance on the ways to accommodate both of these concerns, consistent with the antitrust laws.[2]

This is the first physician network case in over 20 years where the Commission has the benefit of a full administrative trial and record. This case thus presents an opportunity not only to resolve a specific controversy but also to provide some guidance to the health care community on the appropriate boundary between pro-competitive and anti-competitive activities.

The Administrative Law Judge (ALJ) concluded that Respondent North Texas Specialty Physicians' (NTSP) activities constitute unlawful horizontal price fixing, and that Respondent's collective price setting was not ancillary to any procompetitive activity. After our own *de novo* review of the facts, we agree with the ALJ's conclusions and affirm his decision.[3] We adopt the

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[2] The Commission, along with the Department of Justice, recently issued a report on competition policy and health care, which was based on 27 days of public hearings covering a broad range of health care topics, all focused on ways to promote innovative, cost effective and high quality health care services. The Fed. Trade Comm'n and the U.S. Dep't of Justice, *Improving Health Care: A Dose of Competition* (July 2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf [hereinafter *Health Care Hearings and Report*]. In addition, Commission staff regularly issue advisory letters to physician IPAs seeking advice on proposals for financial and clinical integration. A good example is the Commission staff's advisory letter to MedSouth, Inc., where staff did not object to a clinical integration proposal by an IPA that involved joint setting of fees. Advisory Opinion Letter from Jeffrey W. Brennan, Esq., FTC, to John J. Miles, Esq., Ober, Kaler, Grimes and Shriver 4 (Feb. 19, 2002), http://www.ftc.gov/bc/adops/medsouth.htm [hereinafter *MedSouth*]. The Commission and the Department of Justice have also issued extensive guidelines for antitrust enforcement policy in health care. *See* U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care* (1996) *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,153 [hereinafter *Health Care Statements*]; *see also* Thomas B. Leary, *Special Challenges for Antitrust in Health Care*, 18 No. 2 A.B.A. SEC. ANTITRUST 23 (Spring 2004).

[3] This opinion uses the following abbreviations for citations:
ID - Initial Decision
IDF - Numbered Findings of Fact in the Initial Decision
CX - Complaint Counsel Exhibit
RX - Respondent Exhibit
Tr. - Transcript of Testimony before the Administrative Law Judge
IH - Transcript of Investigational Hearing
Dep. - Transcript of Deposition
O.A. - Transcript of Oral Argument on Appeal
CCAB - Complaint Counsel's Appeal Brief
RAB - Respondent's Appeal Brief

findings of fact of the Initial Decision to the extent those findings are not inconsistent with this opinion.

We find that the activities of Respondent, taken as a whole, amount to horizontal price fixing which is unrelated to any procompetitive efficiencies. Respondent's conduct could be characterized as *per se* unlawful under the antitrust laws, and thus subject to summary condemnation. For the reasons explained below, however, it is more appropriate to apply the "inherently suspect" analysis of our recent decision, *Polygram Holding, Inc.*,[4] as affirmed by the D.C. Circuit, *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005). But, we also emphasize that a *per se* analysis and an inherently suspect analysis are close neighbors, and that the determination of illegality here does not require an elaborate inquiry into effects in the market.

II. Background

A. Respondent's Activities

NTSP is an organization of independent physicians and physician groups that was formed, and is managed and operated by, physicians. Although its size has varied, NTSP had approximately 575 members in 2003 and 480 members at the time of trial in April 2004. IDF 32. As of 2003, NTSP was comprised of practitioners in 26 medical specialties as well as some primary care physicians. *Id.* These doctors are located principally in the Tarrant County, Texas area, which includes the city of Fort Worth. IDF 31. The participant physicians have distinct economic interests reflecting their separate clinical practices. IDF 35. Many members compete with one another. IDF 36.

NTSP's main functions are to negotiate and review contract proposals for member services that are submitted by payors, including insurance companies and health plans; to review payment issues; and to act as a lobbyist for its members' interests. IDF 39. NTSP negotiates both risk-sharing contracts (risk contracts)[5] and non-risk-sharing contracts (non-risk contracts). IDF 46. The former typically reimburse doctors on a dollar amount per patient basis, whereas the

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RR - Respondent's Reply Brief

References to investigational hearing or deposition transcripts included in the trial record as exhibits are made using the exhibit number with the witness' name and type of interview provided in parentheses: CX__ (Van Wagner Dep. at __).

[4] 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003), *available at* http://www.ftc.gov/os/2003/07/polygramopinion.pdf [hereinafter *Polygram*, or *Polygram Comm'n Op.*].

[5] Risk-sharing contracts are also known as capitation contracts.

latter provide "fee-for-service" payment. IDF 13-15. The challenged conduct in this case involves solely the negotiation of non-risk contracts, which are far more common for NTSP.[6] IDF 46, 48-50. NTSP's original focus was on risk contracting when it was founded in 1995. IDF 19, 46. The initial interest of payors in NTSP's risk contract declined, however, and by 2001 NTSP's Board decided to center its focus on how to benefit its members for fee-for-service contracts in addition to risk contracts. IDF 46-50; CX 83 at 3. NTSP's Board has acknowledged that risk contracting "is a small part of the business." CX 83 at 3; IDF 46-50. In fact, at the time of oral argument, NTSP had only one risk contract (albeit a substantial one). IDF 49. Only about half of NTSP's physicians participate in its one risk contract. IDF 51; Van Wagner Tr. 1830; Frech Tr. 1353-54.

NTSP's physicians enter into a Physician Participation Agreement (PPA) with NTSP that grants NTSP the right to receive all payor offers and imposes on the physicians a duty to forward payor offers to NTSP promptly. CX 0276; CX 275 at 24. The physicians agree that they will not individually pursue a payor offer unless and until they are notified by NTSP that it has permanently discontinued negotiations with the payor. CX 0311 at 10; CX 0276; CX 1178 (Hollander Dep. at 68). Each NTSP member's PPA provides that NTSP must promptly forward (messenger) the fee reimbursement and other economic provisions of any non-risk offer to the member physicians. CX 275 at 24. If more than 50 percent of the members accept those provisions, NTSP will then proceed to negotiate the contract. IDF 67; CX 275 at 25-26. At times NTSP has gathered powers of attorney from its physicians, which give NTSP the legal authority to negotiate non-risk contracts on behalf of those physicians. CX 1173 (Deas IH at 56-57); Palmisano Tr. 1250-51.

NTSP conducts annual polls of its physicians to determine minimum reimbursement rates for use in negotiation of health maintenance organization (HMO) and preferred provider organization (PPO) product contracts with payors. CX 1195 (Van Wagner Dep. at 66-67). NTSP's polling form asks physicians individually for the minimum payments that they would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. CX 0565; CX 1196 (Van Wagner IH at 26-29, 43-44, 62). NTSP uses the poll responses to calculate the mean, median, and mode (averages) of the minimum acceptable fees identified by its physicians, and then uses these measures to establish its minimum contract prices. IDF 93. NTSP then reports these measures back to its participating physicians. CX 0103 at 4-5; CX 1196 (Van Wagner IH at 26-29, 43-44, 62); CX 1042. NTSP's polling form explains to the participating physicians that "NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants." CX 0387 at 1; CX 0633.

[6] NTSP has 20 non-risk contracts. IDF 50; CX 1196 (Van Wagner IH at 14). It does not receive revenues from these contracts; it does, however, receive revenues from its one risk contract. IDF 21.

B. History of the Case and Summary of Initial Decision

The Commission's complaint, issued on September 16, 2003, charges NTSP with the unlawful negotiation of agreements among its physicians on price and other terms, refusal to deal with payors except on collectively agreed-upon terms, and refusal to submit payor offers to its physicians unless the terms complied with NTSP's minimum-fee standards. Administrative Law Judge D. Michael Chappell filed an Initial Decision upholding the complaint on November 8, 2004.

In the Initial Decision the ALJ found that NTSP is controlled by its participant physicians and had taken collective action to establish and extract fee concessions from payors. ID at 52-56, 64-66, 70-83. The ALJ rejected the claim that NTSP was a single entity incapable of conspiring with its members. *Id.* at 70-71. He concluded that NTSP's conduct amounted to "a horizontal price fixing agreement." *Id.* at 86. He recognized that courts have applied *per se* analysis to horizontal price fixing, and made a number of specific findings that would support this characterization. IDF 364-80. However, he did not ultimately conclude that NTSP's conduct was *per se* unlawful. Instead, he followed the Supreme Court's analysis in *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999), and distinguished NTSP's conduct from the conduct of the dentists' group in that case. ID at 85-88.

The ALJ found that the PPA gives NTSP the exclusive right initially to negotiate with payors and requires physicians to submit to NTSP offers that they may individually receive. IDF 65. Physicians may negotiate individually only after NTSP discontinues its efforts. IDF 66. The ALJ also found that NTSP reinforces this negotiation exclusivity by powers of attorney or agency authorizations it receives from its members, and that it urges its members to tell payors to communicate their offers directly to NTSP. IDF 70, 76-82.

The ALJ found that, despite the requirements in the PPA, NTSP actually messengers to its members only those non-risk contract proposals in which reimbursement fees exceed NTSP's minimum reimbursement schedule developed from the annual poll of members. IDF 68, 85, 87. This rate is expressed as some percentage of Medicare's Resource Based Relative Value System, a fee schedule used to set the reimbursement amounts Medicare will pay for thousands of different services. IDF 10-12, 89-90. Although doctors do not consult with each other about their responses to the poll, NTSP computes the responses and informs its members of the averages. IDF 92-94. The ALJ found that this information enables members to assess the benefits of collective contracts though NTSP and reduces their uncertainty about other members' price-setting intentions. IDF 99-100.

The Initial Decision described NTSP's negotiations with three health plans – United, Cigna and Aetna, in which NTSP exercised its negotiating authority through its PPA and/or agency agreements or powers of attorney, and utilized its minimum reimbursement schedule. ID at 74-82. In several instances in these negotiations NTSP terminated, or threatened to terminate, its contract with a health plan. *Id.*

The ALJ rejected Respondent's claim that it was a single entity incapable of conspiring with its members, ID at 70-71, and held that evidence of direct agreements among physicians was not needed to demonstrate the conspiracy. *Id.* at 68-69. The ALJ relied on *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 356 (1982), where the Court found concerted action without finding that the competing physicians agreed directly with each other to set prices. The ALJ also found that NTSP had offered no plausible claim that its collective price setting was ancillary to any procompetitive activity. ID at 87. He therefore 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 at 88. He also found that NTSP's actions had caused payors to increase their offers, and concluded that this fact provided sufficient evidence of anticompetitive effects, to the extent an examination of effects is required. *Id.* at 87. The ALJ issued an order that requires NTSP to cease and desist from collective price fixing in its negotiation of non-risk contracts and to terminate any existing non-risk contracts. *Id.* at 92-97.

C. Questions Raised by the Appeal

1. Respondent's Appeal

Respondent appeals from the ALJ's determination that its conduct violated Section 5 of the FTC Act, and also maintains that the ALJ's cease and desist order is not appropriate. Respondent's supporting arguments sometimes overlap, but may be sorted out as follows:

First, Respondent argues that the Commission lacks jurisdiction over NTSP because it is a memberless non-profit organization, which is not engaged in interstate commerce.

Second, Respondent argues that the ALJ erred in finding that Complaint Counsel had shown concerted action when there was no evidence of direct collusion among NTSP's physicians. Respondent asserts that NTSP cannot and does not bind any participating physicians to its non-risk contracts, and that any non-risk contracts to which NTSP decides to become a party must be messengered to the physicians for their individual decisions on whether to join.

Third, Respondent contends that even if Complaint Counsel had shown there was concerted action, the conduct must be analyzed under the rule of reason. Respondent argues that the ALJ therefore erred when he found a violation, because Complaint Counsel did not meet their burden to show anticompetitive effects in a properly defined relevant market.

Fourth, Respondent argues that the ALJ erred when he found that NTSP had insufficient evidence of procompetitive justifications. Respondent asserts that all the evidence available shows that NTSP had legal and business justifications for its actions. Respondent argues that the ALJ compounded this error when he denied NTSP discovery needed to further establish its procompetitive justifications.

Fifth, Respondent argues that it was error for the ALJ to find that NTSP's conduct had a net anticompetitive effect in the absence of any showing by Complaint Counsel that there was a less restrictive alternative or that NTSP's justifications for its conduct were pretextual.

Sixth, Respondent argues that it was error for the ALJ to enter an order that was not narrowly tailored to any antitrust violation properly found.

2. Complaint Counsel's Appeal

Complaint Counsel appeal two aspects of the ALJ's decision, but otherwise ask that the Commission affirm the finding of liability. First, Complaint Counsel argue that it was error for the ALJ to hold it was necessary to prove a relevant market in the case of a *per se* unlawful price-fixing agreement. Complaint Counsel argue that no proof of market definition or market power is required to establish a *per se* violation, and that any naked price agreement among competitors (actual or potential) is conclusively presumed unlawful.

Second, Complaint Counsel argue that the ALJ's order is too narrow and fails to provide essential relief. Complaint Counsel argue that the core prohibitions fail to provide adequate protection against further violation. Complaint Counsel also argue that 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.

III. Jurisdictional Issues

We consider this issue first, although Respondent does not give it prominence. The Commission has jurisdiction over NTSP as a corporation only if NTSP is organized to carry on business for the pecuniary benefit of its members and NTSP's conduct at issue is "in or affecting commerce." 15 U.S.C. §§ 44, 45 (1994). Respondent contends that it was error for the ALJ to find that the FTC has jurisdiction over NTSP because NTSP is incorporated under Texas law as a "memberless" non-profit organization (and therefore its physicians are not "members" of NTSP), and none of NTSP's actions were in interstate commerce. RAB at 58-59.

We find that NTSP clearly is a "corporation" within the meaning of Section 4 of the FTC Act because NTSP is "organized to carry on business for its own profit or that of its members." 15 U.S.C. § 44. In the words of NTSP official Dr. John Johnson, "NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups to hopefully be able to secure contracts, improve patient care, and provide a voice at the table for physicians. . . . [It was] to represent physicians . . . in obtaining contracts from businesses or insurance companies or in dealing with hospitals." CX 1182 (Johnson Dep. at 10-11).[7] NTSP's primary function – marketing its physicians to payors – satisfies the

[7] *See also* CX 350 ("NTSP was started in an attempt to provide a seat at the table of medical business for the individual specialty physicians . . . . NTSP through, [sic] PPO and risk

pecuniary benefit test of FTC jurisdiction. Indeed, we find that NTSP does not appear to have any purpose other than to carry on business for the profit of its members. It is not necessary for the challenged conduct to increase NTSP's members' profits, as NTSP intimates. In *California Dental*, 526 U.S. at 767 n.6, the Supreme Court stated, "[i]t 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."

NTSP's argument that its physicians are not "members" because of the way it is incorporated elevates form over substance.[8] NTSP's physicians possess sufficient indicia of membership to qualify as members within the meaning of Section 4:

- They come together with other members of their profession to promote their common business interests.
- They elect representatives to its governing board.
- They contribute funds to finance NTSP's activities.
- NTSP internal documents refer to its physicians as "members."

IDF 20, 21, 24, 33, 42, 44, 48, 160, 282, 326.

We further find that NTSP satisfies the interstate commerce jurisdictional requirement because NTSP's actions to maintain physician fee levels, if successful, could be expected to affect the flow of interstate payments from out-of-state payors to NTSP physicians. There is no need to prove actual effects on interstate commerce, or to quantify the effect. The Supreme Court on numerous occasions has emphasized the breadth of federal antitrust jurisdiction, even when wholly intrastate conduct of local actors is challenged.[9]

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contracts, has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source."); CX 550.

[8] The mere form of incorporation is not controlling in matters of FTC jurisdiction. *See Cmty. Blood Bank of the Kansas City Area, Inc. v. FTC*, 405 F.2d 1011, 1018-19 (8th Cir. 1969).

[9] *See, e.g., Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 328-31 (1991); *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 241 (1980); *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 743-45 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 784-85 (1975).

IV. Legal Framework

In order to find liability under Section 5 of the FTC Act, we will examine first, whether there was an "agreement" between independent actors and, second, whether this agreement unreasonably restrained trade.[10] Our overall evaluation of NTSP's conduct is guided by a rich jurisprudence that extends over almost 100 years,[11] and particularly by the very recent decision of the Supreme Court in *California Dental* – a case that was in turn followed by the Commission in its own opinion in the *Polygram* case and by the D.C. Circuit Court's affirming opinion, *Polygram Holding*, 416 F.3d 29. We will occasionally refer to the Department of Justice and FTC *Health Care Statements*, but it should be understood that we do not consider the *Health Care Statements* as substantive authority in their own right but rather as concise summaries of what we believe the law to be. We are also informed by our own enforcement experience with combinations similar to NTSP and by the Commission's *Health Care Hearings and Report*. In this section we will explain why we have chosen to apply the flexible tools of *Polygram* rather than a simple *per se* analysis in this case, and we will then describe *Polygram's* methodology in more detail.

A. Choice of Standard

The Commission's unanimous *Polygram* opinion was its first attempt to respond to the approach of the Supreme Court's *California Dental* decision. These opinions describe how the analysis of horizontal restraints has evolved over the last 100 years, and establish a flexible methodology for courts to determine whether a challenged restraint is illegal. They go beyond the simple dichotomy between categories like "*per se*" or "rule of reason," and establish a continuum within which behavior can be analyzed.

At one polar extreme, there still is a category of offenses that are considered *per se* illegal, for which liability depends solely on whether defendants did or did not do certain things. These offenses include, most prominently, so-called "naked" price fixing or market allocation agreements. Longstanding precedent holds that the courts will not entertain any arguments that these restraints will yield beneficial, or even benign, results. Parties cannot defend, for example,

[10] For purposes of this case, we can assume that the definition of "unfair methods of competition" under the FTC Act, 15 U.S.C. § 45, is the same as the definition of a "contract combination . . . or conspiracy, in restraint of trade . . . ." under Section 1 of the Sherman Act, 15 U.S.C. § 1.

[11] The requirement that the restraint be unreasonable – coupled with recognition that some restraints can conclusively be presumed so – dates from 1911 in *Standard Oil Co. v. United States*, 221 U.S. 1, 58 (1911).

on the ground that prices have been set at "reasonable" levels[12] or that coordination is necessary for survival in times of distress.[13] We do not believe that the *per se* condemnation of naked restraints has been affected by anything said either in *California Dental* or *Polygram*.

There is precedent for outright *per se* condemnation of conduct that parallels the conduct in issue here. The Supreme Court held in *Maricopa*, 457 U.S. at 356-57, that traditional antitrust laws apply to price fixing in the context of physician fee negotiation, and held that it was *per se* unlawful horizontal price fixing for a group of competing physicians to agree to set a maximum fee to offer health insurers for providing medical services to patients. The means used to implement a price fixing agreement in *Maricopa* are similar to those used by NTSP. In *Maricopa*, the medical societies: (a) set a maximum price for health services that could be charged to policyholders of approved health insurance plans;[14] (b) used polling as a device for determining the price; (c) did not necessarily have agreement directly between physicians in the price-setting process; and (d) allowed the physicians the freedom to set their own prices.[15]

We also are familiar with these practices and this industry.[16] The Commission has issued complaints in numerous cases, which challenge conduct by physician IPAs similar to that in *Maricopa* and that in the case at hand. *See, e.g., supra* note 1. The FTC and Department of Justice *Health Care Statements* provide specific warning about the illegality of this type of conduct. *See Health Care Statements, supra* note 2, *Statement* 8.

Although NTSP's activities could be characterized as *per se* illegal because they are closely analogous to conduct condemned *per se* in this and other industries, we will not apply that label here and now in this particular case. There are two reasons.

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[12] *See United States v. Trenton Potteries Co.*, 273 U.S. 392, 398-99 (1927); *United States v. Addyston Pipe Steel Co.*, 85 F. 271, 288-91 (6th Cir. 1898), *aff'd* 175 U.S. 211 (1899).

[13] *See United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218-21, 229 (1940).

[14] Note that in one respect the conduct here is even worse than that condemned in *Maricopa* because NTSP has set minimum prices. *See* Section V.B.1.a.

[15] *Arizona v. Maricopa County Med.* Soc'y, 1979 WL 1638 at *1 (D. Az. June 5, 1979), *aff'd*, 643 F.2d 553 (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982).

[16] A *per se* characterization would not necessarily be foreclosed, even if we did not have this industry-specific experience. *Maricopa* stated that the *per se* rule does not need to "be rejustified for every industry that has not been subject to significant antitrust litigation." 457 U.S. at 350-51. On the other hand, *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 9 (1979), emphasized that a *per se* label is appropriate only when courts "have had considerable experience with certain business relationships." We do not need to parse these statements closely, in light of our experience with both the industry and the practices.

First, in the years since *Maricopa* was decided, the Supreme Court has urged caution in the application of the *per se* label to conduct in a professional setting where "the economic impact . . . is not immediately obvious." *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 459 (1986); *see also California Dental*, 526 U.S. at 770-71. Some might claim that the likely economic impact of the restraints in issue here is "immediately obvious" enough to satisfy this standard, but we do not need to reach that question because we have available in this case an extensive record on which to buttress our conclusions about the likely effects of Respondent's conduct.

Second, since *Maricopa*, we have a better understanding of the potential integration efficiencies of physician IPAs. We would view NTSP's activities very differently if NTSP were able to demonstrate that the participating physicians were financially or clinically integrated in performing its numerous non-risk contracts, and thus driven by incentives similar to those present in its single remaining risk contract. Under the well-established law of ancillary restraints, recent precedents like *Polygram*, and the principles described in our *Health Care Statements* and *Competitor Collaboration Guidelines*,[17] Respondent could have prevailed if the integrated venture were likely to enhance efficiencies and NTSP's conduct were reasonably related to the overall agreement and reasonably necessary for achieving those efficiencies. *See* discussion in Section V.C.1., *infra*. This means that some initial inquiries about whether there is integration, the likely effects of integration, and the reasonableness of the specific restraint are necessary in order to decide whether to apply a rule of reason. It is of course possible to conclude we then have a *per se* case based on a *per se* illegal restraint if these initial inquiries are decided adversely to a respondent. But, it is semantically awkward to use a *per se* label once a number of "reasonableness" issues have been addressed, sometimes at length. What does it really mean to say we have a *per se* case, once we have considered and rejected justifications for a restraint? What it means, as a practical matter, is that no further proof of market effects is required; the case is over. As will be made clear in the discussion below, however, we arrive at exactly the same result when we follow the "inherently suspect" analysis outlined in *Polygram* – and the *Polygram* framework more accurately describes the actual analysis of the case.

These considerations might not deter us when we are persuaded by experience and economic logic that the potential for harm is overwhelming and the possible justifications are attenuated and uniformly rejected by courts. We would simply apply the *per se* label. In the health care sector, however, the Commission wants to encourage providers to engage in efficiency-enhancing collaborative activity.[18] We do not want to chill consideration of this

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[17] Fed. Trade Comm'n and U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors* (2000), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,161 [hereinafter *Competitor Collaboration Guidelines*].

[18] *See generally MedSouth*, *supra* note 2, where Commission staff did not recommend the Commission take enforcement action against a physician IPA proposal whereby the IPA physicians would collaborate on information sharing, treatment coordination, practice

activity by use of terminology that could be misunderstood. This is not a factor that was considered in *Maricopa* over twenty years ago, but we do think it is a factor that needs to be considered after a decision like *California Dental*.

So, at least this time, after the first full administrative trial in a generation, we will instead follow the methodology of *Polygram*, and consider each of Respondent's justifications in some detail. We want to emphasize again, however, that this is not the same thing as a full blown rule of reason inquiry. If we find that Respondent's proffered justifications for NTSP's inherently suspect conduct are not legitimate – after the examination that follows – it is not necessary to go on and find actual adverse market effects. *See* Section V.E. *infra*.

B. The *Polygram* Analysis

In the words of the D.C. Circuit, an offense can be described as "inherently suspect" when there is a "close family resemblance between the suspect practice and another practice that already stands convicted in the court of consumer welfare." *Polygram*, 416 F.3d at 37. The determination is based on the conduct's "likely tendency to suppress competition." *Polygram Comm'n Op. supra* note 4, at 29. As the Commission described, "[s]uch conduct ordinarily encompasses behavior that past judicial experience and current economic learning have shown to warrant summary condemnation." *Id*. At this stage, the focus of the inquiry is on the nature on the restraint rather than on the market effects in a particular case.[19] If a plaintiff is able to make an initial showing that particular conduct meets these strictures, and the defendant makes no effort to advance any procompetitive justification for the conduct, then the case is concluded and the practices are condemned. *Polygram Comm'n Op. supra* note 4, at 29.

A defendant can avoid summary condemnation, however, if it can advance a legitimate justification for the practice. As we explained in *Polygram*, "[s]uch justifications may consist of plausible reasons why practices that are competitively suspect as a general matter may not be expected to have adverse consequences in the context of the particular market in question; or they may consist of reasons why the practices are likely to have beneficial effects for consumers." *Id.* The defendant need only articulate a legitimate justification, and is not obliged to prove the competitive benefits. (Remember that the issue at this initial stage is simply whether the practice

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protocols, and enforcement standards. *See also* Thomas B. Leary, *The Antitrust Implications of "Clinical Integration": An Analysis of FTC Staff's Advisory Opinion to MedSouth*, 47 ST. LOUIS U. L. J. 223 (Spring 2003).

[19] As the D.C. Circuit pointed out in *Polygram*, this is not a fixed category. It must evolve "as economic learning and market experience evolve." 416 F.3d at 37; *see also* Thomas B. Leary, *A Structured Outline for the Analysis of Horizontal Agreements*, http://www.ftc.gov/speeches/leary/chairsshowcase.talk.pdf at 7-10, (describing distinction between cases "that focus on the nature of the restraint" and those "that focus on the nature of the market") (emphasis in original).

should be condemned summarily.) The proffered justifications, however, must be both cognizable under the antitrust laws and at least facially plausible. *Id.* at 30-33. The cognizable justification requirement allows a tribunal to reject as a matter of law proffered justifications that are incompatible with the goal of antitrust law to protect competition. We described cognizable justifications in our *Polygram* opinion, *id.* at 31:

> Cognizable justifications ordinarily explain how specific restrictions enable the defendants to increase output or improve product quality, service, or innovation. By contrast, courts since the earliest decades of the Sherman Act have identified classes of justifications that, because they contradict the procompetition aims of the antitrust laws will not save restraints from condemnation. For example, a defendant cannot defend restraints of trade on the ground that the prices the conspirators set were reasonable, that competition itself is unreasonable or leads to socially undesirable results, or that price increases resulting from a trade restraint would attract new entry.

The D.C. Circuit expressly approved the requirement that a proposed justification be both cognizable and plausible. Even though the justification offered by *Polygram* seemed plausible "[a]t first glance," the court rejected it as "nothing less than a frontal assault on the basic policy of the Sherman Act." *Polygram*, 416 U.S. at 37-38 (quoting *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. 679, 695 (1978)).

If the justification for a suspect restraint is cognizable – which is to say, admissible in the first place – a defendant must also show that it would plausibly create or improve competition. Again, to quote *Polygram*:

> A justification is plausible if it cannot be rejected without extensive factual inquiry. The defendant, however, must do more than merely assert that its purported justification benefits consumers. Although the defendant need not produce detailed evidence at this stage, it must articulate the specific link between the challenged restraint and the purported justification to merit a more searching inquiry into whether the restraint may advance procompetitive goals, even though it facially appears of the type likely to suppress competition.

Id. at 31-32.[20]

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[20] The concept of ancillary restraints, which allows an agreement that would otherwise be viewed as a naked restraint of trade to be evaluated in light of the procompetitive effects of an efficiency-enhancing integration of economic activity to which it is reasonably related, is subsumed in the Commission's *Polygram* analysis. *See Polygram Comm'n Op., supra* note 4, at n.42 ("[t]he ancillary restraints doctrine retains its vitality in evaluating efficiency claims. . . . [w]hether or not expressed in terms of ancillarity, the link between defendant's "plausible" justification and a cognizable benefit must be clear."). As will become clear after the discussion of specific facts, NTSP's conduct is not justified under either a pre-*Polygram*

If a defendant is able to advance a justification that meets both of these requirements – cognizable and plausible – the plaintiff must then make a more detailed showing that the restraints at issue are likely to harm competition. *Id.* at 32. The degree of proof required depends on the circumstances of the case and the degree to which antitrust tribunals have experience with the restraint in question. *Id.* The Supreme Court stated succinctly that the inquiry must be "meet for the case." *California Dental,* 526 U.S. at 781. In *Polygram,* the Circuit Court used similar language, stating that, "the extent of the inquiry is tailored to the suspect conduct in each particular case," 416 F.3d at 34. We interpret this precedent as endorsement of a "spectrum" or "sliding scale" analysis, which more accurately describes the way cases are actually decided today.[21]

C. The *Health Care Statements*

The FTC and Department of Justice *Health Care Statements* provide guidance about the agencies' enforcement intentions on issues which are likely to arise in the health care industry. They lay out principles that we believed to be consistent with the state of the law when they were issued in 1993 and revised in 1994 and 1996. Even though the *Health Care Statements* were issued before the *California Dental* or *Polygram* opinions were written, and also before the *Competitor Collaboration Guidelines* were issued, we believe that their analysis of horizontal restraints among competing physicians is still viable and also uniquely valuable because of their specificity. The *Health Care Statements* lay out the circumstances when a rule of reason analysis is appropriate for price-setting conduct between competing physicians and – like the analysis in *Polygram* – they allow for procompetitive justifications in certain circumstances. *See Health Care Statements, supra* note 2, *Statement* 8.

Price-setting conduct of physician networks qualifies for rule of reason treatment where the "physician's integration through a network is likely to produce significant efficiencies" and the agreement on price is "reasonably necessary to realize those efficiencies." *Health Care Statements, supra* note 2, *Statement* 8B1.[22] *The Health Care Statements* describe two different types of integration that can qualify a physician network for rule of reason treatment – financial and clinical. *Id*. The Commission has applied this analysis in numerous enforcement actions.

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ancillarity analysis, or *Polygram's* more inclusive analysis.

[21] We believe that this analytical framework may also help to resolve the apparent inconsistency between those decisions that use *per se* terminology and those that use rule of reason terminology in facially similar situations. *See* cases cited in ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS, 53-58 (5th ed. 2002).

[22] The *Competitor Collaboration Guidelines, supra* note 17, refer to "cognizable efficiencies" for which the restraint in issue is "reasonably necessary." §§ 3.36(a), 3.36(b).

Although our analysis of NTSP's conduct generally follows the legal framework outlined in *Polygram*, we also refer to the industry specific concepts identified in the *Health Care Statements* to the extent appropriate.

V. Analysis of the Challenged Restraints

A. Existence of an Agreement

In order to decide whether there is a violation of Section 5 of the FTC Act in this case, we will first look to see if there is an agreement. There is a fundamental distinction between unilateral and multilateral action. The matter is easy to decide when two or more separate legal entities overtly agree on a restraint that each will adopt. However, an action nominally taken by a single entity is also construed as the product of agreement for purposes of the antitrust laws when the entity is controlled by a group of competitors and is serving as the agent of the group. There are many ways that association/agents can legally act for the collective benefit of the group. Associations can, for example, negotiate prices for office facilities or wages for employees; agents can establish prices for services that the association itself provides for members or non-members. These are matters of no antitrust significance, because there is no conceivable anticompetitive impact. However, if the association negotiates prices for services that the *members* will provide, the organization's conduct is considered to be that of a combination or conspiracy of its members, not unilateral action.[23]

The Commission has also held that when an organization is controlled by a group of competitors, the organization is viewed as a combination of its members, and their concerted actions will violate the antitrust laws if an unreasonable restraint of trade. *In the Matter of Michigan State Med. Soc'y,* 101 F.T.C. 191, 286 (1983). The Commission's long list of consent agreements in this industry are all based on this uncontroversial legal premise. *See, e.g., supra* note 1.

The basis for this jurisprudence is sound. Without it, any group of competitors could avoid antitrust liability for collective price fixing simply by acting through single organizations that they control (as many have attempted).[24] Thus, in order to determine if there is an agreement in this case, we must first determine whether NTSP is controlled by competing physicians.

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[23] *See, e.g., Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 694-96; *United States v. Sealy, Inc.*, 388 U.S. 350, 352-54 (1967). *Cf. Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 509 (1988); *Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of the Univ. of Oklahoma*, 468 U.S. 85, 99 n.18 (1984).

[24] *See supra* note 23. They could, for example, coordinate their activities through a single "trust." It would seem rather odd to immunize this kind of activity, given the popular name of the basic legal regime we apply here: "The Antitrust Laws."

Respondent states that NTSP is a 5.0l(a) memberless non-profit corporation under Texas law.[25] RAB at 14. Respondent argues that because of this "memberless" status, NTSP should be viewed as a sole actor, both in management of its affairs, and in its refusal to deal with payors on non-risk contracts, and that therefore NTSP cannot be found to conspire under Federal competition law. *Id.* at 14-15. At the outset, we reject this argument. Substance prevails over form in antitrust law, and the technical manner in which an organization is incorporated does not control.[26] We have to look beneath the surface.

We find that NTSP is controlled by competing physicians, and therefore is not a sole actor for purposes of the antitrust laws. We agree with the ALJ's conclusion that NTSP's participating physicians have taken collective action to obtain higher fees from payors. ID at 53-55. The fact that NTSP physicians elect representatives from their ranks to serve on the eight-member Board of Directors of NTSP and set NTSP policy supports this conclusion. IDF 23, 24, 33, 38.

Respondent's briefs rely heavily on *Viazis v. American Ass'n of Orthodontists*, 314 F.3d 758 (5th Cir. 2002), to assert that NTSP's mere existence does not satisfy the concerted action requirement of Sherman Act Section 1. RAB at 12. Respondent's discussion of *Viazis* has confused the requirement of "collective action" with the separate requirement of an "unreasonable restraint of trade." *Viazis* merely states that a trade association is not by its nature a "walking conspiracy" even though it inherently involves collective action by competitors – there must also be an unreasonable restraint of trade. *Viazis*, 314 F.3d at 764. We do not disagree.

Respondent also argues that because NTSP cannot and does not bind any of its physicians to non-risk contracts, there cannot be any collusion among physicians (and therefore no agreement). RAB at 8. Respondent cites ALJ findings that the doctors did not discuss among themselves or directly enter into price agreements with one another, and points out that the ALJ's finding that there was no collusion among NTSP's physicians was based on this evidence. RAB at 11. This argument, as presented, conflates what really are two separate issues.

The first issue raised by this particular argument is whether parties can enter into an agreement absent direct communication with each other. It has long been settled that they can. In *Maricopa*, the Supreme Court found an agreement among physicians without finding that the competing physicians agreed directly with each other. 457 U.S. at 356; *see also* ID at 68.

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[25] Section 5.01(a) of the Texas Medical Practice Act allows non-profit entities to engage in the practice of medicine for the purposes of research, medical education, or the delivery of health care to the public. TEX. OCC. CODE. ANN. § 162.001 (Vernon 2004).

[26] In *Community Blood Bank*, 405 F.2d at 1018-19, the circuit court determined that jurisdiction was to be determined "on an ad hoc basis" and that the mere form of incorporation was not controlling.

Similarly, in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia* 624 F.2d 476, 479-81 (4th Cir. 1980), the court found collective action by a group that was controlled by its physician members without finding that the plan's individual physicians had met and agreed directly with each other. The *Health Care Statements* also explain that physicians do not have to directly agree with one another to engage in price fixing, and that a common agent can be used to exert the bargaining leverage of a group of physicians. *Health Care Statements, supra* note 2, *Statement* 9Dl and 9D4 n.66. In this case, it is enough that participating physicians individually authorized NTSP to take certain actions on their behalf, knowing that others were doing the same thing.[27] Indirect communications of this kind are sometimes referred to as "hub-and-spoke" conspiracies.[28]

The second issue is whether it is possible to find that there was an agreement on price even though individual physicians were not bound to adhere to contract terms negotiated by NTSP. We address this issue in the discussion of NTSP's restraints in Section V.B.1. immediately below (analysis of whether NTSP's conduct amounts to price fixing). It is enough to say here that the opt-out right does not negate the existence of an agreement.

B. Restraint of Trade – *Prima Facie* Case

We next examine whether NTSP's conduct amounts to a restraint of trade, specifically, price fixing. First we look at the factual evidence to determine whether the conduct amounts to price fixing, and is thus illegal absent a cognizable and plausible justification. We discuss different kinds of activity separately for convenience and to provide guidance about what we regard as highly suspect behavior. We want to make clear, however, that our ultimate conclusions in this case do not stand or fall on our assessment of separate actions; the ultimate conclusions are rather predicated on the likely effects of the actions taken together.[29]

After discussion of the restraints separately, we then address in Section V.C. below the justifications advanced for each of them. We also describe the conduct that the Commission

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[27] For example, NTSP would inform physicians who had not yet granted it contract negotiation authority but were considering it, the number of other member physicians who had already given NTSP that authority. CX 1066 at 1; CX 0548 at 1.

[28] *See, e.g., Toys "R" Us, Inc. v. FTC*, 221 F. 3d 928, 934-36 (7th Cir. 2000) (finding evidence of horizontal agreement where petitioner served as "ringmaster"); *United States v. Masonite* Corp., 316 U.S. 265, 276 (1972) (fixing of prices by one member of group pursuant to express delegation, acquiescence, or understanding just as illegal as fixing of prices by direct, joint action); *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 227 (1939) ("unlawful conspiracy may be and often is formed without simultaneous action or agreement").

[29] The decision to view the conduct as a whole in this case should not be understood to mean that any one of the actions is necessarily benign standing alone.

does not find to be price fixing in Section V.D., in order to give guidance to the health care community.

1. Challenged Restraints

a. NTSP's Use of a Poll

NTSP conducts annual polls of its physicians to determine minimum reimbursement rates for use in negotiation of HMO and PPO product contracts with payors. CX 1195 (Van Wagner Dep. at 66-67). NTSP's polling form asks the physicians individually for the minimum price that they would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. CX 0565; CX 1196 (Van Wagner IH at 26-29, 43-44, 62). NTSP uses these poll responses to calculate the mean, median, and mode of the minimum acceptable fees identified by its physicians, and then uses these averages to establish its minimum contract prices. NTSP then reports these measures back to its participating physicians. CX 0103 at 4-5; CX 1196 (Van Wagner IH at 26-29, 43-44, 62); CX 1042. NTSP's polling form explains to the participating physicians that "NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants." CX 0387 at 1; CX 0633.

We find that NTSP's use of a poll facilitated a price-fixing agreement among its competing physician members. Frech Tr. 1316-24; 1326. NTSP physicians were aware that NTSP would use individual member's poll responses to create group "averages" that would be used by their organization in the coming year's negotiations with payors. IDF 88-90, 93-94. It was a way to communicate to their competitors what they would like to get in the future – not what they had gotten in the past, or, indeed, what they might settle for individually. When they cast a vote on the desired minimum price for the group, they were not simply reporting past or current prices, they were telegraphing their intentions about future prices. Thus, NTSP physicians anticipated 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. *See* IDF 88, 96-100. NTSP physician responses to the polls were *interdependent* and not independent.

Respondent argues that NTSP's use of its poll and its minimum reimbursement schedule are not concerted action and have legitimate business purposes.[30] RAB at 21-22. Respondent states that NTSP does not divulge to any physician or board member whether or how any other individual physician responds to the confidential poll conducted by NTSP's staff. *Id.* at 23-24. Respondent also claims that NTSP does not use the averages derived from the polls to negotiate for higher rates, and NTSP's actions related the establishment and use of the threshold rate are purely internal to NTSP. *Id.* at 21-22. Even if NTSP's becomes a party to the contract, Respondent states that each physician still has an individual right to decide whether to become a

[30] We address Respondent's efficiency arguments associated with NTSP's poll in Section V.C. below.

party; physicians are not bound to their poll responses, and the poll does not require or induce a physician to contract in a particular manner or even at all. *Id.* at 22. Respondent points out that less than 34 percent of the physicians responded to the poll. *Id.* at 23. Furthermore, Respondent states that when NTSP's board makes a decision on a payor's offer, it is not binding on the physicians. *Id.* at 22-23.

Respondent further argues that Complaint Counsel's expert (Dr. Frech) was unable to find any evidence of collusion among physicians, and admitted that physicians chose not to contract through NTSP on more than two-thirds of the contract offers NTSP messengered. RAB at 8-10. According to Respondent, Dr. Frech also determined that physicians frequently enter individually into payor contracts at rates both above and below the threshold rate levels. RAB at 10-11, 23.

Respondent's argument that NTSP does not divulge to any physician or board member whether or how any particular physician responds to the poll is of no consequence because liability in this case is not predicated on individual discussions among physicians themselves. It is predicated on an improper delegation of individual pricing authority to a common agent. The fact that NTSP's decisions on payor offers were not binding, and often ignored, does not absolve NTSP from liability because the law is clear that agreements can be illegal even though all the price terms are not specified or adhered to. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 647-48 (1980); *Socony-Vacuum Oil*, 310 U.S. at 218-24; and *Plymouth Dealers' Ass'n of Northern California v. United States*, 279 F.2d 128, 130-33 (9th Cir. 1960), all stand for the proposition that price fixing encompasses a broad range of actions that affect, but do not necessarily determine, the final price. *Socony-Vacuum Oil*, 310 U.S. at 223, made 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. In *High Fructose Corn Syrup Antitrust Litigation*, 295 F.3d 651, 656 (7th Cir. 2002), Judge Posner stated 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." Judge Posner explained that "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.* Even if there is variability, NTSP's use of a minimum schedule (obtained from polling results) affects the level at which variability occurs. NTSP's conduct thus has the same effect on price as the conduct identified in *Plymouth Dealers* and *High Fructose Corn Syrup*.

Complaint Counsel's expert, Professor Frech, explained that NTSP's minimum-fee schedule coupled with its right of first negotiation (via the PPA) hinders payors' ability to contract directly with physicians. Frech Tr. at 1315-17; 1326-27. This was confirmed by payor testimony. *See, e.g.*, Quirk Tr. at 316-17. Professor Frech also explained that the NTSP minimum reimbursement rates were higher than what some physicians were actually willing to accept, and that negotiation of 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 (they can opt out). Frech Tr. 1321-24. Thus, the minimum NTSP price schedule

does have a tendency to increase prices overall, and can be characterized as horizontal price fixing.[31]

The fact that only 34 percent of NTSP physicians responded to the polls does not alter this conclusion. A low response rate could, of course, further reduce the utility of the poll as a prediction of what individual physicians would be willing to accept – and this fact therefore actually *weakens* any argument that a poll would help payors to avoid wasted efforts. *See* discussion in Section V.C.2.b. Moreover, the fact that the poll results – whether actual predictors or not – were disclosed to *all* NTSP physicians encouraged them to reject price offers below the minimum fees indicated, Frech Tr. 1326-27, and NTSP actively encouraged them to reject the offers. *See* CX 1097 at 2; Vance Tr. 1215-18; Frech Tr. 1326-27. Finally, this disclosure of the poll results could also cause NTSP physicians to inflate their poll responses in subsequent years. *See* CX 430 (2002 annual policy form reminded physicians of prior year's averages); IDF 99-100. Thus, the poll results influenced the decisions of all NTSP physicians, regardless of whether they responded.

The manner in which NTSP utilized the minimum reimbursement schedule in its communications with payors also shows that it was using the poll for much more than just an administrative or efficiency-enhancing tool. For example, NTSP regularly informed payors that its physicians had established minimum fees for NTSP-payor agreements, identified the fee minimums, and stated that NTSP would not enter into or forward to any of its physicians payor offers that were below the minimums. CX 1196 (Van Wagner IH at 62-63, 153-54); CX 1173 (Deas IH at 26-29). This evidence is in stark contrast to the picture painted by Respondent about NTSP's activities associated with the poll, and illustrates the need for a multi-faceted definition of price fixing called for in *Socony-Vacuum Oil*.

b. NTSP's Physician Participation Agreement

NTSP's physicians enter into a membership agreement (the PPA) with NTSP that grants NTSP the right to receive all payor offers and imposes on the physicians a duty to promptly forward payor offers to NTSP. CX 0276; CX 275 at 24. Essentially the PPA grants NTSP a right of first negotiation with payors. The physicians agree that they will refrain from pursuing offers from a payor until notified by NTSP that it is permanently discontinuing negotiations with the payor. CX 0276; CX 0311 at 10; CX 1178 (Hollander Dep. at 68). Under the PPA, NTSP is supposed to deliver payor price proposals (and other economic provisions of offers) for fee-for-service contracts to its physicians. CX 0275 at 25-26.

[31] *See Nat'l Elec. Contractors Ass'n , Inc. v. Nat'l Constructors Ass'n,* 678 F.2d 492, 500 (4th Cir. 1982) (*citing Yarn Processing Patent Validity Litig.,* 541 F.2d 1127, 1137 (5th Cir. 1977), *cert. denied,* 435 U.S. 910 (1977) (interference with the market forces freely setting prices sufficient to constitute price fixing)).

We find that the PPA in effect renders NTSP as the sole bargaining agent of NTSP competing physicians and thus facilitates price fixing among NTSP physicians. The terms of the PPA and the manner in which NTSP has utilized them hinder the ability of payors to assemble a marketable physician network in the Fort Worth area without submitting to the collective bargaining of NTSP. Frech Tr. 1313-16.

Respondent argues that NTSP's PPA gives NTSP no authority to bind physicians, and that any non-risk contracts in which NTSP decides to join as a party must be messengered to the physicians for their own individual decisions on whether to join. RAB at 8, 19. In addition, Respondent argues that the PPA's terms do not prevent a physician from negotiating with a payor directly or through another entity. *Id.* at 19.

We find that although the PPA requires NTSP to deliver contracts to its physicians, the evidence shows that NTSP rejects and does not deliver any contract that falls below its minimum reimbursement schedule. CX 1196 (Van Wagner IH at 68-69). Other terms of the PPA are inconsistent with Respondent's assertion that any non-risk contracts must be messengered. For example, the PPA contains provisions whereby 50 percent of NTSP's membership must approve the reimbursement proposal of a payor before an offer is "messengered" by NTSP to the physicians for actual opt-in/out of the proposed contracts.[32] CX 0276 at 1-2. This conduct has the potential to raise the level at which variability occurs, just as the use of polling data does.

We also find that each NTSP physician's ability to opt in or out of a contract – 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 payors over what contract terms will be offered. It is not necessary that there be uniform adherence to specific prices by individual members. In *Maricopa*, the Supreme Court found a price-fixing agreement even though the participating physicians were free to set their own prices. 457 U.S. at 356. The Commission reached a similar result in *Motor Transport Ass'n of Connecticut, Inc.*, 112 F.T.C. 309, 336 (1989), stating that association members "need not agree to a single price level in order to fix prices."[33] In this case, NTSP is able to exert collective bargaining power and hence fix prices because NTSP does not messenger contracts below its minimum reimbursement schedule. Instead it rejects the contracts outright on behalf of its physicians and NTSP's collective bargaining leverage is thus exerted before its physicians even have a chance to opt in or out of a contract.

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[32] The PPA contains another provision allowing for NTSP counter offers to payor rate proposals based on direction from at least 50 percent of NTSP's physicians. CX 0275 at 26.

[33] *See also In the Matter of Kentucky Household Goods Carriers Assoc., Inc.*, Docket No. 9309, 2005 WL 1541548 at *11 (FTC June 21, 2005), *review pending*, No. 05-4042 (6th Cir. Aug. 18, 2005); *cf. In re Petroleum Prods. Antitrust Litig.*, 906 F.2d 432, 445-50 (9th Cir.1990) (circulation of current price lists sufficient for liability, even without evidence of agreement to adhere to them), *cert denied*, 500 U.S. 959 (1991).

c. Powers of Attorney

In several instances, NTSP gathered powers of attorney from members whereby NTSP was appointed as their sole bargaining agent. CX 1173 (Deas IH at 56-57); CX 1065; CX 1061. We find that NTSP used its powers of attorney in a manner similar to the way it used the PPA, and the effect is the same – namely, to solidify its power as a bargaining agent and thus facilitate its price fixing. Jagmin Tr. 1058-60; Beaty Tr. 459-60; Frech Tr. 1327-30.

Respondent argues that this conduct is not evidence of concerted action, that the forms were limited in their application to "any lawful manner," and that NTSP used them only in conjunction with a messenger model.[34] RAB at 20. Respondent emphasizes that the powers of attorney did not commit a physician to accept or reject an offer, nor did they give NTSP any power to bind any physician on a non-risk contract. *Id.*

We find however, that the terms of the powers of attorney were clear on their face and improperly granted NTSP "authority to negotiate the terms of, enter into, execute, amend, modify, extend, or terminate" the relevant contracts. CX 347. To induce physicians to grant it powers of attorney, NTSP would include in its solicitations information about the number of physicians who already had executed the powers of attorney. CX 1066; CX 0548 at 1. NTSP physicians referred payors that were attempting to contract directly with them back to NTSP, often noting the deferral was based on agency or powers of attorney held by NTSP. Beaty Tr. 454-60, Grizzle Tr. 696-98, 724; CX 0760. Furthermore, NTSP advised payors in negotiations that it represented NTSP member physicians though powers of attorney or agency. Roberts Tr. 540-41. In one instance, NTSP sent Aetna a list of 180 physicians who had executed powers of attorney appointing NTSP as their bargaining agent for any direct contracting with Aetna. IDF 304. Unrebutted testimony from Aetna officials shows that Aetna understood this as a clear message that these physicians would not negotiate directly with Aetna and therefore concluded that there was no practical alternative to dealing with NTSP. IDF 305-06.

d. NTSP's Concerted Withdrawals and Refusals to Deal Except on Collective Terms

In several instances NTSP used its agency powers to terminate its members' participation in a health plan or refused to deal with a payor because NTSP determined that the fee-for-service price paid by the payor was inadequate. CX 0546; CX 0802; CX 1054. For example, when NTSP was dissatisfied at one point during negotiations with United Healthcare Services, Inc., it terminated the United contracts of 101 physicians. IDF 147-54. On another occasion, after CIGNA sent contract assignment letters to Fort Worth physicians, in an attempt to contract with them independent of NTSP, NTSP provided its members with a sample letter refusing the contract assignment and directing CIGNA to negotiate with NTSP as their agent. IDF 205. NTSP advised its physicians not to consent to the assignment, and also sent them an agency

[34] We discuss the "messenger model" arguments separately in Section V.B.1.e. below.

agreement authorizing NTSP to negotiate on their behalf. IDF 205. Thereafter CIGNA received 40 letters on behalf of 52 physicians that were virtually identical to the sample letter provided by NTSP. IDF 206. On two other occasions, NTSP threatened to terminate its contract with CIGNA and then later actually terminated its contract, when terms were not satisfactory to NTSP. CIGNA was then forced to capitulate to NTSP's demands. *See* IDF 221-48. We find that NTSP illegally utilized refusals to deal and termination of contracts to enhance the bargaining power of the participating physicians and command higher prices. Frech Tr. 1309-12; 1325.

Respondent argues, first, that NTSP's refusals to deal with payors are protected by the *Colgate* doctrine. RAB at 14-15, *citing United States v. Colgate & Co.*, 250 U.S. 300 (1919). This doctrine holds that a firm, acting unilaterally, may lawfully decide with whom it will, or will not, deal. *Colgate*, 250 U.S. at 307. Respondent views NTSP's refusals of payor offers as the lawful unilateral act of NTSP, and not the act of a group of horizontal competitors acting collectively through its agent, NTSP. RAB at 14-17. It reiterates for this purpose the familiar refrain that (1) NTSP does not have the ability to bind physicians, and (2) that each physician decides individually whether to accept a payor's offer. *Id*. Respondent also cites *Verizon Communications, Inc. v. Law Offices of Curtis v. Trinko, LLP*, 540 U.S. 398, 407-08 (2004), where the Supreme Court reaffirmed the *Colgate* doctrine, and warned that overly zealous enforcement of the antitrust laws can injure competition and innovation. Respondent argues that this admonition should apply to NTSP's refusals to deal. RAB at 15.

Second, Respondent argues as a policy matter that NTSP needs the ability to refuse contracts because it faces potential liability when it becomes a party to a payor contract. RAB at 16. Respondent explains that failure to perform obligations under a contract, involvement in illegal payor conduct, and involvement in deficient medical care can all subject NTSP to liability. *Id.* Further, Respondent states that NTSP has a reputation to protect and involvement in a contract with poor performance can damage NTSP's reputation. *Id.* at 16-17.

We hold that *Colgate* is inapplicable in this case because NTSP's refusals to deal are not the unilateral acts of a single entity but rather are the collective action of all its independent physician members. NTSP's inability to bind members, and the ability of NTSP physicians to reject payor offers does not preclude the conclusion that NTSP has agreed to fix prices. There is a distinction between NTSP's simple refusal to provide services itself and NTSP's refusal to provide services on behalf of the physicians it represents.[35] NTSP was not acting unilaterally but

[35] *See Indiana Fed'n of Dentists*, 476 U.S. at 465 ("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 Am., Inc. v. FTC*, 312 U.S. 457, 468 (1941)).

in concert with its physician members. NTSP's conduct therefore does not fall within the bounds of *Colgate*, and the *Trinko* case is similarly not relevant.[36]

NTSP's further claim that its conduct is a necessary protection against liability and loss of reputation is reminiscent of the agreement that was rejected out of hand in *National Society of Professional Engineers*, 435 U.S. 679, and is entirely without factual support. NTSP itself does not need to engage in price fixing to protect itself from liability and loss of reputation.[37] The conduct challenged in this matter does not have anything to do with this type of potential liability, and the evidence shows that NTSP's refusals to deal were motivated by concerns about price and not liability and reputation. For example, NTSP's former president Dr. Vance summarized NTSP's success in its negotiations with United in a letter to his medical group, writing "United Health Care came to town six months ago and offered a straight, 110% of Medicare contract. . . . Through the efforts of NTSP lobbying the City [of Fort Worth] and terming [terminating] a group contract with Health Texas, United blinked. . . . This United negotiation is a template for other efforts that will need to occur in the near future and would best be coordinated by NTSP." CX 0256; *see also* CX 1199 (Vance Dep. at 316-17). Equally compelling is the fact that once payors have capitulated to NTSP's price demands, NTSP's objections disappeared. *See, e.g.*, IDF 242-48. NTSP's statements and its conduct show an overarching concern over price and not other contractual terms.

e. NTSP's Deviations from the "Messenger Model"

Respondent argues that once it decided to become a party to payor contracts it followed the so-called "messenger model" specifically described in *Health Care Statement* 9C, and hence that its actions were lawful. RR at 16; *see* CX 387 at 1; CX 393 at 1; CX 186; CX 1075 at 2; CX 1122. After review of the evidence as a whole, we find that Respondent has deviated from the accepted parameters of a lawful messenger model in a manner that amounts to horizontal price fixing.

There is a wealth of guidance available on this subject. In addition to the discussion in the *Health Care Statements*, at least ten past Commission consents describe conduct that deviated from a lawful messenger model.[38]

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[36] *Trinko* involved conduct by a single firm charged with monopolization under Section 2 of the Sherman Act, not with "contract, combination or conspiracy" under Section 1 of the Sherman Act. *Trinko*, 540 U.S. at 407. Unlike this case, there was no allegation that the defendant in *Trinko* had agreed with others to fix prices or refuse to deal.

[37] NTSP can communicate with its physicians on non-economic terms of a contract without price fixing. Frech Tr. 1450.

[38] *See, e.g., In the Matter of Partners Health Network, Inc.*, Docket No. C-4149 (Analysis of Agreement Containing Consent Order, issued Aug. 5, 2005),

Properly used, a messenger model is an arrangement designed to reduce transaction costs associated with negotiation of contracts between providers and payors; it is not a device for facilitating horizontal agreements among providers on prices or price-related terms. In a messenger model, a physician network uses the agent to convey to payors information obtained individually from the providers about the prices or price-related terms that the providers are willing to accept, but the agent does not negotiate on behalf of the providers. The agent may convey to the providers all contract offers made by purchasers, and each provider then makes an independent, unilateral decision to accept or reject the contract offers. Alternatively, the agent may receive authority from individual providers to accept contract offers that meet certain criteria as long as the agent does not negotiate on their behalf. The agent can also assist providers to understand the contracts offered, by supplying objective or empirical information about the terms of an offer. For example, the agent may provide a comparison of the offered terms with other contracts agreed to by network participants. On the other hand, it would be dangerous for the agent to express an opinion on the terms offered. *See Health Care Statements, supra* note 2, *Statement* 9C.

If a messenger model is used improperly, it can facilitate an unlawful price-fixing agreement. In a legal messenger model, the agent only facilitates independent, unilateral decisions of the network providers. *Id.* It is illegal to use the messenger model in a way that creates or facilitates collective decisions on prices or price-related terms.

It is necessary to look at specific facts on a case-by-case basis, because there is not necessarily any single feature that determines the outcome. Some examples of activities that can tip the balance toward illegality are: agent coordination of provider responses to a particular proposal, dissemination to network providers of the views or intentions of other network providers about the proposal, expression of an opinion on the adequacy of price terms offered, collective negotiation of price terms for the providers, or decisions not to convey an offer if the agent believes the price terms are inadequate. *Id.* A fundamental question is whether the actions

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http://www.ftc.gov/os/caselist/0410100/0410100.htm; *In the Matter of San Juan IPA, Inc.*, Docket No. C-4142 (Analysis of Agreement Containing Consent Order, issued May 19, 2005), http://www.ftc.gov/opa/2005/05/sanjuan.htm; *In the Matter of Preferred Health Servs., Inc.*, Docket No. C-4134 (Analysis of Agreement Containing Consent Order, issued Mar. 2, 2005), http://www.ftc.gov/opa/2005/03/scdoctors.htm; *In the Matter of White Sands Health Care System, L.L.C.*, Docket No. C-4130 (Analysis of Agreement Containing Consent Order, issued Sep. 28, 2004), http://www.ftc.gov/os/caselist/0310135/0310135.htm; *In the Matter of Southeastern New Mexico Physicians IPA, Inc.*, Docket No. C-4113 (Analysis of Agreement Containing Consent Order, issued June 7, 2004), http://www.ftc.gov/os/caselist/0310134/0310134.htm.

of the messenger are designed to facilitate communications or, instead, to enhance the bargaining power of the providers.[39]

It is important to remember that any time an agent for a group of competitors engages in any discussions that tinge on the prices they will charge, the parties are in an antitrust danger zone. The so-called messenger model, described in the *Health Care Statements*, provides what the agencies believe is a legal path though this danger zone, but it is dangerous to stray off the route. It is not enough for a physician association simply to claim that it has intended to follow the indicated path; it must show that it actually has done so.

NTSP's refusal to messenger contracts where it determined, based on the results of its prospective price poll, that less than 50 percent of NTSP physicians would join, eliminates the ability of NTSP physicians to decide unilaterally whether to accept the un-messengered contracts and hinders the ability of payors to contract individually with NTSP physicians.[40] We also find that NTSP's PPA, use of powers of attorney and activities associated with its poll, discussed above, are inconsistent with an acceptable use of the model. The PPA and powers of attorney allowed NTSP to negotiate on behalf of its physicians, something expressly forbidden in a proper messenger model. The poll and minimum-fee schedule enabled NTSP to coordinate physician responses to payor proposals. NTSP also went beyond the bounds of legitimate messenger activities when it expressed its opinion both to its physician and to the payors themselves on the adequacy of price terms in contract proposals. *See Health Care Statements, supra* note 2, *Statement* 9C.

2. The Inherently Suspect Legal Analysis

The restraints described above, as a whole, are what we describe as inherently suspect under *Polygram*. The conduct itself can be said to have a likely tendency to suppress competition because the likelihood of anticompetitive effects from NTSP's restraints is sufficiently grounded in economic theory and supported in case law. Complaint Counsel's expert, Professor Frech, explained the economic rationale for the legal concerns about NTSP's conduct. Frech Tr. 1315-24. Through the mechanisms described above, NTSP was able to

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[39] There are other widely available materials describing the proper use of a messenger model. 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 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).

[40] *Cf.* Section V.C., which discusses the ability of an agent to charge a reasonable fee for these offers that are unlikely to be accepted.

collectively set prices and present its physicians as a unified and strong force within Fort Worth. These practices reduce the risk that payors would be able to contract around NTSP, and thereby enhance NTSP's bargaining power over price. Frech Tr. 1325-27; Grizzle Tr. 730, 746-47, 750-51. Because NTSP physicians comprise a large percentage of physicians in Fort Worth, their threat to withhold services severely damages the perceived adequacy of a payor's physician network, and makes it more difficult for a payor to obtain or maintain business. Grizzle Tr. 730-31; Jagmin Tr. 1091-92; Mosely Tr. 139-40. Payors are therefore more willing to pay the NTSP physicians' consensus price because of the threat to their physician networks. Grizzle Tr. 730, 746-47, 750-51; Frech Tr. 1325. NTSP itself summarized the concern succinctly: "NTSP has become a 'gorilla network' with 124 PCP's . . . and 528 specialists." CX 0209 at 2; CX 0310. Conduct that confers on competitors a collective power over price falls within the classic definition of price fixing.

Respondent argues that the Supreme Court's *California Dental* opinion prevents the Commission from condemning NTSP's conduct without a full rule of reason analysis. Respondent's first point in this argument is simply a reiteration of a claim already considered in another context. Respondent says that because there was no direct collusion among physicians,[41] NTSP's conduct meets *California Dental*'s threshold test for determining that a "quick look" rule of reason analysis is not appropriate.[42] RAB at 28-29. Respondent adds that a quick look rule of reason analysis is appropriate only in limited circumstances, when it can be shown that "the great likelihood of anticompetitive effects can be easily ascertained." *Id.* at 29 (*citing California Dental*, 526 U.S. at 771). Because there was no direct collusion among NTSP physicians, Respondent states that the only possible candidates for a quick look under *California Dental* are the PPA provision requiring physicians to notify NTSP of payor offers that they receive directly, and the powers of attorney. *Id.* Respondent further argues that because both of these have plausible procompetitive effects, NTSP's conduct must be judged under a full rule of reason. *Id.*

The first problem with Respondent's argument is that it depends on the faulty conclusion that there was no collusion among NTSP's physicians, simply because they did not directly communicate with each other. As discussed above in Section V.A., the physicians combined in other ways and their conduct can be characterized as price fixing. Moreover, *California Dental* essentially involved collective restrictions on advertising, not on the prices charged. The Court observed that the advertising restrictions in question were "very far from a total ban on price or discount advertising." *California Dental*, 526 U.S. at 773. The threshold question in *California*

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[41] As pointed out in Section V.A. above, the fact that the doctors did not communicate among themselves, but rather acted through a common agent, does not affect liability.

[42] We have used "inherently suspect" in *Polygram* and in this opinion to refer to conduct that may be justified in some circumstances but, absent these circumstances, can be condemned without an extensive demonstration of adverse market effects in the case at hand. We believe this level of inquiry is what the Supreme Court means by a "quick look."

Dental was whether the likelihood of anticompetitive effects from restrictions on professional price and quality advertising was sufficiently verifiable in theory and in fact to fall within a general rule of illegality. *Id.* at 771. The Court determined that the restrictions were, at least on their face, designed to avoid false or deceptive advertising in a market characterized by striking disparities between the information available to the professional and the patient. *Id.* Indeed, the Court expressed concern that "the particular restrictions on professional advertising could have different effects from those 'normally' found in the commercial world," *id.* at 773, and that "[t]he obvious anticompetitive effect that triggers abbreviated analysis has not been shown." *Id.* at 778. Unlike *California Dental*, this case involves prices, not advertising; the challenged conduct therefore has the necessary "obvious anticompetitive effect," and not something "very far" removed from it.

C. Respondent's Justifications

Respondent's justifications in this case are intermingled with its arguments about the existence of an agreement. *See generally* RAB at 14-18, 28-34, 45-57. We have attempted to sort them out into separate categories, for clarity.[43]

1. Teamwork and Spillover Efficiencies

Respondent argues that its risk panel physicians "use financial and clinical integration techniques to develop team-oriented improvements in cost and quality." RAB at 49. Respondent further argues that NTSP has a right to "limit" its involvement to non-risk contracts that will be of interest to most of its risk panel physicians, so that their participation will ensure the spillover of the efficient treatment patterns established in the risk contract. *Id.* We interpret Respondent's use of the word "limit" as intended to explain and justify its particular activities associated with its PPA, powers of attorney, refusals to deal and deviations from the messenger model. Respondent also argues that NTSP's poll and board minimums are tools that allow NTSP to identify when a non-risk offer will be of interest to most of its physicians, and therefore help it to enhance the spillover effects. *Id.* at 50.

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[43] Our analysis here deviates somewhat from Complaint Counsel's proffered analysis. Complaint Counsel's arguments against Respondent's proffered justifications are couched in terms of whether NTSP's price fixing was ancillary to any significant productive collaboration among its participating physicians. As we mentioned above in Section IV.A., the doctrine of ancillary restraints is subsumed in the *Polygram* analysis. (The *Polygram* methodology can also be used more broadly to deal with justifications of a different kind. It could be applied, for example, in a case like *Broadcast Music*, 441 U.S. at 20-25, where the argument was that the system could not function at all without collective agreement on price terms, or *United States v. Brown University*, 5 F.3d 658, 677 (3d Cir. 1993), where agreements on student aid could be characterized as pro-competitive overall.) When we use the terminology of *Polygram* rather than the terminology of ancillary restraints, it does not mean that we disagree with Complaint Counsel's alternative analysis.

We first do not accept Respondent's premise that NTSP's poll and efforts to "limit" NTSP's involvement to certain non-risk contracts are justified because they will help NTSP to determine when spillover efficiencies are likely to occur. *Id.* at 48-50. The prices NTSP sets through the minimum reimbursement schedule were not prices sought by risk panel doctors, but instead were averages of the members who responded, which includes non-risk doctors. IDF 51, 87, 89-90, 93. NTSP's Board members and senior management were never informed of individual poll responses; they received only aggregated, average results, which did not reveal to what extent risk panel physicians were likely to participate in non-risk contracts.[44] IDF 94-95. Although these limitations may be prudent, they undercut an argument that the minimum reimbursement schedule could help NTSP determine when spillover efficiencies would occur. As discussed above, it is evident that the poll and limitations were designed for another purpose. *See* discussion in Section V.B.1.a.

Respondent has thus failed to articulate a logical nexus between these activities that facilitate price fixing and the claimed efficiencies. As we stated in *Polygram*, a defendant

> must do more than merely assert that its purported justification benefits consumers. Although the defendant need not produce detailed evidence at this stage, it must articulate the specific link between the challenged restraint and the purported justification to merit more searching inquiry into whether the restraint may advance procompetitive goals, even though it facially appears of the type likely to suppress competition.

Polygram Comm'n Op., *supra* note 4, at 31-32.

This conclusion is reinforced by the statement of NTSP's executive director, Karen Van Wagner. During an investigational hearing when she was asked the question whether reimbursement rates at or above NTSP's contracting minimums were necessary in order for NTSP to achieve clinical integration, she testified:

> I think it's the other way around. We've achieved a certain degree of clinical integration. We've achieved a certain level of medical management. We've achieved a certain amount of cost savings, satisfaction, quality of care for the members. That basically is reflected in the rates that we ask the payors to give us because that's the value we provide them, so I view it the other way around. Clinical integration is necessary to justify the minimums that the members authorize us to go and try and find.

CX 1196 (Van Wagner IH at 145-46). We explained in *Polygram* that "a defendant cannot defend restraints of trade on the ground that the prices the conspirators set were reasonable, that competition itself is unreasonable or leads to socially undesirable results." *Polygram Comm'n*

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[44] Respondent even emphasized in its appeal brief that "it is impossible for [anyone] to determine the response of any specific physician or speciality, or even to determine whether they responded." RAB at 24.

Op., supra note 4, at 30-31. There is no antitrust exception for particularly efficient, higher quality market participants; NTSP is not entitled to "pre-empt the working of the market" to produce the result that it believes payors should choose. *Indiana Fed'n of Dentists*, 476 U.S. at 462. Individual non-risk physicians might well be able to command higher fees from payors if they can promise superior outcomes, but this superior efficiency alone would not justify the exercise of collective bargaining power.

There are additional flaws in the spillover efficiency claim. Respondent does not explain how the NTSP physicians who only enter into non-risk contracts could achieve spillover efficiencies from NTSP's single risk contract. This is a non-trivial point, because non-risk physicians make up half of NTSP's members. Van Wagner Tr. 1830; Frech Tr. 1349. Furthermore, NTSP does not even explain why its risk panel physicians will have the incentive to apply the quality and cost control techniques they utilize on risk patients to any non-risk patients they may have. NTSP has not provided any financial incentive for them to do so, and it does nothing to promote compliance with whatever techniques have been learned under risk contracts. IDF 364-80; Deas Tr. 2553-54. NTSP does not employ the processes it uses to monitor and control the quality and utilization of services provided under its risk contracts to patient care provided under non-risk contracts. IDF 364-80; Deas Tr. 2550-54.

We also note that Respondent's counsel admitted that risk contracts are out of favor in Fort Worth, Texas. O.A. at 23; *see also* Wilensky Tr. 2192; IDF 46, 48. NTSP's actions, purportedly justified as efforts to enhance spillover efficiencies from its one risk contract, seem to be perceived by customers merely as an attempt to regulate the terms of access to the more-desired non-risk product. *See generally* Frech Tr. 1349. This justification is inconsistent with the procompetitive aims of the antitrust laws and is not cognizable.

It is worth noting that we are not challenging NTSP's sole risk contract, which involves financial integration, but which NTSP's Board has acknowledged "is a small part of the business." CX 83 at 3. Moreover, Respondent does not make the argument that NTSP's non-risk contracts are sufficiently clinically integrated, as described in *Health Care Statement* 8B, to justify an in-depth rule of reason inquiry. In fact, Respondent all but admits that its administration of these contracts does not constitute clinical integration as commonly understood – *e.g.*, exchange of clinical information, coordination of treatment, development of protocols and monitored compliance. *See, e.g., MedSouth*, *supra* note 2, at 4-6. Indeed, NTSP's president, Ms. Van Wagner, stated that "NTSP isn't 'there yet' in terms of clinical integration for the care of nonrisk patients."[45] Van Wagner Tr. 1877.

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[45] Respondent argues instead that the concept of clinical integration does not encompass the full scope of conduct that is justifiable under the rule of reason, and that NTSP's "teamwork" yields sufficient cost and quality benefits. RAB at 51. We do not decide here whether there are potential justifications beyond what the Commission has accepted as "clinical" integration in the past. But Respondent's claim that NTSP's "teamwork" yields cognizable cost and quality benefits simply is not supported by significant evidence. Moreover, Respondent does

2. The PPA, Powers of Attorney, Refusals to Deal and Refusals to Messenger Contracts

Respondent also argues that NTSP's PPA notice provision, its use of powers of attorney, its communications with physicians and payors, and its refusal to messenger contracts have plausible procompetitive effects on their own. RAB at 45-57. The PPA ostensibly increases NTSP's contracting opportunities in the marketplace by informing NTSP of new contract opportunities. *Id.* at 30. The powers of attorney ostensibly were gathered by NTSP to inform it of which and how many physicians were willing to be messengered an offer through NTSP. RAB at 31. Respondent also argues that disclosure to physicians that NTSP will not be involved in a particular payor offer will alert physicians that they need to look to other contracting avenues with payors in those situations. RAB at 33.

In addition, Respondent claims that when it informs physicians about a payor's conduct or the status of a payor offer, it is merely collecting and disseminating market information.[46] *Id.* at 34, 53. Respondent states that the procompetitive effects of information sharing in the health care industry, even among competing physicians, is recognized by Complaint Counsel's economic expert and the Commission's advisory opinions. *Id.* Respondent also states that its refusal to convey payor contract offers with prices that NTSP believes are not sufficiently high to attract a majority of its participating physicians is efficient because a physician network has a plausibly valid concern about resources wasted if it were to transmit a payor's offer that is of interest to less than 50 percent of the physicians. *Id.* at 32.

The problem with these arguments is that most efforts by competitors to collectively agree on prices could be said to save costs in negotiations with customers. (Similarly, an agreement to allocate markets is likely to reduce selling expenses.) Arguments of this kind ultimately are based on the idea that competition itself is inefficient, and are thus not cognizable under the antitrust laws.[47] We explained in *Polygram* that "[c]ognizable justifications ordinarily explain how specific restrictions enable the defendants to increase output or improve product quality, service, or innovation." *Polygram* at 30. A justification will fail, however, if it contradicts the procompetitive aim of the antitrust laws. *Id.*

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not address how these nebulous "teamwork" efficiencies are dependent on its price-fixing activities.

[46] Respondent also states that NTSP's comments to a payor about the terms that physicians might find attractive or reasonable can help to educate the payor and expedite contract negotiations. RAB at 34. For reasons discussed in Section V.D. *infra*, this kind of activity is not necessarily suspect.

[47] *See, e.g., Maricopa,* 457 U.S. at 346; *Nat'l Soc'y of Prof'l Eng'rs,* 435 U.S. at 689-90; *Goldfarb,* 421 U.S. at 786-87.

These purported justifications are also inconsistent with the evidence. As discussed above in Section V.B.1., the evidence shows that NTSP's overriding purpose in each of these activities was to exploit its collective bargaining leverage over payors, not to achieve efficiencies. For example, Respondent's assertion that NTSP helps physicians to determine when they will need to communicate with payors in other ways (because of NTSP's refusal to deal) is absurd in light of the fact that NTSP routinely cautioned its physicians not to undermine NTSP solidarity and its pricing consensus. In an "Open Letter to the Membership," NTSP's Dr. Vance stated, "[w]e must continue to move forward as a group or we will surely falter as individuals." CX 0550. In another letter, NTSP warned its physicians that fees will decline unless "NTSP or someone can provide a unifying voice for physicians."[48] CX 0380 at 3. NTSP also implicitly urged its physicians to delay or forgo direct contracting during NTSP's negotiations with payors.[49] These actions are designed to enhance bargaining clout, not to increase efficiency from spillover effects, or to conserve resources, or to spread procompetitive benefits of information sharing.

3. Denial of Discovery Request in Support of Purported Justification

Respondent argues that the ALJ erroneously denied NTSP's discovery request for the payors' "flat file" data that would show how NTSP and other physicians performed on non-risk contracts. RAB at 45-46. Respondent claims that, without these files, it has limited capability to show how NTSP's performance compares to other physician providers. *Id*. Respondent also states that PacifiCare and Cigna had provided NTSP with some information in the normal course of business which showed that NTSP is the best performing group in the Dallas/Fort Wort Metroplex and that spillover from care under capitated contracts occurs. *Id.* at 46 n.190.

We find that the ALJ's denial of the discovery request was not detrimental to Respondent. In the absence of a specific link between the challenged restraints and the purported justification, it would not have mattered if Respondent had been able to obtain further discovery and demonstrate that its physicians performed well. There is no antitrust exemption for more

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[48] *See also* CX 0380 at 2 (informing its members that through "direct" negotiation or affiliation with other IPAs, NTSP obtained prices "5 to 15% over Tarrant County rates"); CX 0550 (stating to members that it "has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source").

[49] *See, e.g.*, CX 0310 (Dr. Deas advising NTSP physicians that "discussions are ongoing with Aetna U.S. Healthcare, Cigna, and other major players which should lead to contracts that are more favorable than we would be able to achieve individually or though other contracting entities"); NTSP regularly sent "fax alerts" to its members and held "General Membership Meetings" to continually provide contracting updates for specific payor negotiations and share NTSP's poll results with the membership. CX 1178 at 21-23 (Hollander Dep. at 21-23); CX 0173 – CX 0180; CX 0182 – CX 0188; CX 0615; CX 0945; CX 0903; CX 0617; CX 0628; *see also* Frech Tr. 1326-27.

efficient, higher quality market participants, absent a demonstration that the challenged practices made an essential contribution to these efficiencies.[50] Evidence on the performance of NTSP physicians, standing alone, would not prove that nexus.

D. Potentially Permissible Conduct

Although we have rejected the proffered justifications for NTSP's particular activities, we do not want this opinion to be read so broadly that it would chill potentially efficient practices. We do not question that NTSP's risk contract and its physicians who participate in it achieve efficiencies, and it could even be possible for these efficiencies to spillover to its non-risk contract in certain circumstances. As we discussed above in Section IV, if an IPA can establish that its joint negotiation of price is reasonably related to an efficiency-enhancing integration of the participants' economic activity and is reasonably necessary to achieve the procompetitive benefits of that integration, the price-related activities may be lawful. A good example of this is described in the Commission staff's advisory opinion letter to MedSouth, Inc., a multi-specialty physician practice association in Denver, Colorado.[51]

Commission staff did not object to MedSouth's partial integration proposal that included joint negotiation for the sale of its participating physicians' services to payors on a fee-for-service basis. *MedSouth, supra* note 2, at 1, 8-9. Commission staff concluded that MedSouth could plausibly produce sufficient procompetitive effects to justify joint negotiations of fees. *Id.* at 1, 8. This conclusion was based on the extensive clinical resource management program that MedSouth developed for its participating physicians, and that was described in detail in the advisory opinion letter. *Id.* at 2-4, 8. It is also noteworthy that MedSouth did not plan to

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[50] *See, e.g., Broad. Music*, 441 U.S. at 23-24 (declining to find blanket license fee plan *per se* illegal where plan contributed to integration of sales, monitoring, and enforcement against unauthorized copyright use); *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 693-95 (rejecting petitioners argument that preventing inferior work justified anti-competitive agreement).

[51] Another example is *In the Matter of California Pacific Medical Group, Inc.*, Docket No. 9306 (consent order issued May 11, 2004), http://www.ftc.gov/os/adjpro/d9306/index.htm, where Commission staff advised California Pacific Medical Group, Inc., d/b/a Brown & Toland Medical Group, that as of that time they would not recommend action against a clinically- integrated PPO product that Brown & Toland Medical Group created after entering into a consent order with the Commission. *See* Advisory Opinion Letter from Daniel P. Ducore, Esq. and David R. Pender, Esq., FTC, to Richard A. Feinstein, Esq., Boies, Schiller & Flexner, LLP (Apr. 5, 2005), http://www.ftc.gov/os/adjpro/d9306/050405cpbresponsetbtnotice.pdf.

negotiate contracts on behalf of its physicians until after the operational plan was fully functioning.[52] *Id.* at 4.

NTSP admittedly is not even close to having the efficiency-enhancing processes that MedSouth had committed to have before it began to negotiate for its physicians collectively. For example, NTSP has no disease management program or patient register that would improve health care quality for patients with specific, long-term conditions. Casalino Tr. 2812-14, 2839; Van Wagner Tr. 1834-36. NTSP has no data for patients under its fee-for-service contracts, and NTSP's hospital utilization management program does not apply to patients under its non-risk contracts. Casalino Tr. 2868-69; Frech Tr. 1352-53; Van Wagner Tr. 1837-38. Furthermore, NTSP does not require adherence to its clinical guidelines and protocols. Van Wagner Tr. 1843-44; *see also* Casalino Tr. 2837-39, 2840.

There could also be lawful ways for an association like NTSP to utilize some of the mechanisms discussed above, even without clinical or financial integration. NTSP could, for example, have lawfully polled its members on future fees in order to give payors a sense of the fee levels that would be acceptable to a majority of NTSP physicians, provided that (1) the results of the poll were not communicated back to the physicians in any manner, to avoid influencing their behavior; (2) NTSP did not use the polling results as a basis for determining which payor offers it would elect to messenger to the physicians; and (3) NTSP did not use the polling results to negotiate price with payors. *See Health Care Statements, supra* note 2, *Statement* 5B. NTSP could also lawfully charge an administrative fee to payors to compensate for the burden of messengering contracts that were unlikely to be accepted. For example, if a contract contained rates that were below the rate a threshold percentage of physicians were likely to consider acceptable based on the polling data, NTSP could impose a reasonable transmittal fee (to reimburse the association for an incremental burden, not to signal disapproval). If a payor refused to pay the fee in these situations NTSP could legally refuse to messenger the contract.[53]

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[52] For example, MedSouth developed a web-based electronic clinical data record system that allows MedSouth physicians to access and share medical information relating to their patients, including transcribed patient records, office visit notes, lab reports, radiographic reports, treatment plans, and prescription information. *MedSouth, supra* note 2, at 3. This system could be expected to increase efficiencies by reducing duplicative testing and procedures, expediting treatment, and decreasing medical errors and adverse drug interactions. *Id.* Also important was MedSouth's plan to adopt and implement clinical practice guidelines and performance goals relating to the quality and appropriate use of services provided by its physicians. *Id.* MedSouth had in place a plan to monitor and enforce physician compliance with the guidelines. *Id.* at 3-4.

[53] *See* Advisory Opinion Letter from Jeffrey W. Brennan, Esq., FTC, to Martin J. Thompson, Esq., Manatt, Phelps & Phillips, L.L.P. (Sept. 23, 2003), http://www.ftc.gov/bc/adops/bapp030923.htm, (Commission staff did not object to a physician IPA proposal to refuse to administer contracts where fewer than 50 percent of the physicians

Note that these modified practices would not be justified on the ground that they contribute to efficiency of medical practice in the same way that integration does. They rather contribute to the efficiency of the contract negotiation process itself. Because they are not designed to enhance the bargaining power of the physicians, they are not suspect in the first place. They are benign even in the absence of integration.

NTSP can also act as a messenger so long as it adheres to legal standards, which the antitrust agencies have attempted to summarize in the *Health Care Statements.* As discussed above, a key to a lawful messenger model is that the IPA must refrain from using prospective polling results in determining which payor offers it would elect to messenger, and refrain from any activity that amounts to influence over physicians, negotiations on their behalf and coercion of payors. NTSP can also review and comment on non-economic terms of a contract. Furthermore, NTSP can utilize powers of attorney or agency agreements in a manner that does not facilitate a price-fixing agreement. For example, a power of attorney could legally authorize NTSP to enter a contract on behalf of a physician when a physician's stated price minimum and other terms are met, so long as NTSP does not attempt to influence those key terms, or use powers of attorney to negotiate with a payor.[54]

There is also nothing inherently objectionable about physicians providing current price information to NTSP for a purpose that is unrelated to the actual establishment of prices. For example, NTSP physicians could agree collectively through NTSP to jointly adopt an electronic billing system that would permit them to run their offices more efficiently. If there are sufficient safeguards to shield the billing rates of individual physicians, the practice would not be suspect.

E. Necessity of Market Definition and Market Power

The ALJ held that it was necessary to define a relevant market, even when analyzing a *per se* unlawful price-fixing agreement. ID 61.[55] Complaint Counsel appeal the Initial Decision in part based on this conclusion, and argue that no proof of market definition or market power is required to establish a *per se* violation, *citing Socony-Vacuum Oil*, 310 U.S. at 221-22. CCAB at 35-36. Respondent argues that the rule of reason requires that the market must be defined in this case and that Complaint Counsel would have had this burden even in a *per se* case, citing *California Dental* and the Initial Decision. RAB at 36.

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accept, unless the payors agree to bear the group's contract administration costs).

[54] We warn, however, that the distinction between lawful and unlawful use of powers of attorney or agency arrangements and the messenger model may require careful counseling. As evidenced by NTSP's conduct in this case, there are many different ways that a power of attorney or agency arrangement and the messenger model can be abused in a manner that facilitates price fixing.

[55] Although Complaint Counsel did not define the market, the ALJ found sufficient evidence to do so on his own. ID at 61-64.

As made clear in the discussion above, we find that proof of market definition and market power is *not* required in this case because Respondent did not meet its burden of establishing a legitimate justification for NTSP's inherently suspect practices. The ALJ may have confused *identification* of a market in which anticompetitive effects are presumed to occur with *definition* of a relevant market in order to measure market share and draw inferences about market power. As we stated in *Kentucky Household Goods Carriers*, "[i]t is obviously necessary to identify the goods or services that are subject to the price-fixing or other anticompetitive restraint . . . [i]t is not necessary, however to show that these goods or services constitute a relevant antitrust product market, as described, for example, in the *Horizontal Merger Guidelines*." *Kentucky Household Goods Carriers*, Docket No. 9309, 2005 WL 1541547 at *11.[56] The restraints in *Kentucky Household Goods Carriers* were found to be illegal *per se*, but this distinction does not matter. As we have explained above in Sec. III.A., if a practice is either *per se* illegal or inherently suspect, the focus is on the nature of the conduct, not the nature of the market. If there is no legitimate justification for the practice, there is no need for a burdensome inquiry into market conditions. *See FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 433-36 (1990). Simply put, it makes no sense to undertake the exercise of market definition if it will not affect the outcome in any way.

Respondent also argues that Complaint Counsel submitted no empirical evidence in this case to prove NTSP's market power, or to prove that NTSP's conduct caused an anticompetitive effect in any market. RAB at 35- 44. Respondent asserts that NTSP does not have market power and that the numerous avenues through which physicians could and did contract undermine the possibility that any market power existed. *Id*. at 40-41. The ALJ found that NTSP did not receive higher rates than those that other physicians and physician groups were already receiving. ID at 82. The ALJ found only that NTSP obtained higher rates or more beneficial economic terms than the health care payors initially offered to NTSP. *Id.* at 82-83. Respondent states that this has no antitrust significance in the absence of a showing that physicians entered into a boycott conspiracy, because NTSP as an entity can choose to participate or not in a payor offer. RAB at 42-43. Furthermore, Respondent argues that Complaint Counsel's focus on physician rates totally ignores the cost and quality effects of patient care, which are more accurate measures of competitive performance. *Id.* at 43- 44.

We agree that higher physician rates, by themselves, are of no antitrust significance. They may indeed be associated with higher quality of care or with different competitive conditions in various localities. Evidence that payors increased their initial offers similarly is ambiguous, standing alone. Those matters are not what this case is all about; this case is about a

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[56] In fact, even in a full blown rule of reason case, it may not be necessary to calculate shares in a relevant market if more direct evidence of market effects is available. *See Indiana Fed'n of Dentists*, 476 U.S. at 460-61; *In the Matter of Schering-Plough Corp.*, Docket No. 9297, 2003 WL 22989651, at *9,11,13 (F.T.C. Dec. 8, 2003) (citations omitted), *rev'd on other grounds, Schering-Plough Corp. v. F.T.C.*, 402 F.3d 1056 (11th Cir. 2005), *petition for cert. filed* (U.S. Aug. 29, 2005) (No. 05-273).

concerted effort by NTSP's participating physicians to increase their bargaining power. As discussed above, because Respondent did not meet its burden to establish a legitimate justification for this inherently suspect conduct, NTSP's conduct can be condemned with no further analysis under *Polygram* and other authorities.

VI. Remedy

The Commission has wide discretion in its choice of a remedy for violations of Section 5 of the FTC Act. *FTC v. Nat'l Lead Co.*, 352 U.S. 419, 428 (1957); *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611 (1946). This discretion includes not just the prohibition of the illegal practice in the manner exercised in the past, but also so-called "fencing-in" relief, which refers to provisions in an order that are broader in scope than the conduct that is declared unlawful. Fencing-in relief is deemed necessary in some cases in order to prevent future unlawful conduct.[57] The Commission's remedy, however, must be reasonably related to the violation. *FTC v. Ruberoid Co.*, 343 U.S. 470, 473 (1952); *Jacob Siegel*, 327 U.S. at 613.

In this case, we have the benefit of the Commission's extensive experience in crafting appropriate remedies for physician IPAs that have engaged in conduct similar to that of NTSP. Over the years the Commission has fine tuned the relief necessary to prevent future illegal conduct in these cases. To the extent order provisions in these cases have proved ineffective or unnecessary, the Commission has appropriately modified them. The order we impose in this case – which was proposed by Complaint Counsel and is somewhat different than the ALJ's order – is consistent with recent past relief accepted in settlement in similar cases, and is based on the Commission's extensive experience. We are therefore confident that the relief will effectively remedy NTSP's illegal conduct and is neither too narrow nor too broad. Our order is designed to protect the public against any further violations by NTSP, but also to allow NTSP to pursue arrangements that may produce efficiencies without significant risk of anticompetitive consequences.

As usual, Paragraph I of the order defines terms that will be used, and Paragraph II contains general prohibitions against participation in or facilitation of a conspiracy among any physicians. It specifically prohibits agreements to "negotiate"[58] with any payor on behalf of physicians or to refuse to deal on their behalf. A proviso to Paragraph II, however, allows NTSP to engage in "qualified" risk-sharing or clinically-integrated arrangements, and even to set prices for its physicians' services when doing so is reasonably necessary to the joint arrangement.

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[57] *See, e.g., FTC v. Colgate-Palmolive Co.*, 380 U.S. 374, 395 (1965); *Kraft, Inc. v. FTC*, 970 F.2d 311, 326-27 (7th Cir. 1992).

[58] Although our order does not define the term "negotiate," we intend it to incorporate the distinctions described in *Health Care Statements* 4 and 5 between the lawful provision of factual information and views to payors (as in a true messenger model) and efforts to enhance the collective bargaining power of the participating physicians.

In a "qualified clinically-integrated joint arrangement," as defined by the order in Paragraph I.I., physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. Any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement. In a "qualified risk-sharing joint arrangement," also defined by the order (Paragraph I.J.), all physician participants must share substantial financial risk in order to create incentives for the physician participants jointly to control costs and improve quality. In both cases, any agreements on price or other terms must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

Paragraph III of the order allows NTSP to act as a messenger or an agent on behalf of physicians for contracts with payors, but for three years NTSP is required to notify the Commission in advance before it does so. This prior notice provision is necessary because of NTSP's past deviations from the messenger model. We have accepted this type of prior notice provision in the past. Our order also requires NTSP to terminate any non-risk contracts it negotiated on behalf of its physicians, so NTSP does not continue to benefit from its unlawfully negotiated contracts. Paragraphs IV.B. and C. set forth the terms by which NTSP is required to terminate the contracts, and additional related requirements. The remaining provisions of our order are either administrative in nature, or relate to NTSP's requirement to notify affected persons of the existence of the order. They impose little burden on NTSP. The order terminates after twenty years.

Respondent argues that the ALJ's order is not narrowly tailored to any antitrust violation properly found. Respondent first asserts that because there was no collusion among physicians, the ALJ's order is not supported in the record. It claims, for example, that because NTSP has the right to negotiate its own contracts, the remedy cannot prohibit NTSP from negotiating contracts. And because there was no collusion among the physicians, it says termination of NTSP's existing physician contracts is not warranted. RAB at 60-62. Respondent also argues that, as worded, prohibitions on NTSP's role in payor negotiations with physicians (particularly on information exchanges among physicians) would apply to non-price as well as price terms and thus conflict with *Health Care Statements* and applicable law. *Id.* at 62.

Respondent's arguments essentially restate their rejected claim that there have been no violations. We find that the prohibitions on collective negotiation and the need to terminate existing contracts are both "reasonably related" to NTSP's unlawful conduct. We also find that the ban on collective bargaining through the use of non-price terms as well as price terms is necessary to ensure that NTSP does not seek to perpetuate its unlawful conduct by orchestrating agreements through non-price or non-economic terms. We also find that it is necessary to terminate NTSP's contracts, so that NTSP's physicians do not continue to reap the benefits of their unlawful price fixing. Even though the contracts are already terminable at will, mandatory termination is necessary to avoid the risk that payors might fear retaliation or suffer short-term

competitive disadvantage if they voluntarily terminate a contract with NTSP. The Commission has used similar or broader fencing-in relief in other physician price-fixing cases.[59]

We find that the ALJ's order is inappropriately narrow in some of its core provisions and therefore fails to provide adequate protection against further violations. Paragraph II of the ALJ's order omitted provisions proposed by Complaint Counsel that would have prohibited agreements on terms of dealing with payors (*i.e.*, without regard to whether there is any agreement to "negotiate") and collective refusals to deal with payors. These limitations were based on the ALJ's view that a prohibition of agreements to refuse to deal would impose on NTSP a broad duty to contract with all payors. ID at 89. The language in our order does not mandate that result. The provisions in question have never been interpreted in that manner in numerous other orders that contain them. These provisions only prohibit conduct by NTSP "in connection with the provision of physician services." Any services provided by NTSP itself that are not directly related to the provision of physician services would not be covered and NTSP would not be forced to contract. As long as NTSP's conduct does not amount to an agreement among physicians to refuse to deal, NTSP will have the ability to refuse certain contracts.[60] Complaint Counsel have proposed the addition of the phrase "with respect to their provision of physician services" and a new definition of "physician services" in order to further clarify ths point. CCAB at 64-65. We have incorporated Complaint Counsel's proposed clarification.

Paragraph II of the ALJ's order failed to include language proposed by Complaint Counsel that would have prohibited agreements that physicians not deal individually with payors or through entities other than NTSP. We find that this is an important provision to include in this case because NTSP facilitated a price-fixing agreement through its physicians' agreement not to deal individually with payors while NTSP was conducting its own negotiations on their behalf *See* Section V.B.1.b. above.

The ALJ's order also contains two unwarranted provisos to Paragraph II of the order that could enable NTSP to continue its illegal conduct: (1) a statement that nothing in the order bars NTSP from "communicating purely factual information" about a payor offer or "expressing

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[59] *See, e.g., In the Matter of Partners Health Network, Inc.*, Docket No. C-4149 (consent order, issued Aug. 5, 2005), http://www.ftc.gov/os/caselist/0410100/0410100.htm, (order requires prior notice for three years before Partners Health Network, Inc. can participate in a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement); *In the Matter of New Millennium Orthopaedics, LLC*, Docket No. C-4140 (consent order, issued May 2, 2005), http://www.ftc.gov/opa/2005/06/fyi0543.htm, (order requires dissolution of IPA).

[60] As noted above, NTSP even has the ability to act as a "messenger" under the order. If Respondent complies with the standards for this activity, described in Section V.B.1.e. above, there would not be an order violation.

views relevant to various health plans,"[61] and (2) a provision stating that nothing in the order would "require respondent to violate state or federal law." ID at 94. We find that neither of the provisos is necessary to protect legitimate conduct by NTSP.[62] The communication of "purely factual information" is already covered by Paragraph III, which allows NTSP to act as a messenger and, given Respondent's history, we believe that advance notification is necessary for a period of time. In addition, because we have found that there is no basis for a claim that NTSP's refusals to deal were prompted by concerns over violations of law, we do not believe it is prudent to leave the door open for similar unfounded claims in the future. There is nothing in the order we enter that will require Respondent to engage in illegal activity.

Respondent finally argues that Complaint Counsel's proposed changes to the ALJ's order raise serious policy questions about the Commission's agenda on physician teamwork efforts. RR at 24. Respondent states that Complaint Counsel's order will chill legitimate conduct on NTSP's part in response to illegal conduct and breaches of contract by insurance companies, and will discourage teamwork efforts among physicians which do not fit the currently narrow definitions of risk-sharing or clinical integration. *Id.* at 31. Respondent also points out that it is difficult to find any economic evidence that the Commission's enforcement agenda has had any positive economic effect, in the effort to control total medical expenses. Respondent states that any Commission policy to arbitrarily limit innovation is questionable. *Id.* at 36-37.

Respondent's arguments here misunderstand the Commission's role in this industry. We have a responsibility to prosecute antitrust offenses, but, as stated at the outset, we also should foster pro-competitive, innovative delivery mechanisms for health care in this country. NTSP's illegal conduct has not helped it achieve any efficiencies. Our order, which proscribes only conduct used to carry out NTSP's unlawful price-fixing activities, will not inhibit any efforts to achieve efficiency and innovation though the teamwork or other integration of physicians. We describe in Section V.D. above the many constructive activities that an IPA can undertake, consist with the antitrust laws. And as noted above, Paragraph II of our order allows NTSP to engage in legitimate joint arrangements and even set prices for its physicians' services, but only when doing so is reasonably necessary to achieve the efficiencies of the joint arrangement.

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[61] The ALJ also limited the scope of a provision barring information exchanges. Paragraph II.B. of the ALJ's order prohibits the exchange of information about the terms on which physicians are willing to deal with a payor, but does not include a prohibition on exchange of information about a physician's willingness to deal with a payor. We have included this prohibition in past physician price-fixing Commission orders and believe it should be included in this order. NTSP was able to orchestrate its unlawful price-fixing scheme in part by communicating that its physicians were unwilling to deal with payors in certain situations.

[62] Nearly anything could be termed providing "information" and "views." For example, NTSP's announcement that its physicians will not contract with payors at prices below a certain level could be characterized as conveying factual "information" or as an "expression of views."

VII. Conclusion

For all of the reasons outlined above, we conclude that NTSP's contracting activities with payors amount to unlawful horizontal price fixing. Through the various mechanisms described above, NTSP was able to orchestrate price agreements among its physicians. In physician IPA cases like this one, the focus is not necessarily on any single price-fixing mechanism, but rather on the conduct as a whole. Here the evidence shows not only negotiation activity in aid of a collective agreement on a minium fee schedule, but also specific enforcement mechanisms – such as the powers of attorney and collective withdrawal from payor networks – in order to coerce agreement from payors. These actions viewed as a whole leave no doubt that the overriding purpose behind NTSP's conduct was to fix prices.

This is not really a close case. NTSP's conduct is similar to conduct that has been held *per se* unlawful and summarily condemned in other contexts. For the reasons stated, we have analyzed the conduct under our more flexible *Polygram* framework, and considered each of Respondent's defenses in depth. Our ultimate conclusion is the same.

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