UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, vs. MEDICAL MUTUAL OF OHIO, Defendant.	)	Civil Action No. 1:98-CV-2172

COMPETITIVE IMPACT STATEMENT

Pursuant to Section 2(b) of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)-(h), the United States submits this Competitive Impact Statement to provide the information necessary to enable the Court and the public to evaluate the proposed Final Judgment that the parties have jointly filed.

I. NATURE AND PURPOSE OF THIS PROCEEDING

Simultaneous with the filing of this Statement, the United States filed a civil antitrust complaint against Medical Mutual of Ohio ("Medical Mutual"), the largest health care insurer in Ohio, for unreasonably restraining competition in the hospital services and commercial health plan markets in violation of Section 1 of the Sherman Act, 15 U.S.C. §1. The Complaint alleges that for over ten years Medical Mutual required that any hospital wishing to do business with it in the "Cleveland Region," a seven-county area consisting of Cuyahoga, Ashtabula, Geauga, Lake, Lorain, Medina, and Wayne Counties, agree to a "Most Favorable Rates" ("MFR") clause;

that this MFR clause had the effect of requiring those hospitals to charge Medical Mutual's competitors significantly more than they charged Medical Mutual or pay substantial penalties; that the MFR clause stifled the development of innovative and less costly health plans; and that, as a result, businesses and consumers in the Cleveland Region paid higher than competitive prices and were deprived of innovative and less costly alternatives for health care services.

The parties have stipulated that the proposed Final Judgment may be entered after compliance with the requirements of the Antitrust Procedures and Penalties Act (15 U.S.C. § 16), and that Medical Mutual shall be bound by the provisions of the proposed Final Judgment pending the Court's approval. The parties also agreed that the United States may withdraw its consent at any time prior to the entry of the Final Judgment by serving notice of that withdrawal on Medical Mutual and by filing that notice with the Court. Entry of the proposed Final Judgment will terminate this action, except that the Court will retain jurisdiction over the matter for any further proceedings that may be required to interpret, enforce, or modify the Judgment or to punish violations of any of its provisions. This Court is required by 15 U.S.C. §16(e) to determine whether the proposed Final Judgment is in the public interest.

II. PRACTICES GIVING RISE TO THE ALLEGED VIOLATION

Medical Mutual, a not-for-profit mutual insurance company organized under Ohio law, is by far the largest commercial health care insurer in the Cleveland Region. With more than 730,000 enrollees there, it covers approximately 36% of the commercially insured population and is roughly twice the size of its closest competitor. Medical Mutual also accounts for approximately 25 to 30% of commercial payments to local hospitals, and nearly all of these hospitals depend on Medical Mutual for the largest share of their commercial business.

A. Medical Mutual's MFR Clause

Starting in 1986, Medical Mutual required a MFR clause as a precondition for entering into an agreement with any hospital in the Cleveland Region. Those provisions, in effect, compelled the hospitals to charge non-governmental health plans with a lower total dollar volume of business than Medical Mutual rates equal to or greater than the rates the hospital charged Medical Mutual. Not content with ensuring that it had the best rate, Medical Mutual -- through its MFR clause -- also required that the hospitals maintain certain percentage differentials between the rates charged Medical Mutual and all other smaller commercial payers. Those differentials provided Medical Mutual with a cost advantage of 15-30% over its competitors in the purchase of hospital services.

Medical Mutual's MFR clause created such rate differentials in several ways. First, it required that the hospitals charge all other payers with less volume at the hospital at least as much as they charged Medical Mutual for services to Medical Mutual's indemnity subscribers. Since Medical Mutual typically paid hospitals 15-20% less for services provided to its managed care subscribers, pegging the MFR clause to its indemnity prices automatically gave Medical Mutual a substantial cost advantage over its managed care competitors. In effect, the MFR created a buffer of at least 15-20% between Medical Mutual's managed care costs and the managed care costs of its rivals.

Second, starting in 1990, Medical Mutual began insisting that the hospitals charge all other health plans 1-10% more than they charged Medical Mutual for its indemnity plan. This requirement not only protected Medical Mutual's indemnity plan against competition, but also further widened the cost differential between Medical Mutual's managed care plans and those of

its rivals. Hospitals were required to charge rival payers up to 30% more than they charged Medical Mutual for the same services.

Finally, while Medical Mutual reluctantly agreed in certain instances to a "like-product" MFR clause in which rates were compared on a product-line basis (indemnity to indemnity, managed care to managed care), it still sought to retain the cost advantage that the traditional MFR clause had given it. It did so by explicitly requiring hospitals with such agreements to charge all other plans with less total volume 10-15% more than they charged Medical Mutual.

B. Medical Mutual's Enforcement of the MFR Clause

Medical Mutual vigorously enforced its MFR clause -- and the rate differentials -- with the express purpose of protecting Medical Mutual against competition and significantly raising its competitors' hospital costs. Typically, if a rival payer received discounts greater than those given to Medical Mutual, the auditor would multiply the percentage difference by Medical Mutual's total payments to that hospital. Thus, a rate 10% lower than Medical Mutual's would yield a $200,000 penalty if Medical Mutual's total business for the relevant contract year at that hospital was as little as $2 million. As Medical Mutual accounted for the largest share of nearly every hospital's commercial business -- dwarfing the volume of most other payers in the market -- the MFR penalties could be quite large and were often grossly disproportionate to the benefit received by the rival plan, i.e., the amount that would have allowed the hospital to avoid violating the MFR provision.[1]

[1] For example, in 1991, Medical Mutual assessed a penalty of $342,916 against St. John West Shore Hospital for giving a rival payer a discount below Medical Mutual totaling $13,831; and in 1992, it assessed a penalty of $417,373 against Fairview Hospital System (then known as HealthCleveland) for giving a different rival payer a discount below Medical Mutual's rates totaling $30,781.

Even more significant was Medical Mutual's requirement that MFR compliance audits be conducted retrospectively -- i.e., after the other payers had reimbursed the hospital for its enrollees' claims. Concerned about the ability of competitors to lower their hospital costs through better management of hospital services, Medical Mutual decided -- despite protests of unfairness by both hospitals and its own consultants -- that the auditor was to determine the rates charged other payers, and thus violations of the MFR clause, retrospectively, i.e., it was to look at actual reimbursement levels and not the contractual rate. By doing so it was able to impose penalties in those situations where the contractual discounts did not violate the MFR clause but where the effective discount, after factoring case mix and utilization management, was below the MFR rate. As one hospital complained to Medical Mutual: "[under] this clause we could find ourselves in violation of the Favored Nations provision if a per diem payer through strong utilization review efforts reduced their length of stay and also their aggregate payments." In effect, the hospital would be penalized for a rival payer's greater efficiency.

C. Anticompetitive Effects of Medical Mutual's MFR Clause

As alleged in detail in the Complaint, Medical Mutual's MFR provision harmed competition and reduced consumer welfare in the hospital services and hospital insurance markets in the Cleveland Region by increasing the costs of hospital services for other plans, businesses, and consumers, and by discouraging innovation in the design of health insurance plans and the delivery of hospital services.

1. Medical Mutual's MFR Provision Substantially Increased the Cost of Hospital Services for Rival Plans

Because the MFR provisions required that hospitals charge Medical Mutual's competitors substantially more than they charged Medical Mutual or suffer significant penalties, various hospitals and hospital systems, including MetroHealth, the Cleveland Clinic, University, Meridia, Lake, Marymount, Southwest General, Mt Sinai, and Fairview, were deterred from offering significant additional discounts -- discounts up to 20% or more -- to competing health plans. The result has been to increase the cost of hospital services to Medical Mutual's rivals and, ultimately, to consumers.[2]

In addition, Medical Mutual's aggressive enforcement of the MFR clause discouraged hospitals from offering rates to rival plans even approaching the MFR rate. Since the differences between payment methods, patient mix, and case management, combined with Medical Mutual's retrospective review of actual reimbursement levels, made it difficult, if not impossible, for a hospital to accurately predict whether a contract would violate the MFR clause, hospitals simply refused to price anywhere near the MFR rate, routinely demanding rates from rival plans significantly above the MFR rate in order to protect against what could be a financially devastating penalty.

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[2] Indeed, where the MFR clause has been inapplicable -- whether due to an exemption or for some other reason -- hospitals have demonstrated a willingness to give lower rates to Medical Mutual's rivals. Thus, when Kaiser Permanente became the largest payer at the Cleveland Clinic in 1994, and therefore exempt from the MFR provision, its per case rate for cardiac services alone declined by $2,000. Similarly, when Total Health Care and other payers handling Medicare and Medicaid enrollees obtained an exemption from the MFR clause, University Hospital and MetroHealth gave those plans rates below the MFR rate. Starting in 1996, when it entered the Medicaid and Medicare market, Medical Mutual stopped granting such exemptions and, as a result, those plans have been required to pay higher rates for hospital services.

2. Hospitals and Rival Plans Entered Into Costly Contractual Arrangements Designed to Avoid Medical Mutual's MFR Provision

In addition to discouraging hospitals from offering favorable prices to rival payers, Medical Mutual's MFR clause forced hospitals to manipulate their contractual arrangements with other payers to avoid incurring a MFR penalty. The effect was to increase the cost of hospital services to Medical Mutual's competitors -- and ultimately to consumers.

For example, some hospitals insisted on using "stop-loss" provisions in their contracts with other payers to avoid MFR penalties. These clauses typically required third party payers to reimburse the hospital at a specified percentage of charges for claims that lay outside pre-determined thresholds. MetroHealth Hospital, for example, insisted on such MFR-related "stop-loss" provisions in 90% of its contracts. University Hospital and Fairview Health System have similar provisions in a number of their contracts as well.[3] The additional costs due to these stop-loss provisions were borne by Medical Muual's competitors and, ultimately, by the consumer.

Similarly, some hospitals required payers to make payments over and above contracted rates to avoid a MFR penalty or to reimburse the hospital for any penalty incurred due to the MFR clause. Both mechanisms had the effect of raising the costs of Medical Mutual's rivals and, ultimately, to consumers. For example, Mt. Sinai Medical Center and CIGNA entered into "reconciliation agreements" beginning in 1992 which required CIGNA to reimburse Mt. Sinai

[3] Even those hospitals that would have insisted on "stop-loss" provisions were there no MFR clause (to avoid the financial risk associated with catastrophic or high acuity cases) demanded lower "stop-loss" thresholds because of the MFR clause. By lowering the "stop-loss" threshold, the hospitals ensured that more services were priced above the competitive rate -- increasing the total cost of hospital care. For example, the Columbia/HCA hospitals (St. Vincent Charity Hospital, St. Luke's Medical Center, and St. John Westshore Hospital) would have agreed to higher "stop-loss" thresholds but for the MFR provisions.

any amounts necessary to avoid a MFR violation. CIGNA made retrospective payments to Mt. Sinai of over $600,000 for the years 1990-1992 alone so that Mt. Sinai could avoid over $4 million in MFR penalties that it would otherwise have owed to Medical Mutual.

Nor was Mt. Sinai the only hospital to do so. The Cleveland Clinic has a reconciliation agreement with Kaiser in the event its volume ever falls below Medical Mutual's volume. MetroHealth demanded that various payers, including Prudential, Aetna, QualChoice, and Personal Physician Care, make additional payments if MetroHealth's own MFR audit suggested a violation. Meridia Health System required some payers to reimburse it for any amount paid for a MFR violation. University Hospital's contracts with Prudential required Prudential to make additional payments of $409,232.82 in 1996 alone.

Hospitals also demanded to re-negotiate existing agreements when faced with potential MFR violations. MetroHealth Hospital, for instance, requested HealthStar to re-negotiate rates in the midst of its 1993-94 contract because the patient mix was not as anticipated and would have caused a MFR violation, and required that Aetna agree to re-negotiate its rates if a MFR violation appeared likely. Southwest General increased Emerald's inpatient reimbursement in the middle of its contract period in 1993, and in 1995 demanded to re-negotiate several contracts, including the contract with HMO Aetna, to avoid a MFR violation. In 1995, the Cleveland Clinic re-negotiated Aetna's contract because the Clinic's new contract with Medical Mutual generated a higher MFR benchmark, one requiring a 20% increase in Aetna's inpatient rates. Still other examples include Lake Hospital demanding that CIGNA re-negotiate its contract after Lake paid a $225,000 MFR penalty; Meridia Health System terminating a contract with Affordable Health and re-negotiating a new contract at substantially higher rates after having

been found in violation of the MFR provision; and Meridia entering into an agreement with United HealthCare requiring the latter to re-negotiate its rates if the MFR clause was violated.

Finally, some hospitals simply terminated contracts with other payers when they were unable to re-negotiate terms: thus, Southwest General terminated its 1994 contract with CIGNA for behavioral services after it learned from Medical Mutual's auditor that CIGNA's 1992 contract violated the MFR clause and CIGNA refused to re-negotiate; Lake Hospital terminated its contract with Prudential because of the MFR and lost its contract with CostLogics after a 1992 MFR audit prompted Lake to request a substantial rate increase; Lakewood lost its HMO Agreement with Metlife in 1992 because of the MFR; and University Hospital and Mutual of Omaha agreed to higher rates when Mutual of Omaha declined University's proposal to incorporate a reconciliation provision in their contract.

Medical Mutual has been well aware of the significant effect the MFR had on its rivals' costs, the demands by hospitals for retroactive payments from its rivals, the re-negotiation of contracts to increase existing rates, and even the termination of such contracts. Indeed, its recent contracts expressly provide that the hospital may elect, in order to avoid a violation of the MFR provision, to terminate, modify, or amend its contract with the other payer. The MFR's purpose and clear effect has been to increase the costs paid by other plans and, ultimately, by the consumer.

3. Medical Mutual's MFR Provision Hindered Innovation in the Delivery of Health Care Insurance

Medical Mutual's MFR provision also discouraged the development of innovative approaches to the efficient delivery of health insurance, particularly new contracting methodologies and novel health plan designs. Confronted by the threat posed by rival payers

willing to invest in additional tools and resources to provide more efficient and better quality health care plans, Medical Mutual, through its MFR clause, required that all payers, regardless of utilization management, case mix, or other factors, pay a hospital at least as much or more than Medical Mutual for similar services. If a hospital's actual price to another payer was below the MFR benchmark for any reason, including more efficient management, Medical Mutual would assess a penalty against the hospital. The result was to force hospitals to raise all rates to Medical Mutual's level (or above), removing the principal incentive for other payers to invest in more efficient case management. Unable to obtain the benefits of more efficient case management, rival payers declined to invest in less costly methods and consumers were deprived of the choice of alternative plans.

Medical Mutual's MFR provisions also created a significant disincentive to the development of low-cost, narrow-panel health care plans in the Cleveland Region, thus depriving consumers of the choice of such plans. By limiting its enrollees to fewer hospitals, a small-panel plan provides higher volume to each of the participating hospitals in exchange for more aggressive discounts from the hospitals. In the Cleveland Region, however, Medical Mutual's MFR clause discouraged hospitals from offering a discount large enough to make such plans marketable.

Medical Mutual's MFR provisions also discouraged the use of "carve-out" contracts -- contracts for such specialty services as obstetrics, organ transplants, or invasive cardiology. These specialty contracts can reduce hospital costs for payers and consumers by allowing a payer to contract for those services in which the hospital has developed a particular expertise and by allowing the hospital to more efficiently use its resources. Medical Mutual's MFR provisions,

however, discouraged hospitals in the Cleveland Region from entering into such specialty contracts by requiring that those payers be charged at least as much as Medical Mutual for such services. For example, both University Hospital and the Cleveland Clinic requested exemptions from the MFR clause in order to enter into such carve-out contracts: University for both soft tissue transplant and obstetrics services; the Clinic for certain cardiology services. Medical Mutual refused them both, and neither participated in the programs because of the significant penalties they would have incurred.

III. EXPLANATION OF THE PROPOSED FINAL JUDGMENT

The parties have stipulated that the Court may enter the proposed Final Judgment after compliance with the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)-(h).

A. Scope of the Proposed Final Judgment

Section III of the proposed Final Judgment provides that the Final Judgment shall apply to Medical Mutual and all other persons (including Medical Mutual's Participating Hospitals[4]) in active concert or participation with it who shall have received actual notice of the Final Judgment by personal service or otherwise.

B. Prohibitions and Obligations

Section IV sets forth the conduct prohibited by the Final Judgment.[5] Section IV(A) enjoins and restrains Medical Mutual from adopting, maintaining, or enforcing for the next ten

[4] Participating Hospitals are all hospitals in the Cleveland Region that have hospital agreements with Medical Mutual.

[5] While the relief here is limited to the Cleveland Region, the proposed Final Judgment does not foreclose the United States from investigating and subsequently seeking relief for comparably anticompetitive conduct by Medical Mutual in other geographic areas.

years a Most Favorable Rates Requirement, defined as any policy, practice, rule, or contractual provision which (1) requires a Participating Hospital to charge any third party payer as much as or more than the rate charged to Medical Mutual by such Participating Hospital, or (2) requires a Participating Hospital to charge Medical Mutual rates equal to or lower than the lowest rate it charges any third party payer. Section IV(A) further enjoins and restrains Medical Mutual for a similar period from adopting, maintaining, or enforcing any policy, practice, rule, or contractual provision having the same purpose or effect.

Section IV(B) enjoins Medical Mutual from adopting, maintaining, or enforcing any policy, practice or agreement that requires a hospital to disclose to Medical Mutual directly or indirectly the rates such hospital offers or charges any other commercial payer. This section is intended to prevent Medical Mutual from achieving an effect comparable to that of the MFR clause by compelling hospitals to disclose information to it or its agents regarding the rates the hospitals charge other payers.

Section V lists various activities Medical Mutual may engage in so long as they do not violate the prohibitions of Section IV in doing so. These activities include negotiating rate arrangements and payment methodologies with hospitals, receiving information about rates charged others under certain conditions, establishing provider networks, recruiting hospitals participating in other plans, having different reimbursement levels for different participating hospitals or panels, and terminating or refusing to contract with hospitals. All such activities are specifically made subject to the prohibitions of Section IV so that they not become surrogates for the MFR clause.

More specifically, Section V(A) permits Medical Mutual to negotiate for or obtain the lowest rate(s) or largest discount(s) from any participating hospital whether on an overall or product line basis. Consistent with Section IV(A)'s prohibition against Medical Mutual's requiring or compelling a hospital to give it the lowest rates, this section allows Medical Mutual to use its bargaining skills to obtain the lowest rate. In addition, Section V(B) permits Medical Mutual to receive rate information from a Participating Hospital when the provision of such confidential information is purely voluntary and not the result of a bargain. Since the disclosure of any rate information, if coerced or purchased, may affect a hospital's willingness to discount, Section V(B) together with Section IV(B) make clear that Medical Mutual cannot request that a hospital disclose the rates it charges other payers, cannot compel a hospital to disclose such rates, and cannot offer consideration for such information. Sections IV(C) and (D) specifically allow Medical Mutual to establish preferred provider networks or alternative delivery systems, to recruit hospitals who have contracts with other payers, and to have different rate arrangements or payment methods for different product lines, hospitals or networks. These activities are least likely to violate the prohibitions of Section IV. Finally, in Section V(F), Medical Mutual is permitted to decline or to refuse to contract or do business with any hospital or terminate any hospital agreement. As with the rest of Section V, however, Section V(F) is permitted only to the extent it does not violate the prohibitions of Section IV. Thus, for example, while Medical Mutual may be permitted to terminate a hospital agreement, the grounds for doing so cannot violate Section IV.

Section VI of the Final Judgment declares all Medical Mutual's MFR provisions null and void, making it clear that no Most Favorable Rates Requirement imposes any obligation on any of Medical Mutual's Participating Hospitals in the Cleveland Region.

Section VII of the Final Judgment sets forth various compliance measures. Section VII(A) requires Medical Mutual to distribute, within 60 days of the entry of the Final Judgment, a copy of the Final Judgment to: (1) all Medical Mutual officers and trustees; and (2) all Medical Mutual employees and agents who are responsible for negotiating, approving, disapproving, or enforcing any of Medical Mutual's hospital agreements with Participating Hospitals, excepting only those employees and agents primarily involved in the administration of payments to and collections from hospitals. Sections VII(B)-(D) require Medical Mutual to provide a copy of the Final Judgment to persons who succeed to the positions of those covered by VII(A), and to obtain and maintain records of present and future officers', trustees', agents', and employees' written certifications that they have read, will abide by, and understand the consequences of their failure to comply with the terms of the Final Judgment. Sections VII(E) and (F) require Medical Mutual to distribute a copy of the Final Judgment to all currently Participating Hospitals and all other hospitals who enter into negotiations with Medical Mutual for a hospital agreement after the entry of the Final Judgment. Finally, Section VII(G) obligates Medical Mutual to report to the United States any violation of the Final Judgment.

Section VIII obligates Medical Mutual to certify its compliance with the requirements of Sections IV, VI, and VII of the Final Judgment. In addition, Section IX sets forth a series of measures by which the Plaintiff may have access to information needed to determine or secure

Medical Mutual's compliance with the Final Judgment. Section X limits the term of the Final Judgment to ten years.

C. Entry of the Proposed Final Judgment Is In the Public Interest

Section 2(e) of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(e), requires that the Court's entry of the proposed Final Judgment be in the public interest. The Act permits a court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's complaint, whether the decree is sufficiently clear, whether enforcement and compliance mechanisms are adequate, and whether the decree may harm third parties. See United States v. Microsoft Corp., 56 F.3d 1448, 1461-62 (D.C. Cir. 1995). Consistent with Congress' intent to use consent decrees as an effective tool of antitrust enforcement, the Court's function is "not to determine whether the resulting array of rights and liabilities is the one that will best serve society, but only to confirm that the resulting settlement is within the reaches of the public interest." Id. at 1460 (internal quotations omitted); see also United States v. Bechtel Corp., 648 F.2d 660, 666 (9th Cir.), cert. denied, 454 U.S. 1083 (1981). The United States submits that entry of this proposed Final Judgment is in the public interest because it addresses the anticompetitive effects alleged in the Complaint and forecloses Medical Mutual from achieving the MFR clause's anticompetitive effects in other ways.

More specifically, by nullifying Medical Mutual's MFR clause and enjoining any policy, practice or rule having the same purpose or effect under Section IV(A), the proposed Final Judgment will ensure unrestrained price competition between Medical Mutual and other health insurance plans and among hospitals in the Cleveland area. Without a price floor set by MFR clauses or other similar provisions, hospitals will have a greater incentive to discount, thereby

lowering health care costs for consumers as well as encouraging more innovation in the delivery of health care services. In addition, Section IV(B) restricts Medical Mutual's ability to compel from its Participating Hospitals, or bargain for, information on the rates the hospitals charge other payers, ensuring that Medical Mutual does not indirectly impose a MFR provision.

Finally, Section V of the proposed Final Judgment allows Medical Mutual to continue to compete on largely the same terms as other health insurance plans. Medical Mutual will not be restricted from negotiating different rate arrangements for different hospitals, establishing preferred provider networks or other forms of provider panels, recruiting hospitals who are participating in other provider panels, or even receiving rate information from its participating hospitals when the disclosure of such information is purely voluntary.

D. Medical Mutual's Voluntary Termination of the MFR Clause Does Not Eliminate the Need for Injunctive Relief

Despite Medical Mutual's recent promise to cease enforcing its MFR provisions and terminate the MFR audits, there is substantial likelihood of future violations of the antitrust laws and recurring harm to consumers in the absence of an injunction. In the absence of an injunction, Medical Mutual's promise is not enforceable, and nothing prevents Medical Mutual from reneging at any time, a possibility made more probable by its apparently strongly held belief that its conduct was lawful.[6] See United States v. Cleveland Trust Co., 393 F. Supp. 699, 710 (N.D. Ohio, 1974). In addition, Medical Mutual has clearly not precluded itself from

[6] In its challenge to the Civil Investigative Demand issued to it in 1995, Medical Mutual, then known as Blue Cross and Blue Shield of Ohio, vigorously contended that its conduct could not be investigated as it was procompetitive as a matter of law. This Court (Aldrich, J) soundly rejected that position in Blue Cross and Blue Shield of Ohio v. Bingaman, 1996 WL 677094 (N.D. Ohio), 1996-2 Trade Cas. 71600, aff'd. 113 F.3d 1420 (Table, text at 1997 WL 400095)(6th Cir. 1997).

instituting schemes short of reinstituting the MFR provision, schemes which could include auditing participating hospitals to determine other payers' rates or simply requiring the hospitals to disclose the rates they charged other payers, and then demanding comparable or lower rates. Given Medical Mutual's high market share in the Cleveland area relative to other payers and thus its correspondingly significant bargaining power, all of those arrangements, contractual or otherwise, are real options for Medical Mutual, and if implemented, could have the similar anticompetitive effects of deterring hospitals from discounting to other payers or participating in more innovative and efficient health care delivery systems.

Moreover, injunctive relief is particularly appropriate in this instance because Medical Mutual's voluntary abandonment was clearly occasioned by the government's then-imminent enforcement action. If an antitrust defendant is allowed to simply abandon its challenged conduct on the eve of a government action, then the enforcement of antitrust laws by the United States would be significantly hampered. United States v. W.T. Grant Co., 345 U.S. 629, 632 (1953). A trial court's wide discretion "is not to be exercised to deny relief altogether by lightly inferring an abandonment of the unlawful activities from a cessation which seems timed to anticipate suit." United States v. Parke, Davis & Co., 362 U.S. 29, 48 (1960).

IV. ALTERNATIVES TO THE PROPOSED FINAL JUDGMENT

An alternative to the proposed Final Judgment would be a full trial on the merits of the case, which would involve substantial time and expense to the United States and Medical Mutual and create uncertainty in the ultimate relief to be obtained by the United States. A trial is also undesirable because the United States believes that the proposed Final Judgment fully remedies the violations of the Sherman Act alleged in the Complaint.

The United States considered a claim for treble damages arising from overcharges the United States paid for the health insurance of federal employees in the Cleveland Region. Because Medical Mutual's use of a MFR clause had artificially inflated the cost of health insurance in the Cleveland Region, it similarly increased the amount of contribution the United States paid on behalf of its employees through the Federal Employees Health Benefit Program ("FEHBP") to rival health plans in Cleveland.

However, in light of the costs and delay associated with litigation necessary to secure damages, and the fact that payments by the United States for its employees' health insurance constitute only a modest percentage of the total health insurance cost in the Cleveland area, it was determined that the time and resources required to pursue damages were unwarranted. Moreover, private litigants, such as competing health plans, may be in a position to pursue damages claims against Medical Mutual. Should health plans whose enrollees include federal employees succeed in recovering damages from Medical Mutual, such recovery would also likely be passed on to the United States in the form either of rebates under the cost-plus provisions of such contracts or through lower premiums. The United States concluded, therefore, that the public interest is better served by securing the immediate, certain, and substantial relief set forth in the proposed Final Judgment without pursuing a damages claim.

V. REMEDIES AVAILABLE TO PRIVATE LITIGANTS

Section 4 of the Clayton Act, 15 U.S.C. § 15, provides that any person who has been injured as a result of conduct prohibited by the antitrust laws may bring suit in federal court to recover three times the damages suffered, as well as costs and reasonable attorney's fees. Entry of the proposed Final Judgment will neither impair nor assist in the bringing of such actions.

Under the provisions of Section 5(a) of the Clayton Act, 15 U.S.C. § 16(a), the Final Judgment has no prima facie effect in any subsequent lawsuits that may be brought against Medical Mutual in this matter.

VI. PROCEDURES AVAILABLE FOR MODIFICATION OF THE PROPOSED FINAL JUDGMENT

As provided by the Antitrust Procedures and Penalties Act, any person believing that the proposed Final Judgment should be modified may submit written comments to Gail Kursh, Chief; Health Care Task Force; Department of Justice; Antitrust Division; 325 7th Street, N.W.; Room 404; Washington, D.C. 20530, within the 60-day period provided by the Act. Comments received, and the Government's responses to them, will be filed with the Court and published in the Federal Register. All comments will be given due consideration by the Department of Justice, which remains free, pursuant to Paragraph 2 of the Stipulation, to withdraw its consent to the proposed Final Judgment at any time before its entry if the Department should determine that some modification of the Judgment is necessary to protect the public interest. The proposed Final Judgment itself provides that the Court will retain jurisdiction over this action, and that the Parties may apply to the Court for such orders as may be necessary or appropriate for the modification, interpretation, or enforcement of the Judgment.

VII. DETERMINATIVE DOCUMENTS

No materials and documents of the type described in Section 2(b) of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b), were considered in formulating the proposed Final Judgment. Consequently, none are filed herewith.

DATED: September 23, 1998

Respectfully submitted,

/s/
Paul J. O'Donnell

/s/
Jean Lin

/s/
Andre Barlow

/s/
Frederick S. Young
Attorneys,
Antitrust Division
U.S. Department of Justice
325 7th Street, N.W.
Washington, D.C. 20530
(202) 616-5933