DEPARTMENT OF JUSTICE

Antitrust Division

United States v. Mountain Health Care, P.A., Civil Action No. 1:02CV288–T (W.D.N.C.) Response to Public Comments

Notice is hereby given pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)–(h), that Public Comments and the Response of the United States have been filed with the United States District Court for the Western District of North Carolina in *United States* v. *Mountain Health Care, P.A.* Civil Action No. 1:02CV288–T (W.D.N.C., filed December 13, 2002). On December 13, 2002, the United States filed a Complaint alleging that defendant, Mountain Health Care, P.A. (''MHC'') and its physician owners and members, restrained competition in the sale of physician services to managed health care purchasers, in violation of Section 1 of the Sherman Act, 15 U.S.C. 1. The proposed Final Judgment, filed at the same time as the Complaint, requires MHC to dissolve.

Public comment was invited within the statutory 60-day comment period. Such Comments, and the Responses thereto, are hereby published in the **Federal Register** and have been filed with the Court. Copies of the Complaint, Stipulation, proposed Final Judgment, Competitive Impact Statement, Public Comments and the Response of the United States are available for inspection in Room 4000 of the Antitrust Division, Department of Justice, 1401 H Street, NW., Washington, DC 20530 (telephone: 202–307–0001) and at the Office of the Clerk of the United States District Court for the Western District of North Carolina, Room 212, 401 West Trade Street, Charlotte, North Carolina.

Copies of any of these materials may be obtained upon request and payment of a copying fee.

Constance K. Robinson,

Director of Operations, Antitrust Division.

United States District Court for the Western District of North Carolina

United States of America, Plaintiff, v. Mountain Health Care, P.A. Defendant; Response to Public Comments

[Civil No.: 1:02CV288–T; Filed]

Pursuant to the requirements of the Antitrust Policies and Procedures Act, 15 U.S.C. 16(b)–(h) (the ''APPA'' or ''Tunney Act''), the United States responds to public comments received regarding the proposed Final Judgment submitted for entry in this civil antitrust proceeding.

I. Background

On December 13, 2002, the United States filed a civil antitrust complaint alleging that defendant, Mountain Health Care, P.A., (''MHC'') and its physician owners and members, restrained competition in the sale of physician services to managed health care purchasers, in violation of Section 1 of the Sherman Act, 15 U.S.C. 1. MHC is a physician-owned network consisting of the vast majority of physicians practicing in the greater Asheville, North Carolina area. MHC was formed in 1994 to increase the bargaining power of its physicians with managed care insurance companies, self-insured employers, and third-party administrators (collectively, ''managed care purchasers''). Complaint ¶ 8; Competitive Impact Statement (''CIS'') II.B. To facilitate that objective, MHC and its physicians established a uniform fee schedule that it incorporated into contracts with certain managed care purchasers. Complaint ¶ 10. The use of that fee schedule eliminated price competition among MHC's physicians, who did not clinically or financially integrate their practices in a way that would have justified their collective price setting conduct. Complaint ¶11. This resulted in increased physician reimbursement fees to managed care purchasers in the greater Asheville area. Complaint ¶14. MHC also exclusively represented its member physicians in negotiations with certain managed care purchasers. Complaint ¶ 13.

Also on December 13, 2002, the United States filed a proposed Final Judgment and a Stipulation signed by both it and defendant MHC agreeing to entry of the Final Judgment following compliance with the Tunney Act. Pursuant to the Tunney Act, the Stipulation, proposed Final Judgment and Competitive Impact Statement (''CIS'') were published in the **Federal Register** on January 10, 2003. 68 FR 7, 1478–1482. A summary of the terms of the Complaint and the proposed Final Judgment were published for seven consecutive days in the Asheville Citizen-Times from January 24 through January 30, 2003. Pursuant to U.S.C. 16(b)–(d) the 60-day period for public comments on the Proposed Final Judgment began on January 11, 2003 and expired on March 12, 2003. During that time, nine comments and one *amicus* brief were received.

II. Response to Public Comments

A. Amicus Brief Filed by S.M. Oliva, President of Citizens for Voluntary Trade, and the Comments of Citizens for Voluntary Trade

On February 15, 2003, S.M. Oliva, president of Citizens for Voluntary Trade (CVT), filed a motion for leave to file an *amicus curiae* brief. Attached to that motion was Oliva's 7-page *amicus* brief (attached, along with the motion, as Exhibit A). On March 7, 2003, Oliva submitted the 48-page Public Comments of Citizens for Voluntary Trade to the Proposed Final Judgment (Exhibit B), repeating the same arguments made in Oliva's *amicus* brief and including lengthy recitations of CVT's view of the history of the government's intervention in health care and other ''background'' information. On March 19, 2003, the United States filed a response to Oliva's *amicus* request, stating that it did not oppose the Court accepting his brief and treating it as another comment to the Proposed Final Judgment. On March 27, 2003 the Court ordered that Oliva's *amicus* brief be treated as a supplemental comment to the proposed Final Judgment. In this Response, the United States responds to the assertions made in both Oliva's *amicus* brief and CVT's comments.

1. CVT's and Oliva's Arguments About Why This Case Should Not Have Been Brought Are Irrelevant in a Tunney Act Proceeding

The vast majority of the comments made by CVT and Oliva relate to whether this case should have been filed in the first instance, not to whether the relief in the Proposed Final Judgment is adequate to address the harm alleged in the Complaint. *E.g.,* Exh. A at 3 (''no need for the government's proposed remedy—dissolution of MHC—because there is no illegal behavior taking place''). Oliva asks the Court to dismiss the complaint for failure to state a claim. Exh. B at 13. Because Oliva relies on factual assertions beyond the scope of the allegations in the Complaint, this request is, in effect, a motion, under Rule 56 of the Federal Rules of Civil Procedure, for summary judgment against the United States.

Comments alleging that the United States does not have sufficient evidence to support the case it has pled, and requesting dismissal of the United States' complaint, are beyond the scope of this hearing. A Tunney Act proceeding is not an opportunity for a ''*de novo* determination of facts and issues,'' but rather is intended ''to determine whether the Department of

Justice's explanations were reasonable under the circumstances'' because ''[t]he balancing of competing social and political interests affected by a proposed antitrust decree must be left, in the first instance, to the discretion of the Attorney General.'' *United States* v. *Western Elec. Co.,* 993 F.2d 1572, 1577 (D.C. Cir. 1993) (citations omitted). Courts consistently have refused to consider ''contentions going to the merits of the underlying claims and defenses.'' *United States* v. *Bechtel,* 648 F.2d 660, 666 (9th Cir. 1981.) CVT contends that the legislative history of the Tunney Act authorizes a review of the merits of the underlying case, and not just the adequacy of the proposed relief. Exh. B at 44–45. This is incorrect. During the Senate hearings on the Act, one witness specifically urged that ''as a condition precedent to * * * the entry of a consent decree in a civil case * * * the Department of Justice be required to file and make a matter of public record a detailed statement of the evidentiary facts on which the complaint * * * was predicated.'' [1] That recommendation, however, was rejected. Congress did not intend to turn every Tunney Act proceeding into a full-blown trial on the merits of the Untied States' complaint.

For this reason, assertions that the Untied States lacks jurisdiction, that MHC was a non-exclusive physician network, that it was really operating under a ''messenger model'' of contracting that has been approved by the United States, and that MHC's conduct did not cause anti-competitive effects—all of which pertain to the merits of the underlying case, but not the proposed remedy—are irrelevant to this proceeding, and should not be considered by this Court.[2] Nonetheless, the United States responds to those assertions below.

2. The Complaint States a Claim Upon Which Relief Can Be Granted

Even if CVT or Oliva had the right to file a motion to dismiss the Complaint under Rule 56, that motion would fail because the Complaint states a claim upon which relief can be granted. *Federal Trade Commission* v. *Indiana Federation of Dentists,* 476 U.S. 447 (1986) (A horizontal agreement by health care providers, causing an anticompetitive impact on third party payors, is an unreasonable restraint of trade). CVT and Oliva have not provided any evidence to dispute the allegations made in the Complaint. Nor do CVT or Oliva appear to have any independent knowledge of the health care market in Western North Carolina. Rather, it appears they reach their concussions on the basis of what Oliva says he learned during a telephone interview with Ellen Wells, President of defendant MHC, and from reading newspaper articles found on the defendant's Web site.[3] The interest of CVT and Oliva appear to stem less from their knowledge of the Western North Carolina physician market and more from their ideology that the antitrust laws in general are unconstitutional, and that antitrust enforcement against physicians promotes socialism.[4]

The information already disclosed in the Complaint provides sufficient basis for this Court to make a public interest determination. The request of CVT and Oliva for highly detailed market information—for example, data to ''assess the state of the affected marketplace'' and ''empirical evidence demonstrating how the proposed remedy is likely to restore competition'' (Exh. A at 5)—is not justified. As noted above, this request is not relevant in this Tunney Act proceeding to the extent it relates to whether the United States had a good faith basis for concluding that MHC's conduct was anticompetitive and violated the antitrust laws. *See supra,* Section II.A.1. The United States is not required in its Complaint or in a Tunney Act proceeding to specify in detail all of the evidence upon which it based its decision to file a case here. Indeed, Congress specifically rejected such a requirement when the Act was being considered in the Senate. *See supra* Section II.A.1. Requiring the disclosure of this kind of evidence—that akin to the kind of information that would have to be disclosed during litigation in expert reports and other filings—would substantially undermine the benefits of settling government antitrust cases. One of the major benefits of antitrust consent judgments is that they enable the government ''to reallocate necessarily limited [enforcement] resources,'' *Microsoft Corp.,* 56 F.3d at 1459, and that benefit would be lost if the United States were forced to compile and disclose during a Tunney Act proceeding the same kind of information it is required to disclose during litigation.

a. The United States has jurisdiction to challenge Mountain Health Care's conduct in this case. CVT questions whether the United States has jurisdiction to bring this case because at least some of MHC's contracts were with businesses organized and doing business solely in North Carolina. Exh. B at 6–9. As alleged in the Complaint, MHC has contracts with out-of-state employers and those businesses ''remit substantial payments to MHC physicians in North Carolina.'' Complaint ¶ 5. This is more than sufficient to meet the Sherman Act's expansive reach. *Summit Health, Ltd.* v. *Pinhas,* 500 U.S. 322 (1991) (interstate commerce nexus found where hospital and medical staff conspired to exclude single physician from Los Angeles market); *McLain* v. *Real Estate Board of New Orleans, Inc.,* 444 U.S. 232 (1980) (price fixing by local real estate brokers); *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738 (1976) (conspiracy to block relocation and expansion of rival hospital).

CVT further claims that, beyond the question of jurisdiction, this case raises the question of whether it is in the ''public interest'' for the United States to bring the charges because such an action infringes upon the ''regulation of private health care networks'' by the State of North Carolina. Exh. B at 8. Nothing about this case, or any of the relief in the Proposed Final Judgment, undermines the state's regulation of health care providers.

b. Mountain Health Care was an exclusive network with substantial market power. Based solely on hearsay, CVT and Oliva claim that MHC is not really an exclusive network, that its providers contract freely with other networks and plans, and that those patients covered by MHC contracts make up only 8% of the patients seen by MHC's providers. *E.g.,* Exh. B at 10. Whether a physician network is ''exclusive'' or ''non-exclusive'' is

[1] The Antitrust Procedures and Penalties Act: Hearings on S. 782 and S. 1088 Before the Subcommittee on Antitrust and Monopoly of the Senate Judiciary Committee, 93d Cong., 1st Sess. 26, 57 (1973) (prepared statement of Maxwell M. Blecher, attorney).

[2] Even farther afield are the lengthy and wide-ranging attacks in CVT's comments on various other subjects: The Medicaid and Medicare statutes (Exh. B at 14); the HMO Act of 1973 (*id.* at 15); settled Supreme Court precedent, *Arizona* v. *Maricopa County Medical Society,* 457 U.S. 332 (1982), holding that price fixing by physicians is unlawful (*id.* **AT 18–20);** the Health Care Policy Statements issued by the Department of Justice and Federal Trade Commission (*id.* at 20–23); the ''morality'' of this case and others like it, which in CVT's view are not designed to protect consumers but to ''deny wealth to its rightful owners'' (*id.* at 23–25); and several cases against physician groups brought not by the Untied States Department of Justice, the plaintiff in this case, but by the Federal Trade Commission (*id.* at 26–36).

[3] Exh. A at 3 n.5 and accompanying text (citing Jan. 23, 2003 telephone interview); Exh. B at 46 (relying on information ''Mountain president Ellen Wells told CVT''); Exh. B Appendix A (attaching several documents from Mountain Health Care website).

[4] *See* CVT Comment at 36 (''the Sherman Act is unconstitutional in CVT's judgment''); at 48 (government's enforcement efforts moving country ''closer towards the complete socialization of health care under central control'').

relevant to an inquiry into the competitive effects of that network. As explained in the Health Care Policy Statements issued by the U.S. Department of Justice and Federal Trade Commission:

> In an 'exclusive' venture the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans. In a 'non-exclusive' venture, on the other and, the physician participants in fact do, or are available to, affiliate with other networks or contract individually with other plans.

U.S. Department of Justice and Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust (''Health Care Policy Statements'') August 1996, at 58, available at *http://www.atrnet.gov/policies/health.* [5] Those guidelines set forth ''antitrust safety zones,'' meaning that the government would not challenge absent extraordinary circumstances, exclusive physician joint ventures comprising 20 percent or less, and non-exclusive ventures comprising 30 percent or less, of the physicians in each specialty with active hospital privileges who practice in the relevant geographic market and share substantial financial risk. *Id.* at 58–59.

In this case, MHC was a physician-owned network made up of the vast majority of physicians practicing in the Asheville area—in some specialties, 100 percent of the physicians—who did not share financial risk. Further, MHC, and members of its Board, made substantial efforts to discourage physicians from joining other networks.

The assertion that MHC's members comprise only 8 percent of the provider's patient base is misleading because that calculation includes in the denominator a substantial number of patients that are not affected by MHC's contracting practices with managed care plans: Those patients covered by Medicare and Medicaid and those patients with no insurance at all.[6] Further, in the provision of physician network services to employers self-insuring for their employees health care benefits, MHC had nearly 100% of the market.

At a more basic level, MHC possessed substantial market power given the fact that such a high percentage of Asheville-area physicians were members. This is apparently not disputed by CVT, which concedes that, ''[i]f every doctor now affiliated with Mountain were to cease practicing medicine tomorrow, the managed care companies and consumers in western North Carolina would have no recourse.'' Exh. B. at 43.

c. Mountain Health Care did not use a ''messenger model'' in contracting with managed care plans. CVT and Oliva allege—again, based solely on hearsay information—that MHC was no longer using its uniform fee schedule but rather using (or ''transitioning'' to) a ''messenger'' model in contracting with managed care purchasers. Exh. A at 3; Exh. B at 5–6. The Health Care Policy Statements describe how a physician network is able to contract with managed care purchasers on behalf of competing physicians without engaging in *per se* unlawful price fixing, by using a ''messenger model''. The ''messenger model'' is an arrangement where a third party offers each individual physician an opportunity to decide individually whether or not to accept an offer from a managed care provider. Health Care Policy Statements, August 1996, at 114, available at *http://www.atrnet.gov/policies/health.* ''The key issue in any messenger model arrangement is whether the arrangement creates or facilitates an agreement among competitors on prices or price related terms.'' *Id.* Proper use of the messenger model may mean that a physician network's conduct may not rise to the level of *per se* illegal price fixing, but it does not mean, as Oliva and CVT appear to believe, that any agreement among physicians to ''messenger fees'' is insulated from antitrust challenges, when, as here, the agreement has resulted in actual anti-competitive effects.

The United States thoroughly investigated the issue of whether Mountain Health Care's conduct was causing actual anticompetitive effects, regardless of whether it was using a messenger model. It bears clarification, however, that the Complaint alleges that Mountain Health Care was not merely a messenger for its member physicians; it was their exclusive bargaining agent. Physicians bargained through MHC which developed a uniform fee schedule for use in those negotiations. That collective activity among physicians to establish and bargain with that fee schedule anticompetitively raised the prices paid for physician services and thus violated section 1 of the Sherman Act. CIS, II.C.

d. Mountain Health Care's conduct resulted in a substantial lessening of competition and increased prices paid by managed care plans. Despite the Complaint's allegations to the contrary, CVT and Oliva argue that MHC's conduct did not lessen competition or increase prices, and accuse the United States of disclosing inadequate information in its Complaint and CIS about the relevant market in which MHC competed, the prices it was charging, and how its actions actually harmed consumers. Exh. A at 4–6; Exh. B at 9–13, 37–38. These arguments lack merit.

As alleged in the Complaint, the relevant market affected by MHC's conduct is Western North Carolina, encompassing Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey Counties. Complaint ¶ 2. Within that market, MHC possessed substantial market power, given that its membership included the vast majority of physicians practicing in that market, including the bulk of physicians with admitting privileges at Mission St. Joseph's Hospital, the only hospital available to the general public in the Asheville area. Complaint ¶ 8.

MHC's collective price-setting activity increased prices paid by managed care purchasers. Complaint ¶ 17. This is not surprising, given that MHC was created in 1994 for the purpose of increasing its members' bargaining leverage over managed care purchasers. Complaint ¶ 8; CIS § II.B.

3. There Are No ''Determinative'' Documents

CVT and Oliva assert that the United States is withholding ''determinative'' documents, in violation of the Tunney Act. Exh. at 4, 6; Exh. B at 38–40. The Tunney Act requires that the United States make available to the public copies of the proposed Final Judgment ''and any other materials and documents which the United States considered determinative in formulating such proposal.'' 15 U.S.C. 16(b). The scope of documents considered

[5] The Health Care Policy Statements were originally issued by the United States Department of Justice and the Federal Trade Commission in 1993 to clarify the types of cooperative conduct that health care providers, including physician networks, could engage in without concerns of violating antitrust laws. To further clarify what cooperative conduct was permissible, the agencies committed to issuing expedited Department of Justice business reviews and FTC advisory opinions in response to requests for guidance on specific proposed conduct involving the health care industry.

[6] These numbers are substantial. In the 17 counties served by MHC, there are approximately 150,000 Medicare beneficiaries (*see www.cms.gov/healthplans/statistics/mpsct/*), and 66,000 Medicaid enrollees (*see www.dhhs.state.nc.us/dma/ca/enroll/caenrl1102.pdf*). In addition, approximately 15% of the North Carolina's population as a whole is uninsured. *www.unitedhealthfoundation.org/shr2002/components/risks/LackHealthInsurance,* citing Current Population Survey, March 2002, U.S. Bureau of the Census.

determinative, however, is extremely limited. Only documents that were ''a substantial inducement to the government to enter into the consent decree'' are subject to disclosure. *United States* v. *Bleznak, et al.,* 153 F.3d 16, 20–21 (2d Cir. 1998). *See also Massachusetts School of Law at Andover, Inc.* v. *United States,* 118 F.3d 776, 784 (D.C. Cir. 1997) (only documents, ''such as reports to the government, 'that individually had a significant impact on the government's formulation of relief—*i.e.,* on its decision to propose or accept a particular settlement' '' need be disclosed). Even the one case cited by CVT recognized that the Tunney Act ''does not require full disclosure of Justice Department files, or grand jury files, or defendant's files, but it does require a good faith review of all pertinent documents and materials and a disclosure of those ''materials and documents that substantially contribute to the determination [by the government] to proceed by consent decree * * *.'' *United States* v. *Central Contracting Co.,* 537 F. Supp. 571, 577 (E.D. Va. 1982).

In this case, there are no determinative documents. The United States conducted a thorough investigation, involving the review of extensive documents from MHC as well as from MHC physicians, customers, and competitors. None were determinative in the decision to seek MHC's dissolution, nor were there any that constituted a substantial inducement to seek such relief.

4. The Dissolution of Mountain Health Care Is a Reasonable Remedy Given Its Substantial Market Power and Conduct Over the Past Nine Years

The dissolution of MHC is an appropriate remedy based upon the facts cited in the Compliant and CIS. These facts show that MHC was created in part to enhance its market power through collective negotiations, that it has effectively used that market power through the use of a common fee schedules since its creation, and continued to enter or renew contracts under that common fees schedules until shortly before agreeing to dissolve. The Count is required to determine not whether a particular decree is the one that will best serve society, but whether the settlement is ''within the reaches of the public interest.'' More elaborate requirements might undermine the effectiveness of antitrust enforcement by consent decree.[7]

An argument that injunctive relief would be appropriate here, because the FTC accepted injunctive relief in other cases involving physicians, has no legal basis. The settlement in a matter between two parties is in no way binding on the manner in which a future matter between two different parties is settled, even if there are some similarities between the matters. Antitrust investigations are very fact specific matters. The particular facts in this investigation led the United States to conclude that the dissolution of MHC was likely to be far more effective than any injunctive relief would be.[8]

5. None of the Various and Inconsistent Request for Relief Made by CVT and Oliva Are in the Public Interest

In the *amicus* brief, Oliva requests the Court to require the United States to file a revised Complaint and Competitive Impact Statement, and then extend the public notice and comment period to permit third parties to comment on these revised disclosures. Exh. A at 7. In his comment on behalf of CVT, however, he makes the contradictory request that the Court reject the proposed Final Judgment, dismiss the Complaint with prejudice, and impose sanctions on the United States under Rule 11.[9] Exh. B at 46–47.

There is no justification for either of these contrary request. The United States made appropriate disclosures of all information. Further, to delay this proceeding would not be in the public interest. Mountain Health Care has been in existence for nine years, using its uniform fee schedule during that entire time. Entry of the Proposed Final Judgment would quickly remedy the competitive harm caused by this conduct.

B. Comment From Center for the Advancement of Capitalism

The Center for the Advancement of Capitalism (''CAC'') submitted a comment raising, in summary form, the same arguments raised by the comment and brief filed by CVT and Oliva.[10] CAC claims, based solely on MHC's assertions, that MHC is complying with the government's Health Care Policy Statements because it is using a ''messenger model.'' Exh. C at 1–2. It accuses the United States, in seeking to reduce health care costs, of ignoring the individual rights of Physicians and resulting in the ''the partial socialization of medicine absent clear congressional authority.'' *Id.* at 2. It accuses the United States of specifically targeting physician groups that are unlikely to offer a defense. *Id.* at 2. And it repeats CVT's assertions that the United States has limited jurisdiction (''tenuous at best'') because MHC's conduct did not affect interstate commerce. *Id.* at 2–3.

All but one of these arguments have been addressed, in detail, in response to CVT's and Oliva's comments. CAC's general accusation that the United States targets physician groups unable to defend themselves is not correct. In this matter, as in all of its matters, the United States targets conduct that is causing substantial anticompetitive effects and is harming consumers.

C. Comment From Marcia L. Brauchler, Physicians Ally, Inc.

Ms. Brauchler, who operates Physicians Ally, Inc., a consulting business which assists physicians in dealing with insurance companies and other payors, submitted a comment opposing the proposed Final Judgment. In her view, the United States ''lacks insights into the practices of MHC's business,'' which was trying in good faith to comply with the government's Health Care Policy Statements. From her personal experience, she believes that the government claims that ''no one operates the messenger model correctly,'' and that physicians are therefore presumed guilty from the outset of an antitrust investigation. She believes that the antitrust laws were intended to be applied to insurance companies, not physicians, who are not, in her view, the cause of rising health insurance premiums. She does not believe that anyone was hurt by MHC's practices. Like CVT and CAC, she states that physicians, as United States citizens, have an absolute right to associate with other professionals for their mutual benefit unless they implement ''actual force against other individuals.'' Finally, she questions

[7] *United States* v. *Bechtel Corp.,* 648 F.2d at 666 (citations omitted) (emphasis added); see *United States* v. *BNS, Inc.,* 858 F.2d 463; *United States* v. *National Broadcasting Co.,* 449 F. Supp. 1127, 1143 (C.D.Cal 1978); *United States* v. *Gillette Co.,* 406 F.Supp. at 716. *See also United States* v. *American Cyanamid Co.,* 719 F.2d 558, 565 (2d Cir. 1983), cert. denied, 465 U.S. 1101 (1984).

[8] CVT's allegation that the United States never consulted customers who would be affected by the dissolution of MHC during the course of the investigation is correct. The United States discussed this possible remedy with numerous MHC customers.

[9] Oliva and CVT have opposed several recent antitrust consent decrees. Many of their comments, both official and unofficial, can be read at the CVT Web site, *www.voluntarytrade.org.*

[10] Oliva is currently a senior fellow at CAC. Exh. A at 1. According to its comment, CAC is a tax-exempt organization that applies Ayn Rand's philosophy of Objectivism to contemporary public policy issues in order to identify and protect the individual rights of the American people. Exh. C at 1 n.1.

why MHC is being forced to disband while other physician groups which have been sued in the past were allowed to continue to operate. Exh. D at 1–2.

As she states in her comment, Ms. Brauchler has had personal experience in settling government antitrust cases. Exh. D at 1. She was a defendant in two antitrust actions brought by the Federal Trade Commission last year, challenging her role representing two physician groups in fee negotiations with managed care purchasers.[11] As with CVT and CAC, the vast majority of her comments relate to whether the United States had a valid basis for finding a violation and filing this case, matters not relevant to this proceeding. *See supra,* Section II.A.1. Based on its thorough investigation during the past two years, the United States believes it obtained evidence about the business practices of MHC and that evidence shows that employers, particularly those employers who opt to self-insure for their employees health care benefits, were hurt by MHC's actions. Ms. Brauchler's implication that the United States is not applying the antitrust laws to insurance companies is simply not true. The United States has brought a number of actions against firms in the health insurance industry.[12]

Finally, the argument that injunctive relief would be appropriate here, because the FTC accepted injunctive relief in other cases involving physicians, as noted in response to the CVT's comments, has no legal basis. Antitrust investigations are very fact-specific matters. The particular facts in this investigation led the United States to conclude that the dissolution of MHC is likely to be far more effective than any injunctive relief would be.

D. Comment From Anonymous ''Concerned Employees''

An anonymous group of ''concerned employees,'' submitted a comment in support of the proposed Final Judgment. This comment states that is ''common knowledge'' among current and former employees that Ellen Wells, MHC's chief executive officer, ''purposely put off changing to Messengering because she was under the impression that the DOJ would just disappear,'' and because she believed that it would affect MHC's collections and impact her bonus. Exh. E. Other than expressing support for the dissolution of MHC this comment is primarily a personal criticism of Ms. Wells and raises issues that are not relevant to the relief contained in the proposed Final Judgment.

E. Comment From Anonymous Person Attaching Newspaper Advertisements

An anonymous person submitted a comment asking why MHC, if it engaged in the conduct alleged in this case, would run newspaper advertisements implying that it did nothing wrong. Exh. F. This comment does not address the substance of the proposed Final Judgment, and should be considered by the Court.

F. Comment From Janine Mazur, Mountain Health Care Department Head

Ms. Mazur submitted a comment criticizing the government's investigation and filing of this case. She states her opinion that MHC's collective rate setting has not resulted in higher physician reimbursements, claiming that MHC's fee schedule had not been changed since the start of the company. She opines that the physicians intended to provide cost-effective health care, not increase their fees. She believes that the dissolution of MHC will increase the cost of health care because it will increase the market power of national insurance carriers such as Aetna and Cigna, which have higher fee schedules than MHC's schedule. Exh. G.

Ms. Mazur is a department head of MHC, a fact that she does not disclose to the Court in her letter. Although she criticizes the proposed dissolution of MHC, her substantive comments relate entirely to the decision to bring this case in the first instance. As noted above, such comments lack any relevancy in this Tunney Act proceeding. *See supra.* Section II.A.1. Moreover, the United States conducted a thorough investigation of MHC's conduct here, and concluded that MHC's conduct reduced competition, increased prices, and that its dissolution will have a procompetitive effect on the market.

G. Comment From Steward M. Auten, President of Auten Printing, Inc.

Mr. Auten submitted a comment criticizing the government's decision to file this case. In his view, the case is based on ''emotions, circumstantial evidence, hype and superficial information.'' He believes that MHC gives quality care and lower rates, and that the dissolution of MHC will increase health care costs in Western North Carolina. Exh. H.

Again, Mr. Auten's comment relates to the government's decision to file this case, which is not a relevant issue here. *See supra,* Section II.A.1. That decision was made after a thorough, two-year investigation of the local market. One focus of that investigation was to assess the effect that Mountain's collective rate setting conduct had on the fees paid by employers in Western North Carolina. To do that, the government interviewed numerous employers in the area and concluded that MHC's conduct was increasing their health care costs.

H. Two Comments From Individual Consumers

Two comments were received from individual consumers, Mike and Gale Grooms, who have been satisfied with the medical services they have received from Mountain Health Care. (Exh. I) Both oppose this case and the proposed dissolution of MHC. Another consumer submitted a comment that characterizes the filing of this case as ''tyrannical'' and questions how MHC could increase medical costs in the area given that they cover only 8% of the population. Exh. J. Even though these customers liked the service they received from Mountain Health Care, they could have received lower prices and better service with competition. These comments do not raise specific facts relevant to this Tunney Act proceeding.

III. Conclusion

After careful consideration of these public comments, the United States has concluded that entry of proposed Final Judgment will provide an effective and appropriate remedy for the antitrust violation alleged in the Complaint, and is therefore in the public interest. Once these comments and this Response are published in the **Federal Register**, the United States will move the Court to enter the proposed Final Judgment.

Dated: June XX, 2003.

Respectfully submitted.

David C. Kelly,
Department of Justice, Antitrust Division, Litigation I Section, 1401 H Street, NW., Suite 4000, Washington, DC 20530, 202–616–9447.

Motion of S.M. Oliva for Leave To File Brief *Amicus Curiae*

Before: Judge Lacy Thornburg

Pursuant to 15 U.S.C. 16(f), I, S.M. Oliva, acting *pro se,* respectfully move

[11] Docket No. C–4054, In the Matter of Physician Integrated Services of Denver, Inc., Michael J. Guese, M.D., and Marcia L. Brauchler; Docket No. C–4055, In the Matter of Aurora Associated Primary Care Physicians, L.L.C., Richard A. Patt, M.D., Gary L. Gaede, M.D., and Marcia L. Brauchler, at *http://www.ftc.gov/bc/CommissionActions/2002.htm.*

[12] *United States and Texas* v. *Aetna Inc. and The Prudential Insurance Company of America,* 1999–2 Trade Cas. (CCH) ¶ 72,730 (N.D. Texas 1999); *United States* v. *Medical Mutual of Ohio, Inc.,* 63 Fed. Reg. 52,764 (October 1, 1998); *United States* v. *Delta Dental of Rhode Island,* 943 F. Supp. 172 (D.R.I. 1996) & 1997–2 Trade Cas. (CCH) ¶ 71,860 (D.R.I. July 2, 1997); *United States* v. *Vision Service Plan,* 1996–1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996); *United States* v. *Oregon Dental Service,* 1995–2 Trade Cas. (CCH) ¶ 71,062 (N.D. Ca. 1995); *United States* v. *Delta Dental Plan of Arizona, Inc.,* 1995–1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995).

this Court for leave to file the accompanying brief as *amicus curiae.*

I am a public policy analyst specializing in the study of federal antitrust settlements. I am currently a senior fellow at the Center for the Advancement of Capitalism in Arlington, Virginia, and president of Citizens for Voluntary Trade, a nonprofit association located in the District of Columbia. In the past year, I have filed extensive public comments on behalf of both organizations in response to antitrust consent orders negotiated by the Department of Justice and the Federal Trade Commission.

Of particular interest to my work is the impact of antitrust laws on the rights of physicians and other health care providers. In the FTC's consent orders with five separate physician groups last year, I provided the only extended and substantial public comments on the settlements. As such, I am in a unique position to present this Court with insight into the case at bar.

The proposed brief presents information that will hopefully assist the Court in determining whether the Proposed Final Judgment filed in this case on December 13, 2002, satisfies the public interest requirements of the Tunney Act. It is not the goal of this brief to comment on the particulars of the settlement, but on the lack of necessary information necessary to properly make a public interest determination. I expect to separately file substantial public comments discussing the entire case prior to the expiration of the comment period.

For these reasons, I request leave to file the accompanying brief as *amicus curiae.*

Dated: February 15, 2003.

Respectfully Submitted,

S.M. Oliva,
2000 F Street, NW., #315, Washington, DC 20006–4217, Tel: (202) 223–0071, E-mail: voluntarytrade@aol.com. *Amicus Curiae*

Brief of S.M. Oliva, as *Amicus Curiae*

Statement of Interest

I, S.M. Oliva, declare that I have no financial interest in this case, nor do I have a financial interest in any competitor of Mountain Health Care, P.A. The views expressed in this brief are my own, and are based on my experience as a public policy analyst in the field of antitrust and competition law.

Summary

In reviewing the Proposed Final Judgment before the Court in this case, *amicus* offers two arguments:

- The United States failed to disclose material facts in their complaint and Competitive Impact Statement (CIS).
- The United States provided insufficient information in the CIS regarding the status and role of Mountain Health Care in the relevant marketplace, as well as how Mountain's acts directly impacted competition in those markets.

A major purpose of the Tunney Act [1] is to facilitate public comments which may assist the Court in determining whether a proposed consent decree is in the public interest. The CIS, in part, is supposed to provide the public with an adequate description of the ''practices or events'' giving rise to an alleged antitrust violation, as well as disclosure of any ''determinative materials or documents'' considered by the government in preparing the proposed Final Judgment.

In this case, the CIS failed both of these tests. The United States took substantial shortcuts in complying with the Tunney Act, and in the process failed to fulfill Congress's underlying objectives. This Court, however, possesses broad statutory power to remedy this situation, by directing the United States to file a revised CIS that provides the public—and the Court—with adequate information to decide whether the proposed decree is in the public interest.

Failure To Disclose Material Facts

In the complaint, the United States asserts that Mountain ''organized and directed an effort to develop a uniform fee schedule to be used to negotiate and contract for fees for physician reimbursement'' [2] from a number of managed care companies and other third-party benefit providers. This fee schedule, according to the government, ''unreasonably restrained competition'' in violation of section 1 of the Sherman Act.[3] As a result, the United States filed suit to obtain the dissolution of Mountain ''before further inquiry to consumers in North Carolina or elsewhere occurs.'' [4]

This ''uniform fee schedule'' is the nexus of the complaint and the resulting proposed Final Judgment. So long as Mountain maintains this schedule, consumers remain in danger under the Sherman Act. The only way to get rid of the schedule, in the government's view, is for Mountain to be denied its very existence. Otherwise, this fee schedule will continue to run amok, spreading its anti-competitive effects throughout western North Carolina.

But the problem is, the fee schedule the government speaks of may no longer be in play. According to statements made to *amicus* by Ellen Wells, Mountain's president and chief executive, Mountain's current ''fee schedule'' is nothing more than individual doctors informing an independent consultant about their general pricing terms. In other words, a third party spoke to Mountain's physicians separately, obtained independent fee requests, and passed that information along to the managed care companies and other payors. At no point, according to Wells, was there an agreement or conspiracy among Mountain physicians to create a ''universal'' schedule of fixed fees.[5]

Not only does this system not violate the Sherman Act, the United States expressly endorses this type of ''messenger model'' as a safe haven from the general prohibition on independent physicians collectively bargaining with payors. According to the 1996 revisions to the Department of Justice-Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care:

> Some networks that are not substantially integrated use a variety of ''messenger model'' arrangements to facilitate contracting between providers and payers and avoid price-fixing agreements among competing network providers. Arrangements that are designed simply to minimize the costs associated with the contracting process, and that do not result in a collective determination by the competing network providers on prices or price-related terms, are not per se illegal price fixing.

If Mountain's claim, then, is true, and they were employing (or transitioning to) a messenger model, there is no need for the government's proposed remedy—dissolution of Mountain—because there is no illegal behavior taking place. Yet nowhere in the complaint or CIS does the United States discuss, or even acknowledge, Mountain's claim that they employed a messenger model. The government doesn't even offer evidence to refute the claim. Instead, the complaint and CIS present a carefully edited, limited recitation of the facts, omitting a key detail that might influence the public's analysis of the case. In the absence of these disclosures, the public is left to incorrectly conclude that Mountain was simply an illegal price-fixing arrangement among physicians, and that

[1] 15 U.S.C. § 16(b)–(h).

[2] Compl. ¶ 1.

[3] *Id.*

[4] *Id.*

[5] Telephone interview with Ellen Wells, President of Mountain Health Care, P.A. (Jan. 23, 2003).

they made no good faith efforts to comply with the law.

Insufficient Information

Congress acknowledged, in passing the Tunney Act, that the public has an interest in ''the integrity of judicial proceedings'' involving proposed antitrust settlements.[6] To that end, the United States has an obligation to disclose enough facts about a case to enable the public to form reasoned judgments about the terms of a proposed Final Judgment. Of key importance is information that details the government's analysis of the marketplace, the competitive problem arising thereto, and the selected remedy. Here, we have little to go by. The United States insists that ''[t]here are no determinative materials or documents'' within the Tunney Act's meaning that warranted public disclosure.[7] *Amicus* disagrees.

The complaint and CIS repeatedly argue that Mountain's actions illegally ''increased physician reimbursement fees.''[8] The complaint argues that customers ''have paid higher prices for physician services sold through managed care purchasers than they would have paid in the absence'' of Mountain's actions.[9] The CIS further states that Mountain's physicians ''have not clinically or financially integrated their practices'' in such a way as to justify maintaining their uniform fee schedule.[10]

None of these arguments are supported by evidence, at least not evidence that's presented for public review in the complaint or CIS. For example, the public knows nothing, from the government's disclosures, of the exact nature of the market for physician services in western North Carolina. We don't know who Mountain was competing with, what prices they were charging, or even how consumer prices fared in comparison to neighboring marketplaces. We certainly don't know if Mountain's action actually harmed any consumers. We simply don't know much of anything, beyond the government's mere allegation that there was a fee schedule, and that it was illegal.

Once again, *amicus* faces conflicting information. The United States claims that Mountain increased costs and harmed consumers. Mountain's Ellen Wells, in contrast, claims to *amicus* that Mountain's customers realized an average 14–20% savings over other service networks. Nothing in the complaint or CIS points this out.[11] Furthermore, there is no evidence in the public record that suggests any Mountain customer was dissatisfied with their services or costs. Even one customer complaint would provide valuable information to the public on the exact nature of the alleged illegal actions. But once again, we're left only with the government's word, despite the existence of evidence that refutes key points of their argument.

It's worth noting that the government's lack of disclosure is hardly unusual in a Tunney Act proceeding. In the overwhelming majority of antitrust settlements, the CIS provides little useful information about a case. In one recent proceeding, Albert Foer of the American Antitrust Institute noted: ''The [Justice] Department has traditionally been reluctant to say a great deal in its CIS disclosures, presumably because it risks disclosure of confidential information, adds to the staff's workload, and opens up the door to additional inquiry.''[12] All of these explanations may be applicable in this case, but none of them justify withholding relevant and material information from the public.

At an absolute minimum, the United States should provide the public with enough information to assess the state of the affected marketplace at the time the complaint is filed, and also empirical evidence demonstrating how the proposed remedy is likely to restore competition allegedly lost. The government may consider this an inconvenient burden, but the Tunney Act does not contain exceptions for official laziness.

This Court has clear authority to compel government disclosure of relevant information. Congress stated as much in the Tunney Act's legislative history, noting ''the court must obtain the necessary information to make its determination that the proposed consent decree is in the public interest.''[13] And in one of the few cases where a court actually employed its Tunney Act discretion, *United States* v. *Central Contracting Co.,*[14] the district judge emphasized the importance of vigorous judicial enforcement of the public's right to information:

> The need for scrutiny is important in any case, but judicial scrutiny is perhaps more important in a run-of-the-mill case on which public attention is not focused and where abuse may escape unnoticed than in a ''big case'' where public interest supplements the court's scrutiny. If the Court in this case doesn't scrutinize there wil be no independent scrutiny.[15]

Similarly, this ''run-of-the-mill'' case runs the risk of escaping public attention and scrutiny completely. Without timely intervention by this Court to procure necessary additional information, it is likely the proposed Final Judgment will be entered without any serious examination of the government's arguments. This would render the Tunney Act effectively worthless in safeguarding the public interest.

Conclusion

The public—and this Court—cannot rely on the complaint and CIS, in their present form, to make a proper determination under the Tunney Act on whether entry of the proposed Final Judgment is in the public interest. The United States omitted key facts from the complaint, and failed to disclose relevant information that would assist the public in forming reasoned judgments about this case. The Tunney Act grants the Court ample power to ensure the government's full compliance, and this case warrants exercise of that power.

Accordingly, the Court should direct the United States to file a revised complaint and CIS, addressing the objections and concerns set forth in this brief. Additionally, the Court should extend the public comment period to allow third parties adequate time to review the revised disclosures so that they may provide appropriate comments to the Court.

Dated: February 15, 2003.

Respectfully Submitted,

S.M. Oliva,
2000 F Street, NW., #315, Washington, DC 20006–4217, Tel: (202) 223–0071, E-mail: smoliva@voluntarytrade.org, Amicus Curiae.

Certificate of Service

I hereby certify that on this 15th day of February, 2003, I caused a true and correct copy of the foregoing Motion for Leave to File and Brief of Amicus Curiae to be mailed by First Class United States Mail to:

For Plaintiff United States of America:

[6] H.R. Rep. No. 93–1463 (1974), reprinted in 1974 U.S.C.C.A.N. 6536, 6539.

[7] Competitive Impact Statement, 68 FR 1478, 1481 (Jan. 10, 2003).

[8] Compl. ¶14.

[9] Compl. ¶17(c).

[10] CIS, 68 FR at 1480.

[11] Telephone interview.

[12] Letter from Albert A. Foer to Roger W. Fones 2 (Dec. 27, 2002) (available at *http://antitrustinstitute.org/recent2/223a.pdf).*

[13] H.R. Rep. No. 93–1463, reprinted in 1974 U.S.C.C.A.N. at 6538 (citing S. Rep. 93–298).

[14] 537 F. Sup. 571 (E.D. Va. 1982).

[15] *Id.* at 575.

Mark J. Botti, Antitrust Division, Litigation I Section, 1401 H Street, NW., Suite 4000, Washington, DC 20530, Tel: (202) 307–0001.

For Defendant Mountain Health Care, P.A.:

Jeff Miles, Olber, Kaler, Grimes & Shriver, 1401 H Street, NW., Washington, DC 20005;

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S.M. Oliva.

Public Comments of Citizens for Voluntary Trade to the Proposed Final Judgment

Before: Judge Graham C. Mullen

Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. (b)–(h), and the notice filed by the United States in the January 10, 2003, edition of the **Federal Register,** Citizens for Voluntary Trade respectfully submits the enclosed public comments in response to the proposed Final Judgment in the above-captioned case.

Filed: March 7, 2003.

S.M. Oliva,

President, Citizens for Voluntary Trade, 2000 F Street, NW., #315, Washington, DC 20006, (202) 223–0071.

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Resolution

The Board of Directors of Citizens for Voluntary Trade,

Considering the fundamental role of judicial review in protecting the rights of Americans from the abuse of government power,

Recognizing the ever-increasing impact of antitrust law on the ability of Americans to maintain a capitalist system based on the principle of voluntary trade for mutual benefit,

Noting that the principles of capitalism are inconsistent with the enforcement of the antitrust laws,

Affirming that antitrust law is not the proper means of promoting honest competition and free trade among individuals and businesses,

Recalling the numerous abuses of federal antitrust authorities in applying the antitrust laws unjustly to the collective bargaining actions of physicians and health care providers,

Believing that the case currently pending against Mountain Health Care is baseless as a matter of fact, law, and justice,

Convinced that the only means to protect the rights of Mountain Health Care, and of Americans generally, is for immediate judicial action,

1. Directs the president of Citizens for Voluntary Trade to file timely and substantial comments with the United States opposing entry of the proposed Final Judgment against Mountain Health Care;

2. Appeals to the United States District Court for the Western District of North Carolina to reject entry of the proposed Final Judgment;

3. Urges the United States Department of Justice to dismiss its complaint against Mountain Health Care; and

4. Calls upon the United States Government to rescind its Statements of Antitrust Enforcement Policy in Health Care with all deliberate speed.

Introduction

On December 13, 2002, following a two-year investigation, the United States Department of Justice (DOJ) sued Mountain Health Care, P.A. (Mountain), a North Carolina corporation operating as a preferred-provider organization under state law. Mountain is a network of more than 1,800 health care providers, approximately 400 of whom are physician shareholders. Mountain sells access to its network to managed care purchasers and other insurers throughout the greater Asheville, North Carolina area, and generally in western North Carolina.

The DOJ alleged Mountain violated the Sherman Act by maintaining a fee schedule that effectively fixed prices for network services. Rather then contest the government's charges in court, Mountain agreed to surrender without a fight, and acquiesce in the government's demand for Mountain's immediate dissolution. A proposed Final Judgment directing this dissolution was submitted by the DOJ and Mountain to the United States District Court for the Western District of North Carolina on the same day as the government's complaint was filed.[1]

On January 10, 2003, pursuant to the federal Tunney Act, 15 U.S.C. 16, the United States published the proposed Final Judgment, along with a required Competitive Impact Statement (CIS) in the **Federal Register**, thereby commencing a 60-day comment period. Citizen for Voluntary Trade (CVT) henceforth submits the following comments in response to the proposed Final Judgment.

CVT is a national nonprofit association based in Washington, DC. CVT is organized to promote the public welfare by examining the enforcement and antitrust and competition laws against private businesses and individuals. CVT's standing policy is to file comments in all proceedings where the United States seeks to violate the individual rights of businesses through unjust and unfounded antitrust prosecutions.[2] This case presents just such a situation, where an innocent business in the form of Mountain Health Care is being punished despite the fact they committed no crime against the public interest. For the reasons stated below, CVT opposes entry of the proposed Final Judgment and respectfully requests the government withdraw its complaint against Mountain.

For the record, Citizens for Voluntary Trade does not have a financial interest in the outcome of this case, nor do we have any financial interest in any competitor of Mountain Health Care. These comments reflect the veiw of the Board of Directors of Citizens for Voluntary Trade.

Part I: Analysis of the Complaint

A. Mountain and the ''Uniform Fee Schedule''

We begin our comments by examining the government's complaint against Mountain. The DOJ's central claim is that Mountain ''organized and directed an effort to develop a uniform fee schedule'' which Mountain allegedly used in negotiations with managed care companies and other third-party

[1] The case was initially assigned to Judge Lacy Thornburg, who recused himself on February 20, 2003, and the case was subsequently reassigned to Chief Judge Graham C. Mullen on February 25.

[2] S.M. Oliva, the present of Citizens of Voluntary Trade, filed a brief as *amicus curiae* with the Court on February 15, 2003, seeking the release of additional information from the United States on the allegations contained in the complaint. At the time of the filing, the Court has not yet ruled on Oliva's motion to file the brief or on the brief's substantive requests. A copy of the brief is included in the appendix to these comments.

insurers.[3] The DOJ claims this fee schedule violated Section 1 of the Sherman Act by ''unreasonably'' retraining competition among physicians in western North Carolina,[4] approximately 400 of whom were Mountain shareholders.

Mountain's alleged crimes seem to have begun at the time of their incorporation in 1994, eight years before the DOJ took action.[5] In essence, Mountain's very existence is considered by the government as *prima facie* evidence of antitrust violations simply because its provider network includes ''the vast majority of private practice physicians in the greater Asheville area.'' [6] Of particular interest is the DOJ's belief that Mountain ''has not clinically or financially integrated its physicians to create efficiencies'' that would justify setting a uniform fee schedule.[7]

The government objects to Mountain's alleged fee schedule because Mountain relied ''exclusively'' on this schedule in contract negotiations with managed care companies, which the DOJ believes resulted in unfairly higher prices in the marketplace.[8] Since the DOJ considers this a legal injury to consumers, they allege Mountain violated Section 1 of the Sherman Act.

The nexus of the government's argument is that Mountain's fee schedule equaled a price-fixing scheme; that is, Mountain's participating physicians agreed to abide by the schedule exclusively in setting prices for their individual practices. Mountain publicly denied this was the case. Mountain claims they are not an exclusive network, and member physicians set their own office charges and may even join other provider networks and health plans not affiliated with Mountain.

Mountain does not deny that they've used non-exclusive fee schedules in the past. But as they note, such fee schedules are common to the majority of health plans operating in North Carolina. Mountain further contends that ''[i]n response to existing antitrust guidelines, Mountain Health Care has transitioned to a messenger model where each payer negotiates directly with each physician.''[9] The messenger model is an exception to the DOJ's general prohibition on physician collective bargaining arrangements. Under the model, a group of doctors may pass along fee information to an insurance company through a third-party ''messenger,'' but the doctors may not speak with one another about fees or otherwise jointly discuss contract terms.

Dr. Stephan Buie, a psychiatrist and a member of the Mountain network, offered this description of Mountain's operations:

> [Mountain Health Care] works through a blind messenger system, whereby MHC negotiates a rate for services with an employer and then sends those rates to each member practice. Each practice independently decides whether to accept the rate or to counter propose a different rate. All members have been informed that it is not legal to consult with other practices about their participation or their rates. Employers were free to negotiate with other managed care organizations.[10]

Curiously, the complaint makes no mention of Mountain's messenger model claims. This omission changes the entire character of the government's case. If Mountain's claim is true, then the DOJ intentionally withheld a material fact from its complaint. Consequently, the government's view that Mountain was nothing more than a ''price-setting organization'' [11] would be erroneous, since the price-setting behavior itself is no longer taking place. At the very least, the DOJ should explain why Mountain's ''messenger model'' claim is false, why Mountain's actions still warrant the charges and remedy set forth in the complaint.

B. Jurisdictional Issues

The next problem with the complaint is the government's assertion of jurisdiction. On the one hand, the complaint's description of Mountain's actual business activities described commerce occurring exclusively within North Carolina.[12] But on the other hand, the government forcefully claims that Mountain's actions fall under interstate commerce, which is a predicate for the DOJ to bring action under the Sherman Act.[13] It is unclear whether the alleged misconduct fell within the sphere of interstate commerce. Thus, it is possible the DOJ has not met its burden to establish federal jurisdiction in this case.

Mountain is a professional corporation organized under North Carolina law. It is registered with North Carolina's commissioner of insurance as a ''preferred provider organization,'' a tightly regulated form of physician network. Generally, regulation of health care and health insurance providers occur at the state level. If Mountain were to operate in another state, it would be subject to that jurisdiction's separate rules for health care and health insurance regulation. Since Mountain only operates in counties comprising western North Carolina [14], it is only subject to North Carolina regulation. This raises the question of whether state officials would be more competent to assess the legality of Mountain's operations than the DOJ, but we will address that point later. For purposes of assessing this Court's jurisdiction, it is only relevant to determine whether the alleged crimes involved interstate commerce.

The government claims Mountain's contract—the products of the illegal fee schedule—included arrangements with ''business located outside North Carolina.'' [15] What is unclear is the precise identity and nature of these businesses. The government admits Mountain's doctors only render services within North Carolina boundaries.[16] The businesses receiving these services only do so within North Carolina. At all times, these intrastate transactions are conducted under the careful regulatory eye of North Carolina officials. Thus, the DOJ is asserting jurisdiction here solely because some of the businesses—and we don't know how many—Mountain provides services to may be organized outside of North Carolina.

At a minimum, some of the contracts Mountain entered into were wholly intrastate affairs; that is, Mountain provided services to businesses organized and doing business *only* in North Carolina. These arrangements are not the proper subject of a federal antitrust proceeding, but may be actionable under state law. In any case, the DOJ's complaint may not cover such acts, at least not under the Sherman Act. The complaint fails to distinguish and identify the character or Mountain's clients, however, and we are thus left with an incomplete picture.

The DOJ is overextending its reach here, at least so far as the complaint covers all contracts Mountain entered into, whether intrastate or interstate in

[3] Compl., ¶ 1.

[4] *Id.*

[5] Compl. ¶ 15.

[6] Compl. ¶ 8.

[7] Compl. ¶ 11.

[8] Compl. ¶ 14.

[9] ''Myths and Facts about Mountain Health Care,'' *Asheville Citizen-Times* (Jan. 6, 2003) (accessed online at *http://www.mountainhealthcare.com/pressrelease.htm.*)

[10] Stephan Buie, ''Competition needs to grow between insurance companies,'' *Asheville Citizen-Times* (Dec. 30, 2002) (accessed online at http://www.mountainhealthcare.com/pressrelease.htm).

[11] Compl. ¶ 14.

[12] Compl. ¶ 2.

[13] Section 1 of the Sherman Act, 15 U.S.C. 1, only applies to ''trade or commerce among the several States, or with foreign nations.''

[14] See Compl. ¶ 5.

[15] *Id.*

[16] Compl. ¶ 2.

character. Furthermore, it's also unclear whether the contracts Mountain entered into with businesses organized outside North Carolina actually involved overt acts of interstate commerce. If these contracts were between Mountain and subsidiary offices wholly operating within North Carolina, these contracts too might fall outside the reach of the Sherman Act.

In any case, there is a fundamental ''public interest'' question here as to whether the DOJ should be acting in a case where state authorities posses a more direct, not to mention more developed, interest in the alleged misconduct. Regulation of private health care networks remains largely a state affair, and the DOJ's actions here infringe upon the state's traditional sphere of influence. This should be a factor the Court takes notice of in reviewing the complaint and proposed Final Judgment.

C. Marketplace Description and Analysis

The complaint provides little useful information regarding the marketplace for health care services in western North Carolina. Instead, the government offers a highly generalized description of how physicians relate to managed care companies:

> Physicians frequently contract with managed care purchasers. These contracts establish the terms and conditions, including price, under which physicians will render care to the enrollees of managed care purchasers. In negotiations with managed care purchasers, physicians frequently agree to charge rates lower than their customary rates, in order to gain access to the managed care purchaser's enrollees. As a result of this lower rate, such contracts often lower the managed care purchasers' cost, and therefore lower the cost of health care for their enrollees.[17]

There are two unproven statements in this claim. The first is that physicians always seek access to the greatest number of patients for the lowest compensation. The second is that lower physician costs equals lower costs for managed care customers. Both of these statements are possibly true, but in the absence of clear and convincing evidence, they cannot simply be taken as axiomatic. The complaint includes no supplemental information that would support either claim in the context of this case. There is no description of the actual market for health care services in western North Carolina; for example, the complaint tells us nothing of who Mountain is competing with, the structure of fees in the market before and after Mountain's incorporation, or the structure of managed care contracts with individual consumers. Additionally, the complaint makes no effort to assess whether physicians prefer to accept more patients at a lower per capita reimbursement, or whether they've individually expressed a preference to see fewer patients at a non-discounted rate.

The complaint states that Mountain's network provided ''access to substantially all of the physicians in Asheville and the surrounding counties.''[18] While this is true, the access was apparently not exclusive. As noted above, Mountain denies they were ever an exclusive network: ''[P]roviders are free to participate with any network or plan they choose. Your employer does not have to contract with Mountain Health Care in order for you to see those providers.''[19]

The government believes Mountain acted as an exclusionary monopoly, unreasonably controlling the marketplace. But once again, Mountain denies this, arguing they faced more than ample competition: ''Employers in the Western North Carolina market place are contracted with many different health plans. *Mountain Health Care members make up an average of only 8% of our providers patient base,* and the overwhelming majority of Mountain Health Care providers participate with other plans''[20] (emphasis added). Clearly, Mountain's operation did not leave consumers without other options.

There is simply no evidence which refutes Mountain's description of the marketplace as competitive, non-exclusionary, and otherwise free of coercive influence. In the absence of such proof, Mountain's denials should be taken at face value, since the government has the burden of establishing its case by a preponderance of the evidence, not the other way around. Having failed to meet this burden, the government's complaint is defective simply because they have not demonstrated the marketplace itself suffered from any anti-competitive effects arising from Mountain's activities.

D. Anti-Competitive Effects

Despite not proving any defects in the marketplace, the government nevertheless insists Mountain's actions harmed consumers in western North Carolina. The complaint alleges three specific harms: unreasonable restraint of price competition, denying the ''benefits of free and open competition'' to managed care companies and their enrollees, and forcing consumers to pay higher prices for physician services.[21] None of these allegations have merit.

As discussed above, the government never demonstrates that Mountain's fee schedule was exclusive. Mountain's own denial suggests the fee schedule was nothing more than a loose coordination of independent operators. The schedule did not cover office charges, and any patient was free to obtain services from a Mountain physician without going through the network.[22] Thus, it is unreasonable for the government to define Mountain's fee schedule as a ''restraint'' on price competition, since no actual restraint existed.

Next, on the question of whether Mountain denied consumers the ''benefits of free and open competition,'' it is unclear precisely what ''benefits'' are at issue. The government alludes to the fact that consumers faced higher prices for physician services as the result of Mountain's actions. But that statement appears to be false. Mountain's prices apparently varied little between 1994, when the network was incorporated, and 2002, when the government filed the complaint. Indeed, as Dr. Buie noted, ''Managed care organizations have taken a hard line with payment to physicians, either decreasing payments or holding them steady during the last 10 years.''[23] Mountain was in the same boat as every other physician network as this respect. While it is true that premiums paid by enrollees of managed care plans have increased substantially in the past decade, even the government attributes that primarily ''on larger increases in the indices for prescription drugs and hospital services,''[24] not higher physician reimbursements.

Finally, on the issue of whether consumers paid unreasonably higher prices to Mountain physicians, there is once again a lack of evidence, or even a proper standard to judge evidence. The complaint does not reveal how much Mountain charged under its fee schedule, how much non-Mountain providers charged, or how much Mountain providers charged prior to joining the network. Furthermore, there's no indication of what the government's standard is for assessing price levels. We have no indication as to what price levels are acceptable,

[17] Compl., ¶ 6.

[18] Compl., ¶ 8.

[19] ''Myths and Facts about Mountain Health Care.''

[20] *Id.*

[21] Compl., ¶ 17.

[22] ''Myths and Facts about Moutain Health Care''.

[23] *Id.*

[24] *Id.* (citing *Modern Healthcare,* Jan. 21, 2003).

either for physicians nationally or for those located within the western North Carolina marketplace. Without evidence or standards, the complaint's assertion that the physicians increased prices unreasonably is simply arbitrary and capricious.

E. Request for Relief

Since the complaint's requested relief was essentially obtained through the proposed Final Judgment, we will reserve commentary on this subject until Part IV. However, since the analysis above demonstrates the government's complaint is defective in nearly every aspect, the Court could simply dismiss the complaint for failure to state a claim entitling the government to obtain relief.[25]

Part II: Historical Background

A. Origins of Government Intervention in Healthcare

The case against Mountain ultimately has little to do with enforcing the Sherman Act and everything to do with protecting the federal government's intrusive role in the healthcare market. Indeed, if the DOJ actually believed in the type of free market they claim to be protecting here, they would be seeking to protect Mountain's right to exist rather than destroy it. But as things stand, the government maintains a direct interest in destroying Mountain, and in general preventing physicians from collectively bargaining with managed care companies. This interest is not genuinely motivated by antitrust concerns, but by simple budget politics.

In 1965, Congress brought an end to the free market that successfully served Americans for most of the republic's history. That year, Congress created Medicaid and Medicare, two programs designed to finance healthcare for the indigent and elderly, respectively.[26] The original concept was for the government to simply pay the bills for medical expenses while not interfering with physicians and the services they provided. This concept soon proved unworkable.

The core problem with Medicaid and Medicare was the divorcing of demand for services from the ability to pay. Once health care became free for certain individuals, these folks were able to spend indiscriminately. Recognizing this problem (but refusing to admit defeat), Congress responded by imposing arbitrary cost controls on Medicare and Medicaid. Originally, the two programs paid ''reasonable costs'' of services chosen and provided by physicians. But following passage of several amendments in 1983, Medicare and Medicaid switched to a payment system based on DRGs, or ''diagnosis-related group.'' This change was intended to lower government spending on health care.

The DRG approach is precisely the kind of non-market price fixing the government now accuses Mountain of. A DRG divides all medical problems into a set number of categories, and then assigns a fixed, arbitrary fee for each ''diagnosis,'' a figure that supposedly represents the average cost for treating the problem. A health care provider gets only the fixed DRG amount, regardless of actual work performed. This means that for the provider to make a profit, he must incur costs below the DRG rate.

The DRG approach is used not just under Medicare and Medicaid, but in privately owned insurance programs as well. Because the government's 1965 interventions led to an exponential rise in health care costs, Congress decided to encourage a DRG approach in private insurance by passing the HMO Act of 1973. HMOs, or health maintenance organizations, exist as comprehensive prepaid insurance plans, where providers accept a DRG-like fixed rate for medical services irrespective of actual costs. Prior to 1969, the only HMO of significant stature was Kaiser Permanente, which relied on labor unions compelling their members to join.[27] Today, of course, HMOs are the dominant provider of private health insurance coverage in the United States.

The rise of HMOs derives not from their popularity in the market, but from the 1973 law. Congress essentially rigged the market in favor of HMOs, giving them generous subsidies, and expanding tax incentives for employers that enrolled their employees in HMOs. The government's encouragement made HMOs a dominant force in the health care marketplace independent of the need to fairly compete for customers.

Indeed, it is difficult to imagine HMOs succeeding in a genuinely competitive free market. The DRG-based approach HMOs use is entirely incompatible with America's capitalist ideals. Customers generally don't voluntarily pay for what they know to be inferior service. Yet HMOs only profit by forcing costs below the level at which optimum customer service can be provided. The economic principle is egalitarian rather than capitalist: it's more important for an HMO to serve everyone than to serve everyone well. In the absence of government encouragement, few customers would voluntarily subscribe to this theory when it comes to something as essential to their life as health care.

Despite all of the government's interference, health care costs continue to rise. Rather than admit fault, the government prefers to scapegoat others for the shortcomings of Medicare, Medicaid, and managed care. Physicians are by far the easiest target. In DRG-based models, physicians are effectively stripped of their power to deal one-on-one with their patients, thus subjecting all medical judgments to the whims of government bureaucrats and HMO administrators, few of whom have any actual knowledge or experience in health care. At the same time, physicians have found their incomes restricted by non-market forces, namely the arbitrary DRG levels that bear little if any relation to actual supply and demand. Despite this, the government promotes the theory, at issue in this case, that it's the physicians that are acting illegally by trying to increase their income and their control over how they provide medical care. According to the DOJ's thinking, it is more important for the HMOs and government insurance programs to be protected from their own errors than to permit physicians even a minimal ability to defend their professions and personal livelihoods.

B. Origins of Physician Antitrust Prosecutions

For more than 80 years, the Sherman Act was not applied to the activities of physicians, attorneys, and other so-called ''learned'' professions. In passing the Sherman Act, Congress's target was alleged industrial trusts, such as Standard Oil and the railroads. But in 1975, the U.S. Supreme Court extended the Sherman Act's reach to independent professionals in *Goldfarb* v. *Virginia State Bar*.[28] There, the Court was asked to examine whether a minimum fee schedule for legal services constituted illegal price fixing, notwithstanding the fact a state bar itself prescribed the schedule.

A unanimous Court ruled against the bar, holding that the Sherman Act contained no exception for specific professions, even those regulated by state governments. At the same time, however, the Court noted: ''In holding that certain anticompetitive conduct by lawyers is within the reach of the Sherman Act we intend no diminution of the authority of the State to regulate

[25] *See* Fed. R. Civ. Proc. 54(c).

[26] *See* 42 U.S.C. 1395, *et seq.*

[27] Scott Holleran, ''What You—and Your Employer—Probably Don't Know About Your Health Plan,'' (Jan. 1999) (available online at *http://www.afcm.org/historyofhmos.html*).

[28] 421 U.S. 773 (1975).

its professions.'' [29] This is noteworthy because while the Court was mindful of protecting the federal government's exclusive authority to regulate interstate commerce, the justices also made it quite clear the states did not surrender their professional regulatory powers. In the context of the case against Mountain, this is a point worth emphasizing, since the DOJ's actions here trample on North Carolina's ability to supervise and regulate physicians and medical organizations, while not advancing a genuine interest related to interstate commerce.

Seven years after *Goldfarb,* the Supreme Court made its first—and to date only—major decision related to antitrust prosecution of physician organizations. In *Arizona* v. *Maricopa County Medical Society,*[30] a divided Court [31] held that a maximum-fee schedule adopted by a physician group was *per se* unlawful under Section 1 of the Sherman Act. The majority explicitly rejected any call to put the Medical Society's actions in proper context, citing the circular nature of the *per se* rule:

> The respondents' principal argument is that the per se rule is inapplicable because their agreements are alleged to have procompetitive justifications. The argument indicates a misunderstanding of the per se concept. The anticompetitive potential inherent in all price-fixing agreements justifies their factual invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application. Even when the respondents are given every benefit of the doubt, the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition.[32]

In dissent, Justice Powell preferred to actually look at the facts, and concluded:

> The medical care plan condemned by the Court today is a comparatively new method of providing insured medical services at predetermined maximum costs. It involves no coercion. Medical insurance companies, physicians, and patients alike are free to participate or not as they choose. On its face, the plan seems to be in the public interest.[33]

The situation in *Maricopa* is not dissimilar from this case. Like *Maricopa,* no coercion was involved, and the fee schedule arrangement—to the extent one actually exists here—is wholly voluntary. And if the government were to go to trial in this matter, they would almost certainly use a *per se* standard in analyzing Mountain's actions. In doing so, the government would be able to obtain a judgment against Mountain without having to prevent any substantial evidence as to the actual context of Mountain's operations or their effect on the marketplace; the government would only need to demonstrate that prices were fixed in some manner to prevail. Yet, as Justice Powell warned us in *Maricopa,* this approach often works against the supposed intent of the antitrust laws:

> It is settled law that once an arrangement has been labeled as ''price fixing'' it is to be condemned per se. But it is equally well settled that this characterization is not to be applied [457 U.S. 332, 362] as a talisman to every arrangement that involves a literal fixing of prices. Many lawful contracts, mergers, and partnerships fix prices. But our cases require a more discerning approach. The inquiry in an antitrust case is not simply one of ''determining whether two or more potential competitors have literally 'fixed' a 'price.' * * * [Rather], it is necessary to characterize the challenged conduct as falling within or without that category of behavior to which we apply the label 'per se price fxing.' That will often, but not always, be a simple matter.'' *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.,* 441 U.S. 1, 9 (1979).
>
> Before characterizing an arrangement as a per se price-fixing agreement meriting condemnation, a court should determine whether it is a '' 'naked restrain[t] of trade with no purpose except stifling of competition.' '' *United States* v. *Topco Associates, Inc.,* 405 U.S. 596, 608 (1972), quoting *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963). See also *Continental T.V., Inc.* v. *GTE Sylvania Inc.,* 433 U.S. 36, 49–50 (1977). Such a determination is necessary because ''departure from the rule-of-reason standard must be based upon demonstrable economic effect rather than * * * upon formalistic line drawing.'' *Id.,* at 58–59. As part of this inquiry, a court must determine whether the procompetitive economies that the arrangement purportedly makes possible are substantial and realizable in the absence of such an agreement.[34]

In *Maricopa,* the Medical Society's purpose was not to stifle competition, but to contain rising medical costs. Here, there is no evidence which suggests Mountain's intentions were to stifle or impair competition. Instead, Mountain's principal function was to provide patients and insurers with access to a broad network of health care providers. Superficially, at least, this would seem to be ''pro-competitive.'' But once again, there is substantial evidence to suggest the government's actions in cases like *Maricopa* and Mountain are about something other than antitrust.

C. The DOJ–FTC ''Statements''

In the years following *Goldfarb* and *Maricopa,* the DOJ and FTC developed substantial experience going after physician organizations. The DOJ has filed five civil claims against physician groups since 1991, all of which have resulted in consent orders. None of these cases involved a remedy as drastic as the one imposed here on Mountain—outright dissolution—although in 1983, a preferred provider organization did dissolve on the eve of DOJ action. There is no record of any DOJ or FTC complaint against a physician group proceeding to trial, judgment, and appeal. Thus, there is no controlling precedent from the Supreme Court or any court of appeals on the constitutionality of the specific policies used by the government in reviewing and prosecuting physician activities.

The major policy at issue is the FTC–DOJ Statements of Antitrust Enforcement Policy in Health Care (''Statements''). The Statements were adopted by joint action of the FTC and DOJ Antitrust Division in September 1993, and revised by the agencies in 1994 and 1996. Congress never enacted the Statements into law, and thus these policies remain nothing more than the opinion of the FTC and the DOJ's Antitrust Division.

In physician network cases, the critical policy is Statement 8, which effectively labels all networks owned by nominally competing physicians as *per se* illegal. Statement 8 says these networks are only legal under the Sherman Act if the physicians ''share substantial financial risk.'' As lawyers at the firm representing Mountain before this Court noted in 1996: ''It is this requirement that has generated the most controversy. This is so not because the concept of sharing risk is unusual in the context of a legitimate joint venture. Instead, the controversy stems from the fact that the enforcement statements 'approve' only two forms of risk sharing: capitation and withholds.''[35] Capitation means physicians are paid a fixed amount per month for each consumer enrolled in a given health plan; withholds means the payer keeps a certain percentage of a physician's reimbursement unless certain cost

[29] 421 U.S. at 793.

[30] 457 U.S. 332 (1982).

[31] The case was decided by a 4–3 vote, because Justices Blackmun and O'Connor were recused.

[32] 457 U.S. at 351.

[33] *Id.* at 357.

[34] *Id.* at 361.

[35] Bruce R. Stewart and E. John Steren, ''Will New Guidelines Clarify Role of Antitrust Law in Health Care?'' Legal Backgrounder, Vol. 11, No. 23 (June 21, 1996).

containment goals, such as reducing particular procedures. Physician networks have no choice under Statement 8 but to employ one of these two methods, despite the fact that both capitation and withholds substantially increase physician risks without providing any actual benefit to physicians or health care consumers.

If physicians don't wish to share risk under Statement 8, but still want to negotiate with insurance companies through a network, the doctors must turn to Statement 9, which authorizes the ''messenger model'' described earlier. The messenger, as the name implies, is not supposed to be a negotiator, but a one-way courier of information from insurance companies to independent physicians. Or, put another way, ''the messenger acts essentially as a mute and blindfolded delivery boy between the payer and each physician in the network.''[36]

Statements 8 and 9 create an unworkable marketplace where physicians possess no genuine bargaining power. The three tools at the physicians' disposal—capitation, withholding, and messengering—are insufficient in dealing with HMOs on a level playing field. The government is well aware of this, and maintains these options precisely for that reason. After all, HMOs are government-sponsored entities that would perish in a truly free market. The only way to maintain the HMO's viability is to eliminate the ''threat'' of concerted physician action. That's what Statements 8 and 9 are designed to accomplish, and they've done so quite effectively, albeit at the expense of the government's integrity in enforcing its own laws.

In the context of this case, it must be repeated that Mountain claimed to employ the messenger model system set forth in Statement 9. This claim is never addressed, because the government intentionally omitted this fact from its compliant. In past cases, however, the government claimed that even though a network employed a messenger model, it did so incorrectly. This means the government itself—which is composed of antitrust lawyers, not health care professionals—subjectively decided they didn't like the look of things. In most recent prosecutions of physician networks, the defendant argues they were following the best available legal advice in employing the messenger model. Yet in every case, this advice did not save them from the government, which changes the rules in mid-game when they don't like a particular result.

[36] *Id.*

D. Constitutional Analysis of the DOJ's Antitrust Policies

At a fundamental level, the prosecution of Mountain represents the latest attack in a full-scale war against physicians and their basic individual rights. The government's legal premise is shaky at best, since they're arguing in favor of a nebulous concept of ''consumer rights'' despite the complete absence of evidence that any consumer was harmed in a legal sense. But beyond that, the government's moral premise is far more troubling. In order to accept the government's argument that Mountain violated the antitrust laws, this Court must also subscribe to the notion that Mountain's physician shareholders are serfs of the HMO's (and by extension the government), since these doctors possess no individual rights whatsoever when it comes to fulfilling their economic self-interest.

By dissolving Mountain, the government seeks to deprive the physician shareholders of any ability to negotiate fairly with insurance companies. This makes it for more likely the physicians will surrender greater amounts of their professional autonomy just to ensure a steady paycheck from week-to-week. In turn, this leads to an economic relationship not unlike ancient feudalism, where the procedures generate wealth which is unjustly appropriated by feudal lords whose only claim to the wealth is the benefit of political power and patronage. HMOs do not earn their wealth through production, but through the appropriate of wealth generated by physicians. The government serves to facilitate the HMOs through policies such as this antitrust prosecution. The goal isn't to protect consumers, but to deny wealth to its rightful owners.

This feudal model will only continue to escalate in the absence of judicial intervention. And such intervention is warranted on constitutional grounds, for one of several independent reasons. First, the government is using antitrust policy in a manner that denies basic rights to some citizens but not others. Physicians aren't just treated differently than HMOs; doctors are also treated differently than almost every other class of professional in this country. Labor unions enjoy exemptions from antitrust laws, not because their acts are less likely to violate the antitrust laws, but because unions are politically well-connected in a way that physicians are not. While one could argue this is simply the nature of a democracy, the Constitution prohibits the federal government from distinguishing rights among arbitrarily selected classes of individuals. The Privileges and Immunities Clause of Article IV, the Due Process Clause of the Fifth Amendment, and the Ninth and Tenth amendments all provide ample support for the equality of physicians to every other class of American citizen.

Furthermore, Congress lacks any affirmative power to provide for the kind of professional destruction imposed by the DOJ in this case and others like it. The Commerce Clause of Article I extends only to interstate commercial acts. Mountain's actions, by the DOJ's own evidence, were wholly intrastate in their actual character, despite the alleged tangential effects on commerce outside of North Carolina. Beyond that, the Tenth Amendment recognizes North Carolina's sovereignty over the regulation of health care matters, a point not challenged by the DOJ in this case.

Ultimately, the government's case against physician networks like Mountain has more to do with moral values than legal judgments. The DOJ's position is that physicians enjoy no basic right to economically benefit from their skills—at least not when such benefits might hamper the government's efforts to ensure the triumph of HMOs in the private insurance market. This contradicts the very principles at the heart of the Constitution and the Declaration of Independence, which hold the individual right to life, liberty, property, and pursuit of happiness as paramount to any policies that force individuals—such as physicians—to sacrifice their rights for the sake of others.

Part III: Recent Cases

A. OGMC of Napa Valley

The Center for the Advancement of Capitalism (CAC)[37] first filed comments on behalf of a physician organization in May 2002, in the matter of Obstetrics & Gynecology Medical Corporation of Napa Valley (OGMC),[38] an FTC complaint against a six-physician network in California.[39] Like Mountain, OGMC was accused of injuring HMOs and health care consumers by attempting to collectively bargain for higher fees. And like the proposed settlement here, OGMC agreed to dissolve. Additionally, the individual OGMC physicians agreed to a variety of

[37] The Center for the Advancement of Capitalism is a nonprofit corporation that generally promotes the moral basis of capitalism. While CVT officials have discussed this case with CAC, this comment letter reflects only the viewpoints of CVT.

[38] FTC File No. 011–0153.

[39] The six physicians were named individually by the FTC in addition to their professional corporation.

restrictions on their personal conduct for a period of 20 years.

CAC submitted timely and extensive comments to the FTC's complaint and proposed settlement. CAC offered four principal arguments: First, OGMC's alleged collective bargaining did not violate the FTC Act, 15 U.S.C. 45, *et seq.;* second, the FTC's action against OGMC was *per se* unconstitutional under the Privileges and Immunities Clause[40] and the Fourteenth Amendment; third, the forced dissolution of OGMC would actually harm competition; and finally, that the proposed settlement itself was contrary to the public interest. CAC's comments offered extensive analysis and proof in support of its arguments, and consequently expected the FTC to seriously consider the comments prior to entering its final order against OGMC.

That did not happen. Not only did the FTC fail to seriously consider CAC's comments, they effectively failed to acknowledge or consider them at all. On May 17, 2002, the FTC announced the adoption of a final consent order against OGMC after a comment period elapsed in which ''no comments were received'' or considered by the Commission. This despite the fact CAC's comments were submitted to the FTC four days before the stated deadline. Upon further inquiry, FTC officials admitted their error in neglecting to consider CAC's comments. However, FTC officials then proceeded to lie to both CAC officials and OGMC's counsel, falsely claiming CAC's comments were both considered and taken into account in formulating the final order.

In documents obtained by CVT through the Freedom of Information Act (FOIA), FTC officials acknowledge they failed to initially consider CAC's comments, but prior to service of the final order on OGMC, the Commission belatedly considered and voted on a reply to CAC's comments. This is inconsistent with the statements of OGMC counsel, however, who addressed the issue to FTC counsel in a letter dated two months after the settlement was approved:

> The final Order, however, does not reflect the receipt of [CAC's] comments, nor does it address any of the substantive points that the Center made in the comments. If the facts are as a representative of the Center has described them to use, we believe that, at a minimum, our clients' procedural due process rights have been violated and, potentially, their substantive due process rights.[41]

According to the FOIA documents received, the FTC denied that any violation of OGMC's rights occurred, yet the Commission has never fully explained the discrepancy between the public statement that no comments were received and the contrary representations made to CAC. CVT and CAC are currently pursuing a FOIA appeal to obtain additional information on this issue.

Procedural shenanigans aside, the substantive problem was that the reply CAC finally received from the FTC contained little substantive refutation of CAC's comments. The government made no attempt to seriously address the constitutional, practical, and ethical arguments raised. Instead, the FTC cited a broad disagreement with CAC's philosophy opposing antitrust. While that disagreement was already understood by CAC, the comments at issue addressed the government's specific conduct in prosecuting OGMC and physician groups generally. To that argument, the FTC could only muster a broad evasion.

> The analysis that the Commission issued when it accepted the consent agreement for public comment provides a detailed basis for this determination, through its extensive discussion of both the complaint and the consent order. Moreover, with respect to [CAC's] concerns about the complaint allegations, it is important to note the consent order is the product of a negotiated settlement between the Commission and the respondents.[42]

As is the case with Mountain, the FTC's complaint and analysis of their settlement with OGMC provided little useful information for the public to disseminate in analyzing the proposed order. Instead, the FTC offered a series of unproven assertions against the defendants, and expected the public to accept them at face value without even minimal scrutiny. Furthermore, the government's argument that the settlement was the product of ''negotiation'' with OGMC is disingenuous at best. As is the case here, the settlement forced the network's dissolution. In general, one rarely finds a party to a negotiation committing suicide as part of a mutual exchange. Indeed, as we will discuss below, the process used by the government in obtaining consent orders from physician groups is anything but a genuine ''negotiation.''

B. The Colorado Cases

Following on their triumph in Napa Valley, the FIC's attention next turned to three settlements with physician groups in the Denver area. While nobody was forced to dissolve, FTC officials did manage to substantially hamper several small businessmen in the greater Denver area in the name of protecting competition.

The FTC's chief target in the Denver cases was Marcia Brauchler, the president of Physician's Ally, Inc., a healthcare management consulting firm. Brauchler is an unusual monopolist, as her annual income is approximately $33,000, less than most government employees earn. Physician's Ally is run out of Brauchler's home, and consists of herself and a single part-time assistant.[43]

Despite her modest operation, the government considered Brauchler a dangerous threat to competition because of her work consulting two physician groups, Aurora Associated Primary Care Physicians (AAPCP) and Physician Integrated Services of Denver (PISD), which each consisted of about 40 physician-owners.

AAPCP and PISD both operated under the federal government's ''messenger model'' requirements, with Brauchler as the third-party messenger. As far as she, the doctors, and her attorneys were concerned, their operation was perfectly consistent with the DOJ–FTC guidelines. Then one day in June 2001, Brauchler received a letter from the FTC announcing they had launched an investigation of her, AAPCP, and PISD. FTC staff immediately demanded more than 13,000 pages of documents, most of which Brauchler produced using a rented photocopier in her living room.

Four months after submitting these documents, the FTC informed Brauchler that she had the option of settling immediately or facing a full-scale investigation and administrative trial. Brauchler was not informed of the actual charges against her, and the FTC said no complaint had been prepared. Nevertheless, the FTC would push for a consent order in the absence of any formal charges.

Despite the government's repeated characterization of the consent order process as a ''negotiation,'' Brauchler's experience provides a more accurate picture. In November 2001, Brauchler was told the FTC would prepare a proposed settlement, send it to her counsel for reivew, and then expect her approval. Brauchler was repeatedly promised an opportunity to see the actual complaint against her, but the

[40] U.S. Const., art. IV, 2.

[41] Letter from Glenn Stover to Jeffrey Klurfeld, Director, FTC Western Regional Office 1–2 (July 17, 2002).

[42] Letter from Benjamin I. Berman, FTC acting secretary, to S.M. Oliva 2 (May 30, 2002).

[43] Unless noted otherwise, all information regarding the case against Marcia Brauchler can be attributed to a series of telephone and e-mail interviews CVT conducted with Ms. Brauchler.

FTC would continually delay this, first promising the complaint in January 2002, then March, before finally delivering it in April, *after* Brauchler had agreed to a settlement.

The settlement itself was the product of coercion. The FTC simply presented a proposal and expected it to be accepted without discusssion. Brauchler describes a January 2002 ''negotiation'' between her attorney and FTC staff attorney Paul Nolan as follows:

> Paul was seeing red flags. Management was strongly behind the staff recommendation in this case, that there wasn't a long window for negotiations, and that the FTC would not accept much less than was in the initial settlement offer. The FTC staff, according to Mr. Nolan, was hearing some ''noise'' that they should start issuing subpoenas if they sensed that there was any ''backsliding'' on PISD's willingness to settle essentially on the terms set forth in the settlement offer. Mr. Nolan gave a short list of non-negotiable items * * * The FTC had no interest in setting up a regulatory framework that would allow PISD to continue in operation as it strove to achieve the necessary levels of integration to permit collective bargaining. Mr. Noland said the FTC would be responsive to very narrow proposals of a technical nature, but not to significant substantive changes. Mr. Noland offered that the FTC viewed the proposed settlement as a vanilla-type order.[44]

Nolan added that should the FTC be required to conduct a full investigation, ''there would be more incentive to pursue disgorgement of the profits derived from the antitrust violation.'' In other words, if Brauchler and PISD asserted their right to a trial, the FTC would seek to punish them by demanding ''disgorgement'' of profits in addition to the other proposed remedies. Keep in mind, the profits Brauchler allegedly earned from these ''antitrust violations'' amounted to little more than $30,000 per year, while the alleged victim of her actions included some of the nation's largest health maintenance organizations.

The process Brauchler describes is not, we believe, atypical. At the same time her cases were being ''settled,'' another Colorado-based physician consultant R. Todd Welter, was also facing the FTC's wrath. Like Brauchler, Welter is a self-employed management consultant. Like Brauchler, he was forced to sign a consent order ''with a gun to my head.''[45] Welter and Brauchler were both innocent victims of an FTC witch-hunt designed to placate HMO complaints.

As a result of the consent order he signed, Welter lost substantial share of his business revenue. What's notable about the Welter case is that the FTC apparently fabricated key facts of its complaint. The FTC claimed that eight physician networks that were clients of Welter were organized by him into a negotiating bloc called ''Professionals in Women's Care'' or PIWC. In interviews with PIWC, however, Welter maintained that PIWC was nothing more than the name of a common folder he kept certain clients in; there was never any effort made to collectively bargain on behalf of the PIWC unit.

What all three Colorado cases have in common is the government's insistence that HMOs—multi-billion dollar corporate entities—were the victim of small physician consulting firms. This is patently absurd on its face. In reality, the government decided to punish these consultants and their physician clients for rejecting the HMOs proposed contracts, which the physicians viewed as reimbursing them far below the market value for their services. It was solely a policy question, not a legal one. The government used antitrust law to decide the outcome of a private negotiation, just as the DOJ is prosecuting Mountain now because the government would prefer to see HMOs expand their network within North Carolina.

CVT filed extensive public comments in the Welter case. The FTC barely acknowledged receipt of these comments, refusing to answer the substantive arguments raised by CVT. Consequently, CVT filed a follow-up letter with the FTC asking a series of specific questions about the Welter case and the government's general policy on health care. To date, CVT has received no reply.

C. System Health Providers

At around the same time Welter's case was settled, the FTC also announced a similar deal with a substantially larger group of physicians in Texas, System Health Providers. CVT's comment letter in this case described the situation as follows:

> The facts of this care are fairly simple. Genesis Physicians Group consists of ''approximately'' 1,250 physicians practicing medicine in the ''eastern part of the Dallas-Fort Worth metropolitan area.'' In 1995, GPG formed System Health Providers, a medical management company. Since 1998, GPG has been the sole owner of SHP stock.
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> From 1996 to 1999, GPG engaged in collective bargaining with insurance companies on behalf of its members. These actions were taken under ''risk-sharing arrangements'' where, presumably, some clinical and financial integration of the member physicians' practices took place. These arrangements were consistent with Federal Trade Commission policy, which permits collective bargaining only under ''risk-sharing'' arrangements.
>
> GPG's risk-sharing activities failed miserably. They resulted in ''significant losses'' to the physicians, and the risk-sharing entity formed by GPG was forced to file for bankruptcy protection in 1999. Thereafter, GPG and SHP began to engage in collective bargaining via non-risk-sharing arrangements. In other words, the physicians maintained their individual practices while using a common agent to negotiate with HMOs and other insurance companies. This practice is prohibited by the FTC, because it is considered per se illegal price fixing. Consequently, the FTC began its investigation of GPG and SHP, resulting in the consent agreement now before the public record.[46]

Not only were SHP's physicians punished, they were punished for attempting to maintain the economic viability of their practices. Despite uncontroverted evidence that the business models outlined in Statements 8 and 9 of the FTC–DOJ policies failed, the government maintained they worked. Rather than face a grievous policy error, the government decided to continue blaming physicians.

One interesting note from the FTC's complaint against SHP was this explanation of how the marketplace for healthcare was supposed to work, at least in the government's opinion:

> Medicare's Resource Based Relative Value System (''RBRVS'') is a system used by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for the services they render to Medicare patients. The RBRVS approach provides a method to determine fees for specific services. In general, it is the practice of payors in the Dallas area to make contract offers to individual physicians or groups at a fee level specified in the RBRVS, plus a markup based on some percentage of that fee (*e.g.,* ''110% of 2001 RBRVS'').[47]

This is a curious, but telling statement. If the goal of antitrust policy is to promote free competition, than it should not matter whether HMOs use RBRVS in negotiating their private contracts with physicians. It also shouldn't matter whether physicians adopt RBRVS as the baseline for their own reimbursement demands. After all, in a true market economy, prices are always set by the market actors, not an outside third-party. Yet here the third-party—the federal government—is

[44] E-mail interview with Marcia Brauchler (Jan. 23, 2003).

[45] CVT conducted multiple telephone interviews with Mr. Welter, and any statements of fact in this section should be attributed to these interviews.

[46] Comments of Citizens for Voluntary Trade 2–3 (Sept. 18, 2002) (FTC File No. 011–0196).

[47] Complaint, *In re System Health Providers, Inc.,* and *Genesis Physicians Group, Inc.,* ¶ 10.

arbitrarily imposing price levels on private industry. This further proves the claim that the government's antitrust prosecutions of doctors are motivated by a desire to ultimately protect Medicaid and Medicare from potentially cost-raising actions by physicians asserting their economic rights.

D. Conclusions Based on Recent Cases

While the Court cannot reexamine the government's actions in the prior cases discussed above, it is essential that the Court take judicial notice of how the government conducted these cases, and how their policy judgments are affecting the administration of justice. The cases CVT participated in gave us a clear sense that the government is not acting in good faith when they pursue physician networks and their consultants in antitrust proceedings. Quite the opposite, government ethics seem to go the way of the Spanish Inquisition when it comes to health care policy and antitrust.

Comparisons to the Inquisition may seem overwrought, but in fact the parallels are ominous. The government, much like Torquemada, is on a persistent quest to pursue and punish heresy against doctrine, despite the fact that the underlying dogma is grounded in the complete absence of fact. Much of the antitrust consent decree process is shielded from public view in secret proceedings where the public (and generally the defendants) are unable to obtain a complete understanding of the facts and arguments. The minute the government's policy is called into question, they immediately hide behind dogma or some similarly irrational pronouncement of faith in antitrust doctrine.

This has certainly been CVT's experience in submitting comment letters. Despite repeated, comprehensive, and respectful attempts to gain some insight into the government's antitrust policies and consent decree process, the DOJ and FTC offer little more than token consideration and general platitudes. Both agencies hide behind the Constitution, claiming our arguments amount to nothing more than a constitutional challenge to the Sherman Act itself. While it's true that the Sherman Act is unconstitutional in CVT's judgment, the issue in these cases, and before this Court today, is whether the government's application of the Sherman Act to the exercise of individual rights by physicians is legal and constitutional. This question has never been substantively addressed by a federal court, because if it were, CVT maintains these prosecutions would immediately cease. No rational judge would uphold the government's nonsensical and unconstitutional efforts to impose the will of a handful of bureaucrats on the nation's health care system.

At a minimum, the government should demonstrate some accountability by answering CVT's comments in a careful, rational, and thoughtful manner. This would only benefit the public by providing insight into both the government's enforcement policies as well as the consent order process. As things currently stand, however, the government comes off as an arrogant entity that can't be bothered to explain basic facets of policies that impact a significant sector of the American economy.

Part IV: Analysis of the Proposed Final Judgment

A. The Competitive Impact Statement

Turning to the Competitive Impact Statement, the government makes little effort to actually enhance the public's understanding of the complaint or the proposed judgment. Instead, the CIS largely repeats the unproven and unfounded allegations of the complaint. This approach is not surprising. Even supporters of the government's antitrust policies, such as American Antitrust Institute president Albert Foer, have expressed dismay at the DOJ's lack of candor in past cases: ''The [Justice] Department has traditionally been reluctant to say a great deal in its CIS disclosures, presumably because it risks disclosure of confidential information, adds to the staff's workload, and opens up the door to additional inquiry.''[48] While this may explain the lack of insight from the CIS in this case, it does not justify or excuse the government's failure to uphold their public interest mandate under Tunney Act.

As we noted with the complaint, the CIS makes no serious or credible effort to describe the marketplace Mountain competes in, or how specific customers and individuals within that market were affected by alleged Sherman Act violations. The CIS repeats the complaint's key thesis: ''The physician reimbursement rates that have resulted from Mountain Health Care's negotiations with managed care purchasers are higher than those which would have resulted from individual negotiations with each competing independent physician or medical practice that participates with Mountain Health Care.[49]'' Yet once again, there is nothing in the CIS that proves this statement. The DOJ could have presented a complaint from a managed care purchaser, a comparison of fees between Mountain and non-Mountain contracts, or even a basic economic analysis of the marketplace. The DOJ provided none of this. As a result, it is impossible to credibly show the complaint's allegations possess even a basic level of credibility.

The DOJ will likely take the position, in response to this criticism, that they need not prove any basic facts regarding their case, because to do so would amount to a trial, something which the proposed Final Judgment seeks to avoid. Certainly we can understand the interests of judicial economy require the Court not waste its time proving allegations that both parties have stipulated to. But at the same time, the Tunney Act requires a finding that the proposed Final Judgment is in the ''public interest.'' This should mean the defendant's mere acquiescence to the government's position need not be the final word. Indeed, given that Mountain openly questioned the government's recitation of the facts, we suggest the court has an obligation to conduct some proceedings in order to show the government advanced their complaint and CIS in good faith.

For example, the DOJ asserts in the CIS that no ''determinative materials or documents'' considered by the government in ''formulating the proposed Final Judgment.''[50] Under the Tunney Act, such documents must be released if they exist. Curiously, in almost all antitrust settlements, the DOJ claims no such ''determinative'' documents exist. This is yet again proof that the government seeks to avoid any genuine scrutiny or accountability for their actions. In 1982, just a few years after the Tunney Act's passage, a federal judge concluded the DOJ was not doing its best to act in good faith where ''determinative'' documents were concerned:

> The Court simply cannot accept an interpretation of legislation that permits the government to assert in 172 out of 188 cases that it considered neither documents nor any other materials determinative in reaching its conclusion to enter into a consent decree.[51]

The Tunney Act does not require full disclosure of the DOJ's files, but it does require a good faith review. Only action by the Court can effectively remedy the government's failure to disclose

[48] Letter from Albert A. Foer to Roger W. Fones 2 (Dec. 27, 2002) (available at *http://antitrustinstitute.org/recent2/223a.pdf).*

[49] CIS, 68 FR 1,478, 1,480 (Jan. 10, 2003).

[50] CIS, 68 FR at 1,481.

[51] *U.S.* v. *Central Contracting Co.,* 537 F. Supp. 571, 577 (E.D. Va. 1982).

''determinative'' documents, since in a case such as this one, the DOJ's mere assertion that no such documents exist is insufficient. As noted by the district court in 1982:

> The need for scrutiny is important in any case, but judicial scrutiny is perhaps more important in a run-of-the-mill case on which public attention is not focused and where abuse may escape unnoticed than in a ''big case'' where public interest supplements the court's scrutiny. If the Court in this case doesn't scrutinize there will be no independent scrutiny.[52]

From a public standpoint, the case against Mountain is not a ''big case,'' at least not from a national perspective. And sadly, in the majority of antitrust settlements, there is ''no independent scrutiny.'' This seems part of the government's design. By targeting small businesses which lack the resources to force the government to trial (or even discovery), the DOJ is able to build a track record of antitrust victories. This is not just important from a political standpoint—impressing congressional appropriators—but from a judicial one. The courts become far more perceptive towards antitrust prosecution once the government establishes ''expertise'' in a given field, such as physician networks. What few courts realize, however, is that this experience is built on a foundation of coercion and fraud. The government wins by never facing any serious scrutiny, and this is contrary to the intent and language of the Tunney Act.

B. The Proposed Remedy

Even if the government could prove its antitrust allegations against Mountain, the remedy contained in the proposed Final Judgment is completely inconsistent with antitrust law. The settlement requires ''the complete and permanent dissolution of Mountain Health Care as an on-going business entity'' and the termination of ''all preexisting contracts with payers,'' all within either 120 days of the filing of the DOJ's complaint against Mountain, or 10 days after this Court enters the final judgment, whichever is later.

The function of the antitrust laws—at least in theory—is to restore competition lost, not to impose punitive remedies on antitrust offenders. In this case, the dissolution of Mountain and the termination of its contracts constitute a punishment, rather than a restoration of competition. For this reason alone, the proposed Final Judgment must be rejected.

In Napa Valley, the FTC required OGMC to dissolve. That case, however, only involved a small network encompassing a single specialty, and OGMC was already planning to dissolve their cooperative arrangement prior to the FTC's action. In this case, Mountain was not planning to dissolve, and its network provides far more comprehensive services to its customers.

In most of the prior antitrust cases discussed above, the government generally obtained remedies short of dissolution. These remedies took the forms of injunctions restricting the physicians' ability to jointly negotiate with payers and insurers. While these remedies were equally illegal and unjustified, they do demonstrate the excessive nature of the required dissolution of Mountain. The DOJ could simply have adopted conduct restrictions similar to those in the Colorado cases or System Health Providers. This would have, in theory, satisfied the government's antitrust concerns while not substantially disrupting the health care market in North Carolina.

Indeed, the government's arrogant disregard for Mountain's consumers is galling. By requiring Mountain to terminate their existing contracts, the DOJ manages to violate the rights of thousands of individuals, not just Mountain's shareholders. Based on the documents presented by the government, it's safe to assume these customers were never consulted as to what they wanted, or even if they had any problem with Mountain in the first place. Despite the government's assertion that antitrust laws are about protecting consumers, there is not a single piece of evidence that demonstrates consumer interest was ever taken into account here.

Finally, there is nothing in the government's filings that prove its main argument justifying this remedy—dissolving Mountain will lower consumer health care costs. The entire history of government-sponsored managed care tells us that higher costs are solely a function of government intervention and interference in the free market, and that collective bargaining action by physicians have no substantial impact on what ultimate consumers—patients—actually pay. According to the Congressional Budget Office, which studied the physician collective bargaining issue in 1999, allowing physicians the right to jointly negotiate with HMOs would only increase consumer premiums by about 1.9% annually. This is hardly a figure that justifies the massive government regulation imposed by this proposed Final Judgment. The government also never takes into account the fact that Mountain's physicians, like most doctors nationally, are facing continued reductions in HMO and federal insurance reimbursements. Indeed, Mountain argues their doctors have not experienced significant fee increases in more than 10 years. In no other marketplace would the government penalize individuals for seeking a pay raise once every decade. Of course, in no other industry does the government so blatantly tip the scales in favor of one side as they do with managed care providers.

C. Defining the ''Public Interest''

The first principle of the Tunney Act is that a proposed settlement must be in the ''public interest.'' This term is never defined in the act, nor any other statute where it is employed. The Constitution certainly never speaks of a ''public interest.'' So we're left to divine the phrase's correct meaning.

The government's definition is simple—the ''public interest'' is whatever we say it is. This is why they can impose a remedy, such as dissolving Mountain by force, that noboby asked for and that yields no particular benefit for anyone aside from the government's lawyers. Obviously the Tunney Act rejects this thinking, since it requires the Court to actually scrutinize the government's action, rather than simply acting as a rubber stamp. The failure of previous courts to scrutinize antitrust judgments has, in effect, misled the government into believing in their own omnipotence.

In an individual rights republic like the United States, the more appropriate definition of the ''public interest'' is nothing more than the aggregate of private interests. Protecting the public from violations of individual rights should be the government's paramount aim in any case brought under the authority of the United States. In this case, as we've aptly demonstrated, the government is initiating a violation of Mountain's individual rights rather than protecting the rights of Mountain's consumers.

If every doctor now affiliated with Mountain were to cease practicing medicine tomorrow, the managed care companies and consumers in western North Carolina would have no recourse. Without any providers of medical service, the marketplace would no longer exist. Herein lays a fundamental truth that the government refuses to acknowledge—producers create and define the marketplace, not consumers. Consumers can demand all the services they want, but in the end somebody must provide those services according

[52] *Id.* at 575.

to mutually agreed upon terms. To do otherwise, as the government proposes here, would be to enslave producers to the whims of consumers. If that's how the DOJ defines ''public interest,'' then its antitrust policies have more in common with Karl Marx and Benito Mussolini than they do Thomas Jefferson and Abraham Lincoln.

D. The Court's Powers and Duties

Finally, the government, through the CIS, asks this Court to take to adopt a very selective reading of the Tunney Act in determining its role in reviewing the proposed Final Judgment. The DOJ cites case law that dissuades the Court from taking an active role in assessing the government's case. Citing the D.C. Circuit in *United States* v. *Microsoft,*[53] the DOJ argues:

> [T]he court's role * * * is limited to reviewing the remedy in relationship to the violations the United States alleges in its Complaint, and does not authorize the court to ''construct [its] own hypothetical case and then evaluate the decree against that case.'' * * *the court'' is only authorized to review the decree itself,'' and not to ''effectively redraft the complaint'' to inquire into to other matters that the United States might have but did not pursue.[54]

This position essentially permits the government to present a complaint unchallenged without even minimal scrutiny, regardless of the actual merits of the government's case. This is not consistent with the letter or intent of the Tunney Act. The law gives the Court broad discretion to assess every aspect of an antitrust settlement, including the complaint, the government's good faith in bringing the case, and the impact of the proposed remedies on individual rights and welfare. If this Court finds the government's complaint or CIS is defective on key questions of fact or application of law, there is nothing in the Tunney Act which commands the Court to simply ignore that.

The legislative history of the Tunney Act supports an expansive interpretation. The House Judiciary Committee concluded ''the public does have an interest in the integrity of judicial procedures incident to the filing of a proposed consent decree by the Justice Department.'' The House also concluded: ''Nor is [the Tunney Act] intended to authorize techniques not otherwise authorized by law. The legislative language, however, is intended to isolate further and, thereby, to perclude factors identified as contributing to the rise of the so-called abuse of ''judicial rubber stamping.'' This hardly sounds like commanding language foreclosing the Court's ability to examine the government's complaint to ensure that it conforms to actual facts and law.

It must also be pointed out that while the government cites a number of precedents in the CIS with respect to the Court's role in this proceeding, none of the cases cited emanate from the Supreme Court or the Fourth Circuit. Therefore, this Court is not bound to follow those decisions. Combined with the lack of any case law on the underlying constitutionality of the government's antitrust Statements on health care, this Court is well within its rights to act as a court of first impression on many of the issues raised in these comments.

Part V: Alternatives to the Proposed Final Judgment

For any of the numerous independent grounds cited in these comments, the Court should reject entry of the proposed Final Judgment as inconsistent with the public interest 15 U.S.C. 16(f). The Court should also dismiss the complaint with prejudice, given the government's failure to set forth any claims that would entitle them to relief under the Sherman Act, and because the government omitted material facts from the complaint in order to defraud the Court and the American people.

If the Court decides not to dismiss the complaint, than alternatively it should order a full trial on the merits. While Mountain signed the consent order in large part to avoid a trial, this action must be viewed in the context of an antitrust consent decree procedure. No actual ''negotiation'' took place, as the government obtained all the relief they would have sought at trial. Furthermore, Mountain's counsel advised them to settle immediately before even permitting some discovery or attempting to actually negotiate with the government. In retrospect, Mountain president Ellen Wells told CVT that Mountain now regrets signing the consent agreement, and considers the proposed Final Judgment a mistake. This Court is certainly not required to coddle a defendant's remorse in agreeing to a settlement, but given the enormous imbalance in Mountain's bargaining position relative to the government, the Court should take appropriate action to ensure the interests of justice are not comprised by the government's abuse of discretion.

If the Court were to order a full trial on the merits, the United States would likely withdraw the complaint or immediately negotiate a more equitable settlement with Mountain. The DOJ has never tested the viability of its physician network policies at trial, and we believe they're not about to start here. Thus, ordering a trial would likely produce a result more conducive to the interests of Mountain and the public generally.

Finally, given the blatant and intentional misconduct of the government in prosecuting this case, CVT asks the Court to consider imposing sanctions on the United States under Federal Rule of Civil Procedure 11. The Court, on its own initiative, may impose sanctions against a party when they make representations to the Court which have no evidentiary support. In this case, the government made numerous allegations, described above, for which there is no evidentiary support or where material facts were omitted in order to mislead the Court into reaching an erroneous conclusion. Sanctions are certainly warranted, either in the form of monetary compensation to Mountain, or in such other manner as the Court deems appropriate.

Conclusion

The government's war on physicians must end. Every day the United States spends trying to blame doctors for the failure of three decades of government policies is a day that this country moves closer towards the complete socialization of health care under central control. While the Court is not in a position to make policy pronouncements, this case presents a compelling opportunity for the judiciary to defend its rightful place in the constitutional order from government manipulations. At every turn, in this case and dozens more, the DOJ has subverted the integrity of the judicial system by advancing fraudulent and unethical antitrust ''settlements'' that amount to nothing more than a web of deceit. This pattern simply cannot be allowed to continue.

Mountain Health Care is the innocent victim of the United States' failure to protect the individual rights of physicians and consumers. Sanctioning the proposed Final Judgment amounts to judicial coercion, a rubber-stamping of the government's mob assault on the freedoms and liberties of physicians to join together voluntarily to preserve and promote their economic self-interest. This is not a valid use of the antitrust laws, or any laws propagated by a republican society. Rejection of the proposed Final Judgment is the only possible outcome that would serve the public interest.

[53] 56 F.3d 1148 (D.C. Cir. 1995).

[54] CIS, 68 FR at 1,481.

Appendices to the Public Comments of Citizens for Voluntary Trade

Before: Judge Graham C. Mullen

Filed: March 7, 2003.

S.M. Oliva,
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Appendix A—Documents From Mountain Health Care's Website

Source: *http://www.mountainhealthcare.com/pressrelease.htm.*

Mountain Health Care To Dissolve, Liquidate Assets

Asheville, NC—(Friday, Dec. 13, 2002)—Mountain Health Care (MHC), the largest preferred provider health care network in Western North Carolina, confirmed today that it has consented to the decision by the U.S. Department of Justice (DOJ) to dissolve and liquidate its assets. The company hopes to sell its assets to a new buyer that will continue to provide physicians' services to the community, which includes 22 western North Carolina counties.

The government Friday filed what's known as a complaint and consent decree in U.S. District Court in Asheville, triggering a timetable for dissolution in April, 2003.

According to Todd Guthrie, M.D., chairman and president of the board of Mountain Health Care, the filing is a result of two years' review of documents and several health care organizations in the region as part of an examination of antitrust rules that effectively prohibit physicians from operating provider networks. To date, only Mountain Health Care is affected by this ruling.

MHC is privately held, with 401 physician stockholders, and that fact alone—not the admission of any unlawful conduct—is a substantial reason for the government-ordered closure. ''We are but one of numerous physician-owned organizations operating under similar business models from across the nation who are facing the same situation,'' Guthrie said. ''While we don't find solace in that fact, it is important to know that we apparently have not been singled out.''

''We are terribly saddened and shocked by this news,'' he said. ''Since 1994, Mountain Health Care has been a vibrant, pro-competitive force in our community, helping to protect the health of nearly 70,000 of our neighbors at reasonable and competitive prices. We obviously disagree with the DOJ decision.''

Mountain Health Care has more than 1,800 providers including hospitals, ancillary services, laboratories and primary and specialty care providers.

Chief Executive Officer Ellen M. Wells, said that all stockholders, third party administrators and brokers and nearly 300 employers representing about 70,000 employees, have been notified of the government's decision. She said there are no benefits in challenging the decision.

''According to our attorneys, our only opinion was to go to trial against the DOJ, and we were advised that the cost of doing so far exceeded an amount we can afford,'' Wells said. ''Simply put, we don't have the same resources as Microsoft, for example, which did take on the government in protracted legal proceedings. It would be ethically and morally wrong for us to pass costly legal expenses on to our customers and ultimately to patients,'' she said.

Wells emphasized that the consent decree filing is not evidence of any wrongdoing, rather an agreement to dissolve and sell its assets to another owner. ''The reason is that Mountain HealthCare is a large, physician-owned network, and government antitrust guidelines are complex and permit physicians to own and operate networks only under very narrow circumstances. They don't treat physician-owned companies like they do others owned, for example, by insurance companies. We think this is wrong.''

Wells also pointed out that the government's antitrust rules for networks are not simple. ''The DOJ thought Mountain HealthCare network included too many physicians—which we though benefited consumers since it gives them more physicians from which to choose, as opposed to a smaller, more restrictive network.''

With respect to sale of its assets, Guthrie said the board has already discussed such a sale with a number of potential buyers who are interested in doing business in the Asheville areas. ''We hope to liquidate our assets to a buyer that will continue to provide physicians' and other providers services to our community. In the meantime, we will continue to respond to the needs of our constituency.'' Guthrie said.

Guthrie said the review process and identity of potential buyers is confidential. ''Mountain HealthCare will maintain high-quality, proficient levels of professional service to its network and employers until the assets sale process is complete'', Wells said.

Competition Needs To Grow Between Insurance Companies

By M.D. Stephan Buie
Posted: Dec. 30, 2002 11:06 p.m. (Asheville Citizens Times)

The Citizen-Times reported on Dec. 14 that the U.S. Justice Department has ordered Mountain HealthCare to dissolve, based on accusations of price fixing. People interviewed in the article expressed the hope that dissolving Mountain HealthCare will lead to increased competition and lower health-care costs. What people outside health care do not understand is that for the last 10 years or more physician costs have been controlled by managed care companies and have risen at a rate lower than general inflation. The competition that is needed is among insurers, and dissolving Mountain HealthCare will decrease that competition rather than increase it.

Mountain HealthCare is an association of independent medical practices and was set up not to fix prices, but to compete with managed care organizations. It is not an insurance company, but provides a panel of physicians for insurance companies to contract with. It was established with the advice of attorneys who are experts in federal antitrust law. It works through a blind messenger system, whereby MHC negotiates a rate for services with an employer and then sends those rates to each member practice. Each practice independently decides whether to accept the rate or to counter propose a different rate. All members have been informed that it is not legal to consult with other practices about their participation or their rates. Employers were free to negotiate with other managed care organizations. The physician members also are on panels of other managed care organizations. It is not clear to me how this is price fixing, but as the article indicates, MHC, unlike Microsoft, does not have the money to battle the Department of Justice.

The article about the Mountain HealthCare dissolution stated, ''local businesses were socked with premium increases of 30 percent or more this year.'' Insurance rates are affected by physician costs, hospital costs, drug costs, and the administrative costs of the insurance companies, whose major executives have salaries in the millions of dollars. Managed care organizations were initially created to contain costs and to increase efficiencies in health care. They were successful in decreasing costs initially, and brought increases down to the rate of general inflation. After they cut the fat out of the provider systems, though, it is not clear that they have been as effective in trimming their own fat. Their methods of controlling costs have led ot greater inefficiencies in medical practices, however, in terms of collecting for charges and excessive requirements for treatment plans. Managed care organizations have taken a hard line with payment to physicians, either decreasing payments or holding them steady during the last 10 years. The individual medical practice has no bargaining power with these large companies. It is their way or the highway. If you own a business, imagine running that business without a price increase for the last 10 years.

MHC gave local physicians an organization that provided employers what they need from a managed care organization but would be more responsive to the physicians. In fact, I have often been frustrated that MHC was not more responsive to the needs of the physicians. Their billing was often as confusing as the managed care organizations, but at least they answered the phones when we called.

More physicians are moving away from enrollment in managed care organizations and are demanding cash payment for services. Billing for our services has become extremely complex, time-consuming and costly. Each managed care organization may have several claim centers. If we send our claim to the wrong one, it is rejected without explanation. Their claim centers apparently have no cross-referencing so they can't tell us the correct center to send the claim to. The insurance staff in my office have become convinced that this confusion is intentional, as the harder it is to collect for services, the less the insurance companies have to pay. They do not want to make the system work because it is to their benefit for it not to work.

We are spending more and more time chasing less and less money.

The long-term effect of this will be that insurance will be worth less even as one pays more for it. Fewer physicians will be on managed-care panels because they cannot afford to and one will have to pay out of pocket for one's medical care and submit one's own claim for insurance reimbursement. That is already happening in several local medical offices. The competition will not be among providers but among patients to see who can get medical care. My hope is that some type of reform will prevent that, while allowing physicians to collect for services provided.

Stephen Buie, M.D., is a specialist in psychiatry practicing with the Pisgah Institute in Asheville. He is also an active member of the Buncombe County Medical Society. He lives in Asheville.

Myths and Facts About Mountain Health Care

Posted: January 6, 2003 (Asheville Citizens Times)

Since the federal government's announcement of a forced dissolution of Mountain Health Care a few weeks ago, some of the facts of the case have gone unanswered. Here are answers to some of the misunderstandings and most commonly-asked questions about this issue.

Myth: Mountain Health Care is an insurance company and/or contracts with managed care companies.

Fact: Mountain Health Care is a fully credentialed network of providers (physicians, therapists, nurses and medical laboratories, to name a few) which contracts directly with self funded employers and fully insured companies. Mountain Health Care does not approve or pay claims, and has no contracts with managed care companies.

Myth: In order for an individual to see a Mountain Health Care provider his/her employer must participate with Mountain Health Care.

Fact: Since Mountain Health Care is not an exclusive network, providers are free to participate with any network or plan they choose. Your employer does not have to contract with Mountain Health Care in order for you to see those providers.

Myth: The Mountain Health Care fee schedule resulted in artificially higher reimbursements for physicians.

Fact: The majority of health plans covering lives in Western North Carolina have fee schedules, most of which offer higher total reimbursements than Mountain Health Care's fee schedule. In response to existing antitrust guidelines, Mountain Health Care has transitioned to a messenger model where each payer negotiates directly with each physician.

Myth: Mountain Health Care providers set their office charges based on the Mountain Health Care fee schedule.

Fact: Providers in WNC establish their own office charges. These charges apply to all patients seen by the provider regardless of their health plan, are set independently and are not shared with other providers.

Myth: All Mountain Health Care providers are company shareholders.

Fact: Of the 1800 participating providers in the Mountain Health Care network only 401 physicians have chosen to be stockholding members.

Myth: Mountain Health care has no competition in the Western North Carolina market.

Fact: Employers in the Western North Carolina market place are contracted with many different health plans. Mountain Care members make up an average of only 8% of our providers patient base, and the overwhelming majority of Mountain Health Care providers participate with other plans.

Myth: The federal government discovered the Mountain Health Care's fee schedule is so high is has led to higher health care costs in Western North Carolina.

Fact: Premiums have increased in all types of health care plans and in most regions across the country; the increase in healthcare costs in Western North Carolina is not unusual. There are many factors that influence overall health care costs across the nation including improved technology, rapidly escalating drug prices, an aging population, the trend toward higher jury awards in medical malpractice cases and hospital consolidations. Physician fees account for less than 22% of total health-care costs and it is difficult to see how Mountain Health Care, whose covered lives represent only 8% of our providers' patient base, could be held primarily responsible for these increases. The January 21 issue of Modern Healthcare magazine stated, ''The government blamed the acceleration [of health-care costs] on larger increases in the indices for prescription drugs and hospital services,'' while MHC's prices, with minor exceptions, did not increase between 1994 and the present.

Myth: The doctors who formed Mountain Health Care did so in an attempt to secure comparatively higher reimbursement rates.

Fact: Mountain Health Care was formed to ensure quality, cost effective health care for the residents of western North Carolina. We hope that our members and all residents of western North Carolina, after considering all the facts, understand that the existence of Mountain Health Care did not cause your health care costs to increase. We also hope you will realize that the forced dissolution of Mountain Health Care will in no way lower or drastically alter health care costs within the region. Now, as always, Mountain Health Care and its participating providers have the best interest of our members and community at heart and will do all that we can to continue to provide cost effective, quality health care to you.

Appendix B

Brief of S.M. Oliva as *Amicus Curiae*

Statement of Interest

I, S.M. Oliva, declare that I have no financial interest in this case, nor do I have a financial interest in any competitor of Mountain Health Care, P.A. The views expressed in this brief are my own, and are based on my experience as a public policy analyst in the field of antitrust and competition law.

Summary

In reviewing the Proposed Final Judgment before the Court in this case, *amicus* offers two arguments:

- The United States failed to disclose material facts in their complaint and Competitive Impact Statement (CIS).
- The United States provided insufficient information in the CIS regarding the status and role of Mountain Health Care in the relevant marketplace, as well as how Mountain's acts directly impacted competition in those markets.

A major purpose of the Tunney Act [1] is to facilitate public comments which may assist the Court in determining whether a proposed consent decree is in the public interest. The CIS, in part, is supposed to provide the public with an adequate description of the ''practices or events'' giving rise to an alleged antitrust violation, as well as disclosure of any ''determinative materials or documents'' considered by the government in preparing the proposed Final Judgment.

In this case, the CIS failed both of these tests. The United States took substantial shortcuts in complying with the Tunney Act, and in the process failed to fulfill Congress's underlying objectives. This Court, however, possesses broad statutory power to remedy this situation, by directing the United States to file a revised CIS that provides the public—and the Court—with adequate information to decide whether the proposed decree is in the public interest.

Failure To Disclose Material Facts

In the complaint, the United States asserts that Mountain ''organized and directed an effort to develop a uniform fee schedule to be used to negotiate and contract for fees for physician reimbursement'' [2] from a number of managed care companies and other third-part benefit providers. This fee schedule, according to the government, ''unreasonably restrained competition'' in violation of section 1 of the Sherman Act.[3] As a result, the United States filed suit to obtain the dissolution of Mountain ''before further injury to consumers in North Carolina or elsewhere occurs.'' [4]

This ''uniform fee schedule'' is the nexus of the complaint and the resulting proposed Final Judgment. So long as Mountain maintains this schedule, consumers remain in danger under the Sherman Act. The only way to get rid of the schedule, in the government's view, is for Mountain to be denied its very existence. Otherwise, this fee schedule will continue to run amok, spreading its anti-competitive effects throughout western North Carolina.

But the problem is, the fee schedule the government speaks of may no longer be in play. According to statements made to *amicus* by Ellen Wells, Mountain's president and chief executive, Mountain's current ''fee schedule'' is nothing more than individual doctors informing an independent consultant about their general pricing terms. In other words, a third party spoke to Mountain's

[1] 15 U.S.C. § 16(b)–(h).

[2] Compl. ¶ 1.

[3] *Id.*

[4] *Id.*

physicians separately, obtained independent fee requests, and passed that information along to the managed care companies and other payors. At no point, according to Wells, was there an agreement or conspiracy among Mountain physicians to create a ''universal'' schedule of fixed fees.[5]

Not only does this system not violate the Sherman Act, the United States expressly endorses this type of ''messenger model'' as a safe haven from the general prohibition on independent physicians collectively bargaining with payors. According to the 1996 revisions to the Department of Justice-Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care:

> Some networks that are not substantially integrated use a variety of ''messenger model'' arrangements to facilitate contracting between providers and payers and avoid price-fixing agreements among competing network providers. Arrangements that are designed simply to minimize the costs associated with the contracting process, and that do not result in a collective determination by the competing network providers on prices or price-related terms, are not per se illegal price fixing.

If Mountain's claim, then, is true, and they are employing (or transitioning to) a messenger model, there is no need for the government's proposed remedy—dissolution of Mountain—because there is no illegal behavior taking place. Yet nowhere in the complaint or CIS does the United States discuss, or even acknowledge, Mountain's claim that they employed a messenger model. The government doesn't even offer evidence to refute the claim. Instead, the complaint and CIS present a carefully edited, limited recitation of the facts, omitting a key detail that might influence the public's analysis of the case. In the absence of these disclosures, the public is left to incorrectly conclude that Mountain was simply an illegal price-fixing arrangement among physicians, and that they made no good faith efforts to comply with the law.

Insufficient Information

Congress acknowledged, in passing the Tunney Act, that the public has an interest in ''the integrity of judicial proceedings'' involving proposed antitrust settlements.[6] To that end, the United States has an obligation to disclose enough facts about a case to enable the public to form reasoned judgments about the terms of a proposed Final Judgment. Of key importance is information that details the government's analysis of the marketplace, the competitive problem arising thereto, and the selected remedy. Here, we have little to go by. The United States insists that ''[t]here are no determinative materials or documents'' within the Tunney Act's meaning that warranted public disclosure.[7] *Amicus* disagrees.

The complaint and CIS repeatedly argue that Mountain's actions illegally ''increased physician reimbursement fees.'' [8] The complaint argues that customers ''have paid higher prices for physician services sold through managed care purchasers than they would have paid in the absence'' of Mountain's actions.[9] The CIS further states that Mountain's physicians ''have not clinically or financially integrated their practices'' in such a way as to justify maintaining their uniform fee schedule.[10]

None of these arguments are supported by evidence, at least not evidence that's presented for public review in the complaint or CIS. For example, the public knows nothing, from the government's disclosures, of the exact nature of the market for physician services in western North Carolina. We don't know who Mountain was competing with, what prices they were charging, or even how consumer prices fared in comparison to neighboring marketplaces. We certainly don't know if Mountain's actions actually harmed any consumers. We simply don't know much of anything, beyond the government's mere allegation that there was a fee schedule, and that it was illegal.

Once again, *amicus* faces conflicting information. The United States claims that Mountain increased costs and harmed consumers. Mountain's Ellen Wells, in contrast, claims to *amicus* that Mountain's customers realized an average 14–20% savings over other service networks. Nothing in the complaint or CIS points this out.[11] Furthermore, there is not evidence in the public record that suggests any Mountain customer was dissatisfied with their services or costs. Even one consumer complaint would provide valuable information to the public on the exact nature of the alleged illegal actions. But once again, we're left only with the government's word, despite the existence of evidence that refutes key points of their argument.

It's worth noting that the government's lack of disclosure is hardly unusual in a Tunney Act proceeding. In the overwhelming majority of antitrust settlements, the CIS provides little useful information about a case. In one recent proceeding, Albert Foer of the American Antitrust Institute noted: ''The [Justice] Department has traditionally been reluctant to say a great deal in its CIS disclosures, presumably because it risks disclosure of confidential information, adds to the staff's workload, and opens up the door to additional inquiry.'' [12] All of these explanations may be applicable in this case, but none of them justify withholding relevant and material information from the public.

At an absolute minimum, the United States should provide the public with enough information to assess the state of the affected marketplace at the time the complaint is filed, and also empirical evidence demonstrating how the proposed remedy is likely to restore competition allegedly lost. The government may consider this an inconvenient burden, but the Tunney Act does not contain exceptions for official laziness.

This Court has clear authority to compel government disclosure of relevant information. Congress stated as much in the Tunney Act's legislative history, noting ''the court must obtain the necessary information to make its determination that the proposed consent decree is in the public interest.'' [13] And in one of the few cases where a court actually employed its Tunney Act discretion, *United States,* v. *Central Contracting Co.,*[14] the district judge emphasized the importance of vigorous judicial enforcement of the public's right to information:

> The need for scrutiny is important in any case, but judicial scrutiny is perhaps more important in a run-of-the-mill case on which public attention is not focused and where abuse may escape unnoticed than in a ''big case'' where public interest supplements the court's scrutiny. If the Court in this case doesn't scrutinize there will be no independent scrutiny.[15]

Similarly, this ''run-of-the-mill'' case runs the risk of escaping public attention and scrutiny completely. Without timely intervention by this Court to procure necessary additional information, it is likely the proposed Final Judgment will be entered without any serious examination of the government's arguments. This would render the Tunney Act effectively worthless in safeguarding the public interest.

Conclusion

The public—and this Court—cannot rely on the complaint and CIS, in their present form, to make a proper determination under the Tunney Act on whether entry of the

[5] Telephone Interview with Ellen Wells, President of Mountain Health Care, P.A. (Jan. 23, 2003).

[6] H.R. Rep. No. 93–1463 (1974), reprinted in 1974 U.S.C.C.A.N. 6536, 6539.

[7] Competitive Impact Statement, 68 FR 1,478, 1,481 (Jan. 10, 2003).

[8] Compl. ¶ 14.

[9] Compl. ¶ 17(c).

[10] CIS, 68 FR at 1,480.

[11] Telephone Interview.

[12] Letter from Albert A. Foer to Roger W. Fones 2 (Dec. 27, 2002) (available at *http://antitrustinstitute.org/recent2/223a.pdf*).

[13] H.R. Rep. No. 93–1463, reprinted in 1974 U.S.C.C.A.N. at 6538 (citing S. Rep. 93–298).

[14] 537 F. Supp. 571 (E.D. Va. 1982).

[15] *Id.* at 575.

proposed Final Judgment is in the public interest. The United States omitted key facts from the complaint, and failed to disclose relevant information that would assist the public in forming reasoned judgments about this case. The Tunney Act grants the Court ample power to ensure the government's full compliance, and this case warrants exercise of that power.

Accordingly, the Court should direct the United States to file a revised complaint and CIS, addressing the objections and concerns set forth in this brief. Additionally, the Court should extend the public comment period to allow third parties adequate time to review the revised disclosures so that they may provide appropriate comments to the Court.

Respectfully Submitted,

Dated: February 15, 2003.

S.M. Oliva,
2000 F Street, NW., #315, Washington, DC 20006–4217, Tel: (202) 223–0071, E-mail: smoliva@voluntarytrade.org, Amicus Curiae.

The Center for the Advancement of Capitalism

March 10, 2003.

Mr. Mark J. Botti,
Chief, Litigation Section, Antitrust Division, U.S. Department of Justice, 1401 H Street, NW., Room 4000, Washington, DC 20530.

Re: Public comments in United States v. Mountain Health Care

Dear Mr. Botti: Pursuant to the rights of the public under the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)–(h), I am writing to express the opposition of the Center for the Advancement of Capitalism (CAC) [1] to the proposed Final Judgment in the case of United States v. Mountain Health Care, now pending before the U.S. District Court for the Western District of North Carolina. CAC has reviewed the Competitive Impact Statement and the proposed Final Judgment and it finds that the proposed Final Judgment undermines the public interest and ought to be rejected by the Court.

1. The Proposed Final Judgment Ordering the Dissolution of Mountain Health Care Is Unjustified by the Facts

The proposed Final Judgment demands the complete dissolution of Mountain Health Care on the grounds that it illegally negotiated a uniform fee schedule with insurance companies. Such a draconian end to a company that has been in existence since 1994 and competently and caringly served the health needs of almost 70,000 North Carolinians is shocking. It clearly implies that Mountain Health Care's mere existence as a physician-owned network of healthcare providers is outside the confines of legal behavior under the government's interpretation of the antitrust laws, whatever Mountain's actual behavior. CAC rejects this implication outright. In no way did the government adequately justify its dissolution of Mountain Health Care.

Under FTC–DOJ policy, doctors may collectively bargain with health insurance companies by using three methods: capitation, withholding, and the messenger model. Capitation requires physicians accept a fixed fee per patient regardless of the actual costs of treating that patient. Withholding allows the insurer to withhold a percentage (20–30% or more) of a physician's reimbursement unless some arbitrary goal is met, such as reducing the frequency of a particular procedure. The messenger model allows a third-party to serve as a one-way conduit from the insurer to the doctors.

Mountain Health Care maintains that in accordance with the above guidelines, it now uses the messenger model in its negotiations. Yet nowhere is this critical fact mentioned in the government's Competitive Impact Statement. CAC considers this to be a galling and relevant omission.

2. The Case Against Mountain Health Care Is an Attempt on the Part of the Government To Erode the Rights of Physicians in the Name of Serving an Improperly Defined Concept of the ''public interest''

The ''public interest'' is properly defined by the principle of individual rights as expressed in the Declaration of Independence and animated by the Constitution. The principle of individuals rights is not mere claptrap to be ignored by DOJ lawyers, but the organizing principle of legitimate government.

Yet CAC's observations of the government's antitrust actions in health-care lead it to believe that the government is simply pursuing a policy of reflexively reducing healthcare costs, even at the price of squelching the rights of physicians to pursue their legitimate economic interests via institutions able to negotiate on-par with health insurance companies.

In effect, current government policies in healthcare uses antitrust to obtain the partial socialization of medicine absent clear congressional authority, violates the rights of physicians to profit from their work, and removes the financial incentive that brings most individuals to pursue careers in the healthcare industry.

Yet every attempt CAC has made thus far to point out these glaring contradictions in other Antitrust Procedures and Penalties Act proceedings has resulted in the government's evasion of CAC's core arguments. We hold that even under the nation's system of antitrust, the government can not make literal serfs of some of its citizens because they seek to pursue their legitimate economic interests. Consumers can not possibly benefit from denying physicians the right to collectively bargain their fees.

3. The Court Ought To Use Its Authority Under the Antitrust Procedures and Penalties Act To Check the Unrestrained Government Incursion Against the Rights of Physicians

CAC notes that the complexities of antitrust proceedings are such that few of the government's targets for enforcement can afford to offer a full defense of their actions, even as they maintain their complete innocence. Mountain Health Care claims that it only agreed to the settlement because it has limited assets that preclude it from fighting the requisite court battle with the government.[2] CAC's observations of the government's antitrust actions in healthcare lead it to believe that the government specifically targets those unlikely to offer a defense. While CAC recognizes the burden on the accused to defend themselves, we nevertheless consider this pattern to be relevant in observing how the government carries out its mission of defining and defending the public interest.

4. Mountain Health Care's Business Under Review Was Not Interstate Commerce

CAC also observes that Mountain Health Care's conduct as a preferred-provider organization took place wholly within North Carolina, as outlined in the Competitive Impact Statement. The Justice Department's assertion of jurisdiction here is tenuous at best.

Conclusion

Ultimately, CAC's observations of these facts lead it to question the appropriateness of the proposed Final Judgment. Considering the impact on both Mountain Health Care doctors and their patents, CAC believes a substantive review and ultimate rejection of the proposed Final Judgment is in order. If the Antitrust Procedures and Penalties Act protects the public interest from inadequate antitrust settlements, than it is incumbent upon the Court to use it to protect the public from excessive antitrust settlements. The ''reaches of the public interest'' apply to both producers and consumers, and gross injustice toward producers can not be held to be in the legitimate interest of consumers.

CAC believes the government's position is clear and direct: any attempt by physicians to advance their own economic rights collectively is inherently suspect, if not outright illegal. It would be refreshing to see the government's case stand the test of a trial, but in that absence, CAC believes the Court still has it within its power to challenge the government's brazenly erroneous conclusions by rejecting the proposed Final Judgment.

Respectfully Submitted,

Nicholas P. Provenzo,
Chairman.

February 25, 2003

Mr. Mark J. Botti (via facsimile 202–307–5802),
Chief, Litigation I Section, Antitrust Division, U.S. Department of Justice, 1401 H Street, NW., Room 4000, Washington, DC 20530.

[1] The Center for the Advancement of Capitalism is a District of Columbia corporation organized in 1998, and exempt from income tax under Section 501(c)(4) of the Internal Revenue Code. CAC's mission is to present to policymakers, the judiciary and the public analyses to assist in the identification and protection of the individual rights of the American people. CAC applies Ayn Rand's philosophy of Objectivism to contemporary public policy issues, and provides empirical studies and theoretical commentaries on the impact of legal and regulatory institutions upon the rights of American citizens. CAC has no financial interest in the outcome of this case, nor has CAC received any compensation from the defendants in connection with these comments.

[2] *http://www.mountainhealthcare.com/pressrelease.htm* on 4/10/03.

Re: Public comments in United States v. Mountain Health Care

Dear Mr. Botti: I am writing to express opposition to the proposed Final Judgment in the case of *United States v. Mountain Health Care,* now pending before the U.S. District Court for the Western District of North Carolina. The proposed judgment will not benefit the public interest, and will actually cause harm to consumers by depriving thousands of North Carolina residents of the benefits of a comprehensive, stable physician network.

In my opinion, the Justice Department lacks insights into the practices of Mountain's business to understand their good faith efforts to comply with the DOJ–FTC Statements of Antitrust Enforcement Policy in Health Care and has ignored the ramifications of the consent decree being imposed on Mountain. Through personal experience with the anti-trust settlement process, the government claims that no one operates the messenger model correctly. This presumption means physicians, and their advisors, are presumed guilty from the beginning of an investigation.

Also, the anti-trust laws, as they are being applied against physician networks, are only helping the parties that the Sherman Act was originally intended to protect the public against * * * the health plans. The modern day ''robber barons'' are the insurance companies, with billions of dollars in profits and unchecked power against employers and healthcare providers. Physicians have not caused rising healthcare premiums, as the standard FTC–DOJ consent language would suggest. In fact, the physician fee schedules from insurance carriers, including the largest payor, Medicare, have not even kept up with normal inflation, much less medical inflation rates since the 1970s.

The ''excuse'' of per se price fixing in pursuing these prosecutions is an attempt by the government to not have to prove a case. The fact that physicians, and their advisors, have no resources to sustain an FTC–DOJ investigation much less contest a settlement offer, should not be a reason for the government to continue bullying professionals into settlement after settlement without providing a reasonable means for physicians to continue to operate a practice in a world dominated by billion-dollar insurers. However, the federal government continues chalking up 'victories' in the arena of physician network dissolution under the guise of ridding the world of anti-trust offenders. I've asked repeatedly, and have not received an answer, ''Who's been hurt?'' in these recent cases pursued by the DOJ and FTC. I ask again, and beg for an answer, ''Who's been hurt?'' in this case against Mountain.

While I'm not happy to have settled anti-trust cases recently, I find the inconsistency in the application of the consent decree with Mountain disturbing. Why should one physician network be offered an opportunity to continue to operate while another is forced to disband? In either event, the physicians are forced to operate their practices with blinders on, practicing as individuals at the mercy of the health plan forced to operate their practices with blinders on, practicing as individuals at the mercy of the health plan contract offers. In both outcomes the physicians are left with no ability to do anything, having ''failed'' at the application of the only safe harbor offered by the government—the exclusive messenger model. How would one treatment of the organization (continue versus disband) affect the members of the patient community differently? Dissolution seems to only serve the purposes of exacting a harsher punishment.

The Justice Department has not taken into account the interests of actual consumers. Nor have they ever considered the rights of Mountain's shareholders and physicians. As citizens of the United States, they have an absolute right to freely associate with other professionals for their mutual benefit. It is not a crime to act in one's economic self-interest, so long as one does not implement actual force against other individuals. Since there's no evidence Mountain ever initiated force against its customers, there is no justification for the extreme remedy provided for in this final judgment.

For these reasons, the Justice Department should withdraw the proposed Final Judgment and dismiss its complaint against Mountain.

Please include these comments in the official record of this case, pursuant to the Tunney Act.

Sincerely,

Marcia L. Brauchler,
Physicians' Ally, Inc., P.O. Box 260661, Littleton, CO 80163–0171, (303) 346–2935.

BILLING CODE 4410–11–M

PHYSICIANS' ALLY, INC.
Health Care Consulting
2722 W. Cactus Bluff Place
Highlands Ranch, CO 80129

Fax

To:	Mark Botti	**From:**	Marcia Brauchler
Fax:	202-307-5802	**Pages:**	3
Phone:		**Date:**	3/10/2003
Re:	Mountain Health Care	**CC:**	

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

Please find following this fax cover a public comment letter.

BILLING CODE 4410–11–C

January 25, 2003.

Dear Mr. Botti, I am writing to comment about the proposed Consent Decree relating to the dissolution of Mountain Health Care. It is common

knowledge among current and former employees that the CEO, Ellen Wells, purposely put off changing to Messengering because she was under the impression that the DOJ would just disappear. She was also concerned that it might reduce the 5% withhold that MHC was charging the providers on their claims and jeopardize the collections, thus impacting her bonus. She has shown noting but total disrespect for the government and total disregard for the employers that contracted with MHC for what they thought were discounted rates from physicians. MHC deserves to dissolve and Ellen Wells deserves to be named as the primary perpetrator of this disaster.

Sincerely,

Concerned employees

January 26, 2003.

Mr. Mark Botti

Chief Litigation I Antitrust division, United States Dept. of Justice, 1401 H Street NW., Room 4000, Washington, DC 20530.

Dear Mr. Botti, If Mountain Health Care did what you say it did, why does the company run ads in the newspaper making it sound like it is totally innocent of anything? (Please read the ads that I include in this letter). I am confused.

Thank you.

Myths and Facts about Mountain Health Care

Since the federal government's announcement of a forced dissolution of Mountain Health Care a few weeks ago, some of the facts of the case have gone unanswered. Here are answers to some of the misunderstandings and most commonly-asked questions about this issue.

Myth: Mountain Health Care is an insurance company and/or contracts with managed care companies.

Fact: Mountain Health Care is a fully credentialed network of providers (physicians, therapists, nurses and medical laboratories, to name a few) which contracts directly with self funded employers and fully insured companies. Mountain Health Care does not approve or pay claims, and has no contracts with managed care companies.

Myth: In order for an individual to see a Mountain Health Care provider his/her employer must participate with Mountain Health Care.

Fact: Since Mountain Health Care is not an exclusive network, providers are free to participate with any network or plan they choose. Your employer does not have to contract with Mountain Health Care in order for you to see those providers.

Myth: The Mountain Health Care fee schedule resulted in artificially higher reimbursements for physicians.

Fact: The majority of health plans covering lives in western North Carolina have fee schedules, most of which offer higher total reimbursements than Mountain Health Care's fee schedule. In response to existing antitrust guidelines, Mountain Health Care has transitioned to a messenger model where each payer negotiates directly with each physician.

Myth: Mountain Health Care providers set their office charges based on the Mountain Health Care fee schedule.

Fact: Providers in western North Carolina establish their own office charges. These charges apply to all patients seen by the provider regardless of their health plan, are set independently and are not shared with other providers.

Myth: All Mountain Health Care providers are company shareholders.

Fact: Of the 1800 participating providers in the Mountain Health Care network only 401 physicians have chosen to be stockholding members.

Myth: Mountain Health Care has no competition in the western North Carolina market.

Fact: Employers in the western North Carolina market place are contracted with many different health plans. Mountain Health Care members make up an average of only 8% of our providers patient base, and the overwhelming majority of Mountain Health Care providers participate with other plans.

Myth: The federal government discovered that Mountain Health Care's fee schedule is so high it has led to higher health care costs in western North Carolina.

Fact: Premiums have increased in all types of health care plans and in most regions across the country; the increase in health care costs in western North Carolina is not unusual. There are many factors that influence overall health care costs across the nation including improved technology, rapidly escalating drug prices, an aging population, the trend toward higher jury awards in medical malpractice cases and hospital consolidations. Physician fees account for less than 22% of total health-care costs and it is difficult to see how Mountain Health Care, whose covered lives represent only 8% of our providers' patient base, could be held primarily responsible for these increases. The January 21, 2002 issue of Modern Healthcare, the industries leading business trade journal stated, ''The government blamed the acceleration [of health-care costs] on larger increases in the indices for prescription drugs and hospital services,'' while Mountain Health Care's prices, with minor exceptions, did not increase between 1994 and the present.

Myth: The doctors who formed Mountain Health Care did so in an attempt to secure comparatively higher reimbursement rates.

Fact: Mountain Health Care was formed to ensure quality, cost effective health care for the residents of western North Carolina.

We hope that our members and all residents of western North Carolina, after considering all the facts, understand that the existence of Mountain Health Care did not cause your health care costs to increase. We also hope you will realize that the forced dissolution of Mountain Health Care will in no way lower or drastically alter health care costs within the region. Now, as always, Mountain Health Care and its participating providers have the best interest of our members and community at heart and will do all that we can to continue to provide cost effective, quality health care to you.

January 8, 2003.

Mark J. Botti, Chief

Litigation I, Antitrust Division, United States Department of Justice, 1401 H Street NW., Room 4000, Washington, DC 20530.

Dear Mr. Botti: In the 16 years I have been in the managed health care industry I have never heard anything as ridiculous as the accusations made by the DOJ and their decision to shut down Mountain Health Care.

The DOJ's press release states that Mountain Health Care's contracting is a practice which resulted in consumers paying increased prices to Mountain Health Care's physician members for health care services. This is ridiculous. Yes, the MHC physician's have a fee schedule, but they also have a fee schedule with Aetna, Cigna, United Health Care, BC/BS and the list goes on and on. In no way was the physician's reimbursement under the Mountain Health Care fee schedule higher than it was under any of the other managed

care contracts the physician's participated on. Their fee schedule had not been changed since the start of the company. In fact, some of the fees they were accepting were lower than Medicare & even Medicaid (both government agencies).

The physicians were not the ones benefiting from this; the community and people covered by Mountain Health Care were. And whether you realize this or not, it was the physician's intent to make sure these people had cost effective affordable health care and not that their reimbursement was higher. Aside from working in the managed health care industry, I also work in a physician's office and I can tell you how pleased the average consumer was who came in and presented their Mountain Health Care cards at the front desk with their Mountain Health Care coverage, not once did I hear a negative word.

''The Antitrust Division is committed to ensuring that consumers buying health care services receive the benefits of competition,'' is the statement your representative made. Having worked in the managed health care industry in Western North Carolina for the past 5 years in both the PPO side and the Physician side concurrently I can tell you that there is plenty of competition going on here.

Having been a spectator of your ''investigation'' into Mountain Health Care and not getting the chance to speak my mind I felt this was my only opportunity to finally speak up. It seemed to me that the moment your investigators arrived on the scene they were determined to shut Mountain Health Care down based upon information and statements given to them by the competition and it just took them two years to find a way they could make it all sound feasible to the consumers, who will be drastically affected by this.

It is sad that the press has interviewed people who have no working knowledge of the healthcare industry for their news articles who make statements about how Mountain Health Care disbanding will decrease their health insurance costs, because their is no way that is going to happen. What is going to happen is the Aetna & Cigna type companies will now move in for the kill and know that these small employer groups and family run companies will have no choice but to go with their costly plans in order to insure their employees and family members. This in itself will drive up the cost of healthcare in this region. This will actually increase the physician's reimbursements since the other company's fee schedule reimbursements are higher than Mountain Health Care's was and people will be forced to join those plans or be uninsured. This will increase their rates and their out of pocket expenses.

The only people who will benefit from your decision to close Mountain Health Care will be the other health care plans and the monopolistic PPO set up by the hospital system here in Asheville. What you have chosen to do here and the decisions you have made are wrong. The DOJ and the judge who signs the order obviously have no idea how much damage they will be doing to the people of Western North Carolina including myself and my children. The economy here is hurt enough. This is only going to make matters worse and I find it hard to believe there isn't one individual within the Department of Justice or the government who is savvy enough to see this.

Sincerely,

Janine Mazur,
301 Spartan Heights, Hendersonville, NC 28792.

Mr. Mark J. Botti,
Chief, U.S. Department of Justice, Litigation/Antitrust Division, 1401 H Street, NW., Room 4000, Washington, DC 20530.

Re: Mountain Healthcare, Asheville, NC

Dear Mr. Botti: Sometimes there is merit in antitrust action; this is NOT one of those times! This decision seems based on emotions, circumstantial evidence, hype and superficial information.

Medical care is costly enough here in Western North Carolina without the Department of Justice pushing costs higher by eliminating a group that gives quality care, lower rates and many options for treatment.

We should not be wasting our government resources on well-intentioned ventures but causing unintended consequences.

I suggest you get an experienced, educated senior official to look through the smokescreen, see the real facts and stop the damage to Western North Carolina.

Regards,

Stewart M. Auten,
President.

January 2, 2003.

Mark J. Botti,
Chief, Litigation 1, Antitrust Division, US Dept of Justice, 1401 H St. NW., Room 4000, Washington, DC 20530.

Dear Mr. Botti: Let me relate to you how concerned I am about the dissolution of Mountain Health Care. For years our family used various insurance companies that our employer contracted insurance for the employees. Never have I been more satisfied with a company as I was with Mountain Health Care. We received our annual physicals therefore cutting down on future expense by the insurance company.

Please reconsider your actions.

Thank you,

Mike and Gale Grooms.

January 9, 2003.

Dear Mr. Botti: Both my wife and I were under Mountain Health Care + we had no complaints. Your people are wrong about charging them with price fixing. How can they raise the area medical cost when they have only 8% of the area population? It is an honest and well run operation. Your action is tyrannical.

Sincerely,

(Name unreadable)

[FR Doc. 03–19051 Filed 7–28–03; 8:45 am]

BILLING CODE 4410–11–M