

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

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/

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

[caenrl1102.pdf](http://www.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.

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