IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

UNITED STATES OF AMERICA and STATE OF TEXAS, *Plaintiffs*, *v.* UNITED REGIONAL HEALTH CARE SYSTEM, *Defendant.*	Civ. No. 7:11-cv-00030

COMPETITIVE IMPACT STATEMENT

Plaintiff United States of America ("United States"), pursuant to Section 2(b) of the Antitrust Procedures and Penalties Act ("APPA" or "Tunney Act"), 15 U.S.C. § 16(b)–(h), files this Competitive Impact Statement relating to the proposed Final Judgment submitted for entry in this civil antitrust proceeding.

I.
NATURE AND PURPOSE OF THE PROCEEDING

On February 25, 2011, the United States and the State of Texas filed a civil antitrust lawsuit against Defendant United Regional Health Care System ("United Regional") challenging United Regional's contracts with commercial health insurers that effectively prevent insurers from contracting with United Regional's competitors ("exclusionary contracts"). The Complaint alleges that United Regional has unlawfully

used these contracts to maintain its monopoly for hospital services, in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

With the Complaint, the United States and the State of Texas filed a proposed Final Judgment that enjoins United Regional from using exclusionary contracts. The United States, the State of Texas, and United Regional have stipulated that the proposed Final Judgment may be entered after compliance with the APPA, unless the United States withdraws its consent. Entry of the proposed Final Judgment would terminate this action, except that the Court would retain jurisdiction to construe, modify, or enforce the provisions of the proposed Final Judgment and to punish violations thereof.

II.
DESCRIPTION OF THE EVENTS GIVING RISE TO THE ALLEGED VIOLATION

A. The Defendant and the Challenged Conduct

This case is about competition for the sale of hospital services in Wichita Falls, Texas, and its surrounding areas. The Defendant, United Regional, is a general acute-care hospital located in Wichita Falls. With 369 beds, United Regional is by far the largest hospital in the region and the only provider of some essential services, such as cardiac surgery, obstetrics, and high-level trauma care.

United Regional was formed in October 1997 by the merger of Wichita General Hospital and Bethania Regional Health Care Center. At the time of that merger, there were no other general acute-care hospitals in Wichita Falls and only one small outpatient surgery center. Soon after the merger, however, a group of doctors began planning for a competing hospital called Kell West Regional Hospital ("Kell West"). Kell West opened

in January 1999 and is now a 41-bed general acute-care hospital, located about six miles from United Regional. Kell West provides a wide range of inpatient and outpatient procedures, but does not provide some key services offered by United Regional such as cardiac surgery and obstetrics.

Beginning in 1998, United Regional responded to the competitive threat posed by Kell West and other outpatient-surgery facilities by systematically entering into exclusionary contracts with commercial health insurers. The precise terms of these contracts vary, but all share the same anticompetitive feature: a significant pricing penalty if an insurer contracts with competing facilities within a region that is no larger than Wichita County.[1] In general, the contracts offer a substantially larger discount off billed charges (*e.g.*, 25%) if United Regional is the only local hospital or outpatient surgical provider in the insurer's network; and the contracts provide for a much smaller discount (*e.g.*, 5% off billed charges) if the insurer contracts with one of United Regional's rivals.[2]

Within three months after Kell West opened in January 1999, United Regional had entered into exclusionary contracts with five commercial health insurers, and by 2010, it had exclusionary contracts with eight insurers. In each instance, it was United Regional that required the exclusionary provisions in the contract—not the insurer. The

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[1] One contract excludes facilities within ten miles of the City of Wichita Falls; two contracts exclude facilities within fifteen miles of the City of Wichita Falls; one contract excludes facilities within certain zip codes in Wichita County; and three contracts exclude facilities located anywhere in Wichita County. Some contracts also exempt specific facilities that would otherwise be covered by the exclusionary provisions; for example, some contracts allow insurers to contract with Electra Memorial Hospital, a small hospital located more than 30 miles from Wichita Falls (but within Wichita County) that would have otherwise been excluded.

[2] Hospitals and insurers often negotiate contracts in which the price that the insurer pays is expressed as a discount off the hospital's list prices (also called "chargemaster" or "billed charges"). Thus, a penalty that reduces an insurer's discount from 25% to 5% (for adding a rival facility) increases the insurer's price from 75% to 95% of billed charges—a 27% increase.

only major insurer that did not sign an exclusionary contract with United Regional was Blue Cross Blue Shield of Texas ("Blue Cross"), by far the largest insurer in Wichita Falls and in Texas.

The Complaint alleges that because United Regional is a "must have" hospital for any insurer that wants to sell health insurance in the Wichita Falls area, and because the penalty for contracting with United Regional's rivals was so significant, most insurers entered into exclusionary contracts with United Regional. Consequently, United Regional's rivals could not obtain contracts with most insurers, except Blue Cross, which substantially hindered their ability to compete and helped United Regional maintain its monopoly in the relevant markets, to the detriment of consumers.

The Complaint alleges that by effectively preventing most commercial health insurers from including in their networks other inpatient and outpatient facilities, United Regional has (1) delayed and prevented the expansion and entry of United Regional's competitors, likely leading to higher health-care costs and higher health insurance premiums; (2) limited price competition for price-sensitive patients, likely leading to higher health-care costs for those patients; and (3) reduced quality competition between United Regional and its competitors.

B. The Relevant Markets

The Complaint alleges two distinct relevant product markets: (1) the market for general acute-care inpatient hospital services ("inpatient hospital services") sold to commercial health insurers, and (2) the market for outpatient surgical services sold to

commercial health insurers. In each case, the relevant geographic market is no larger than the Wichita Falls Metropolitan Statistical Area ("MSA").

1. The sale of inpatient hospital services to commercial health insurers

The sale of inpatient hospital services to commercial health insurers is a relevant product market. Inpatient hospital services are a broad group of medical and surgical diagnostic and treatment services that include an overnight stay in the hospital by the patient. For purposes of the Complaint, inpatient hospital services *exclude* (1) services at hospitals that serve solely children, military personnel or veterans; (2) services at outpatient facilities that provide same-day service only; and (3) psychiatric, substance abuse, and rehabilitation services. There are no reasonable substitutes for inpatient hospital services.

As alleged in the Complaint, the term "commercial health insurers" refers to *private* third-party payers that provide access to health-care providers, such as managed-care organizations, rental networks, and self-funded plans. The term does not include sales to *public* third-party payers—Medicare, Medicaid, and TRICARE.

There is a key difference between the government plans and commercial health insurers. The government unilaterally sets the rates that it pays for Medicare, Medicaid, and TRICARE beneficiaries—rates that are non-negotiable. In contrast, commercial health insurers negotiate their rates with individual health-care providers. Therefore, health-care providers can target a price increase to commercial health insurers, and these insurers cannot avoid the price increase by shifting to government rates. Furthermore, patients who are ineligible for Medicare, Medicaid, or TRICARE cannot substitute into those programs in response to a price increase for commercial health insurance. Thus, a

hypothetical monopolist provider of inpatient hospital services sold to commercial health insurers could profitably maintain supracompetitive prices for those services over a sustained period of time.

2. The sale of outpatient surgical services to commercial health insurers

The sale of outpatient surgical services to commercial health insurers is also a relevant product market. This market is distinct from the market for inpatient hospital services because, as alleged in the Complaint, inpatient hospital services are not reasonable substitutes for outpatient surgical services, and there are no other reasonable substitutes for outpatient surgical services. Furthermore, as with inpatient hospital services, the prices of outpatient surgical services sold to commercial health insurers are determined by negotiations between health-care providers and insurers, while the government unilaterally sets the rates that it pays for outpatient surgical services for Medicare, Medicaid, and TRICARE beneficiaries. Thus, a hypothetical monopolist provider of outpatient surgical services sold to commercial health insurers could profitably maintain supracompetitive prices for those services over a sustained period of time.

3. Relevant geographic market: no larger than the Wichita Falls MSA

The relevant geographic market for both inpatient hospital services and outpatient surgical services is no larger than the Wichita Falls MSA, which comprises three counties in north central Texas: Archer, Clay, and Wichita. Wichita Falls—the largest city in the MSA, with a population of about 100,000—is more than a two-hour drive and at least 100 miles from the nearest metropolitan areas: Dallas-Ft. Worth, Texas, and Oklahoma City, Oklahoma. Because patients typically seek medical care close to their homes or

workplaces, very few patients who live in the Wichita Falls MSA travel outside its borders to seek inpatient hospital services or outpatient surgical services; and providers of those services located outside the Wichita Falls MSA do not compete to any substantial degree in the Wichita Falls MSA for the sale of those services. Thus, as the Complaint alleges, competition for the sale of inpatient hospital services and outpatient surgical services to commercial health insurers from providers located outside the Wichita Falls MSA would not be sufficient to prevent a hypothetical monopolist provider of those services in the Wichita Falls MSA from profitably maintaining supracompetitive prices for those services over a sustained period of time.

C. Monopoly Power

Section 2 of the Sherman Act, 15 U.S.C. § 2, makes it unlawful for a firm to "monopolize." The offense of monopolization under Section 2 has two elements: "(1) the possession of monopoly power in the relevant market and (2) the willful . . . maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident." *United States v. Grinnell Corp.*, 384 U.S. 563, 570–71 (1966). The Supreme Court has defined monopoly power as "the power to control prices or exclude competition." *United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377, 391 (1956).

Monopoly power may be established by evidence that a firm has profitably raised prices above the competitive level. *See United States v. Microsoft Corp.*, 253 F.3d 34, 51 (D.C. Cir. 2001). In the absence of such direct proof, monopoly power may be inferred from circumstantial evidence, including "a firm's possession of a dominant share of a

relevant market that is protected by entry barriers." *Id.* When evaluating monopoly power, relying on current market share alone can sometimes be misleading. But generally, evidence of dominant market share, without countervailing evidence of the possibility of competition from new entrants, is sufficient to show monopoly power. *Id.*

In this case, there is strong direct and circumstantial evidence that United Regional has monopoly power in the relevant markets. First, there is direct evidence that United Regional has charged supracompetitive prices for a sustained period of time. As explained above, United Regional was formed in 1997 by the merger of Wichita General Hospital and Bethania Regional Health Care Center, a merger that eliminated competition between what were then the only two general acute-care hospitals in Wichita Falls. Since that merger, United Regional has been the "must-have" hospital for insurers in the Wichita Falls MSA and has increased its prices to the point that it is now one of the most expensive hospitals in Texas. One commercial health insurer estimated that it pays United Regional almost 70% more than what it pays hospitals in the Dallas-Fort Worth area for inpatient hospital services. In Wichita Falls, United Regional's average per-day rate for inpatient hospital services sold to commercial health insurers is about 70% higher than Kell West's for the services that are offered by both hospitals. Similarly, the Complaint alleges that United Regional's prices for outpatient surgical services are also among the highest in Texas. Yet, despite United Regional's supracompetitive prices, neither Kell West nor other smaller facilities has had a significant competitive impact on United Regional.

Second, market-share data provide circumstantial evidence of United Regional's monopoly power. The Complaint alleges that United Regional has a dominant share of

the markets for both inpatient hospital services and outpatient surgical services sold to commercial health insurers. United Regional's share of inpatient hospital services sold to commercial health insurers is approximately 90% in the Wichita Falls MSA, and its share of outpatient surgical services sold to commercial health insurers is more than 65% in that same region. These shares have remained relatively constant for more than a decade while United Regional's prices have risen. Furthermore, as the Complaint alleges, both relevant product markets have significant barriers to entry—including United Regional's exclusionary contracts. During the last twelve years, no new firms other than Kell West have entered the relevant product markets in the Wichita Falls MSA.

D. Exclusionary Conduct

Possessing monopoly power does not by itself constitute "monopolization." *See Grinnell*, 384 U.S. at 570–71. Rather, Section 2 of the Sherman Act makes it unlawful to *maintain* monopoly power through exclusionary conduct. *See Verizon Commc'ns, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 407 (2004); *Microsoft*, 253 F.3d at 58. The general test for exclusionary conduct is set forth in *United States v. Microsoft Corp*. First, a plaintiff must show that a monopolist's conduct has had an "anticompetitive effect." *Id.* Second, if a plaintiff proves an anticompetitive effect, the monopolist may proffer a non-pretextual "procompetitive justification" for its conduct. *Id.* at 59. Third, if the monopolist's procompetitive justification is unrebutted, the plaintiff "must demonstrate that the anticompetitive harm of the conduct outweighs the procompetitive benefit." *Id.*

The Complaint alleges that United Regional's exclusionary contracts reduced competition and enabled United Regional to maintain its monopoly in the relevant markets by foreclosing its rivals from many of the most profitable health-insurance contracts in Wichita Falls—contracts that are crucial for its rivals to effectively compete.

1. The exclusionary contracts likely caused anticompetitive effects by foreclosing United Regional's rivals from the most profitable health-insurance contracts.

A competitor is "foreclosed" from competition when it is denied or disadvantaged in its access to significant sources of input or distribution. *See United States v. Dentsply Int'l, Inc.*, 399 F.3d 181, 189–90 (3d Cir. 2005). In this case, the foreclosure analysis properly focuses on the profitability of the various payment sources available to health-care providers. Thus, while the relevant product markets are limited to hospital services sold to commercial patients, the foreclosure analysis in this case must account for the ability of health-care providers to serve patients covered by other sources of payment (most significantly, the government plans). If United Regional's competitors could easily replace the profits lost by the exclusionary contracts with additional profits from patients covered by government plans or other payment sources, it is unlikely that the exclusionary contracts would produce anticompetitive effects.

But as the Complaint explains, profits from the government plans are not an adequate substitute for the lost profits from the excluded insurers, making the excluded insurers "significant sources of input or distribution." *Id.* Commercial health insurers pay hospitals and other health-care providers substantially more than the government plans: in the Wichita Falls MSA, all commercial health insurers pay United Regional at least *double* the Medicare payment rate, and all but one insurer (Blue Cross) pay United

Regional more than *triple* the Medicare payment rate. Consequently, to simply calculate the percentage of the total commercial and public-payer lives that the exclusionary contracts deny United Regional's competitors is not an accurate method to assess the contracts' effect on competition. Rather, a more appropriate approach is to assess the degree to which the contracts have foreclosed access to payments for commercially insured patients and account for the foreclosed percentage of profits from all payers.

As the Complaint alleges, by 2010, the insurers that had exclusionary contracts with United Regional accounted for approximately 35% to 40% of all payments United Regional received from commercial health insurers.[3] Most of the remaining commercial payments are attributable to just one insurer—Blue Cross, which pays the lowest rates due to its size.

Because the excluded insurers pay the highest rates, these insurers account for a substantial share of the profits that would otherwise be available to competing health-care providers. In particular, these insurers account for approximately 30% to 35% of the profits that United Regional earns from *all* payers—including the government payers—even though they account for only about 8% of United Regional's total patient volume. The Complaint alleges that if the excluded insurers added Kell West and other health-care providers to their networks, these providers would earn substantially higher profits than they do now, increasing their ability to compete against United Regional. For example, if only 10% of these insurers' patients switched from United Regional to Kell

[3] These "foreclosure" percentages likely underestimate the impact of the exclusionary contracts on United Regional's competitors. As the Complaint alleges, some doctors engage in "block booking," performing surgeries and other procedures at the same facility on a given day. Without the exclusionary contracts, these doctors could be able to refer all their patients on a given day—including patients covered by Blue Cross or the government payers—to one of United Regional's rivals.

West, and these insurers paid Kell West 30% less than they currently pay United Regional, Kell West's profits would still likely increase by more than 40%.

2. The exclusionary contracts have led to higher prices and reduced quality competition in the relevant markets.

By denying United Regional's competitors access to the most profitable commercial insurance contracts, United Regional has increased prices and reduced quality competition in the relevant markets in three ways.

First, the exclusionary contracts have likely delayed and prevented the expansion and entry of United Regional's competitors. For example, without the exclusionary contracts, Kell West likely would have used the profits that it obtained from contracts with the excluded commercial health insurers to expand sooner, and would also likely have added more beds and additional services, such as additional intensive-care capabilities, cardiology services, and obstetric services. Kell West has considered expansion into additional services on numerous occasions, but has been limited in its ability to expand due to its lack of access to commercially insured patients. This effect on entry and expansion has reduced the options available to insurers, likely leading to higher prices for hospital services and higher health-insurance premiums.

Second, the exclusionary contracts have likely limited price competition for price-sensitive patients. Even with the exclusionary contracts, some price competition has already occurred. For example, in 2008 United Regional lowered its list price for gynecological surgeries because it was concerned that too many price-sensitive patients were choosing Kell West and the North Texas Surgi-Center to avoid United Regional's high prices. But because insured patients generally avoid obtaining health-care services from out-of-network providers, the exclusionary contracts make it less likely that many

commercially insured patients would switch to another provider in response to a price increase by United Regional. In the absence of the exclusionary contracts—with the risk that United Regional would lose some of its most profitable patients—this type of price competition would likely increase.

Third, the contracts have likely reduced quality competition between United Regional and its competitors. Just as the exclusionary contracts make it less likely that some patients will choose rival facilities based on price, they have also made it less likely that some patients will choose other providers based on quality. If United Regional's competitors became in-network providers for more commercially insured patients, each of those competitors would have the incentive to make additional improvements in quality to attract those patients to its facility; and United Regional, in turn, would also have the incentive to improve its quality in order to keep patients from choosing Kell West or another competitor. Therefore, as the Complaint alleges, without the exclusionary contracts, United Regional and its competitors would have increased incentives to make additional quality improvements, and the overall level of quality of health care in the Wichita Falls area likely would be higher.

3. The exclusionary contracts fail an appropriate price-cost test.

The exclusionary contracts challenged in this case closely resemble *de facto* exclusive-dealing arrangements. Although the contracts technically offer commercial health insurers a choice between non-exclusivity and exclusivity, in reality the non-exclusive rates were not a commercially feasible option for insurers, and not one insurer opted for the non-exclusive rate for more than twelve years. Thus, as with exclusive dealing, the primary concern is not with the relationship between United Regional's

prices and costs, but with the degree of economic foreclosure caused by its contracting practices.

Yet, while United Regional's contracts resemble exclusive dealing, they do not achieve economic foreclosure through purely exclusive contracts, but through pricing terms—discounts tied to exclusivity. In general, these types of discounts can be either procompetitive or anticompetitive. Discounts tied to exclusivity can be procompetitive if they result from "competition on the merits," in which rival suppliers compete on price so that the most efficient firm will win additional consumers. In contrast, they can be anticompetitive if they would prevent equally or more efficient rivals from attracting additional consumers. Given that such discounts can either benefit or harm consumers, it is useful to analyze them with a "price-cost" test, which helps distinguish between procompetitive and anticompetitive discounts.

In this case, the appropriate price-cost test resembles the "discount-attribution" test adopted in *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883 (9th Cir. 2008). The discount-attribution test applies when a defendant faces competition for only a portion of the services that it sells, but offers a discount that applies to all of its services. In *PeaceHealth*, the court warned that such discounts "can exclude a rival [] who is equally efficient at producing the competitive product simply because the rival does not sell as many products as the bundled discounter." *Id.* at 909. Thus, in the context of bundled discounts, the court held that the proper test requires "the full amount of the discounts given by the defendant on the bundle [to be] allocated to the competitive product or products." *Id.* at 906. If the resulting prices are still above the defendant's incremental cost for providing those services, the discount is likely procompetitive. By

contrast, if the prices are below the defendant's incremental cost—and would therefore tend to exclude an equally-efficient provider of those services—the "anticompetitive-effects" prong of the *Microsoft* framework would be satisfied.

To accurately determine whether United Regional's discounted prices are above cost, however, the entire discount should be attributed not to the entire volume of the "competitive product[s]," as suggested by the court in *PeaceHealth*, *id.* at 909, but rather to the patients that United Regional would actually be at risk of losing if an insurer were to choose non-exclusivity (the "contestable volume").[4] Under some factual circumstances, the contestable volume may consist of the entire volume of the overlap services (those services that both the defendant and its competitors provide). This would be the case if a customer that chooses non-exclusivity would likely obtain *all* of its purchases of the competitive products from a rival supplier. Under other circumstances, however, such as in this case, the contestable volume is likely smaller than the entire volume of the "competitive product" because "the rival producer of the competitive product cannot contest all of the monopolist's sales of that product." *See* Mark S. Popofsky, *Section 2, Safe Harbors, and the Rule of Reason*, 15 GEO. MASON L. REV. 1265, 1294 (2008).

Though measuring the contestable volume may in some cases be impractical, here the contestable volume can be estimated by examining patient usage patterns from Blue Cross and Medicare, two major payers that are not subject to exclusivity. Based on the share of patient volume that United Regional receives from Blue Cross and Medicare, the

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[4] *See* Gianluca Faella, *The Antitrust Assessment of Loyalty Discounts and Rebates*, 4(2) J. COMPET. L. & ECON. 375, 379 (2008) ("A useful indicator of the practice's foreclosure effect is the incremental price of the contestable portion of the customer's demand.").

likely contestable volume is approximately 10% of the patient volume that United Regional receives from the payers that have signed exclusionary contracts. This is partly because competing providers offer a more limited portfolio of services, and partly because, as usage patterns from Blue Cross and Medicare patients suggest, many patients are likely to choose care at United Regional even for services that competing providers offer.

When, for each of United Regional's exclusionary contracts, the entire discount that the insurer receives in exchange for exclusivity is applied to the contestable volume, the resulting price is below any plausible measure of United Regional's incremental costs. In other words, because the contestable volume is small relative to the large difference between the exclusive and non-exclusive rates in United Regional's contracts, a competing hospital would need to offer a price below United Regional's incremental costs for an insurer to profitably turn down United Regional's offer of exclusivity. As a result, United Regional's discounts would likely exclude an equally-efficient competitor.

4. The exclusionary contracts lack a valid procompetitive business justification.

As stated above, "even if a company exerts monopoly power, it may defend its practices by establishing a business justification." *Dentsply*, 399 F.3d at 196. The plaintiff bears the burden of establishing that "the monopolist's conduct . . . has the requisite anticompetitive effect"; when that burden is met, it shifts to the defendant to "proffer a 'procompetitive justification' for its conduct." *Microsoft*, 253 F.3d at 58–59. A business justification will not be accepted where it is pretextual, *see, e.g.*, *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 484 (1992), nor is the fact that the action was taken "in furtherance of [the company's] economic interests" sufficient to

meet this burden, *see, e.g.*, *LePage's Inc. v. 3M*, 324 F.3d 141, 163 (3d Cir. 2003) (en banc).

Here, the Complaint alleges that there is no valid procompetitive business justification for United Regional's exclusionary contracts, making it unnecessary to determine whether "the anticompetitive harm of the conduct outweighs the procompetitive benefit." *Microsoft*, 253 F.3d at 59. United Regional did not use the contracts to achieve any economies of scale or other efficiencies as a result of the additional patient volume that it obtained from the contracts. Moreover, as described above, United Regional's contracts set prices for the contestable patient volume at a level below its own incremental costs, which (1) illustrates that the contracts are not simply lower prices in exchange for volume, and (2) cannot be justified by economies of scale in any event.

III.
EXPLANATION OF THE PROPOSED FINAL JUDGMENT

The prohibitions and required conduct in the proposed Final Judgment achieve all the relief sought from United Regional in the Complaint, and thus fully resolve the competitive concerns raised by the exclusionary contracts challenged in this lawsuit.

A. Prohibited Conduct

Section IV of the proposed Final Judgment seeks to restore competition between health-care providers in the Wichita Falls MSA by prohibiting United Regional from using exclusivity terms in its contracts. In particular, Section IV.A prohibits United Regional from (1) conditioning the prices or discounts that it offers to commercial health

insurers on whether those insurers contract with other health-care providers, such as Kell West; and (2) preventing insurers from entering into agreements with United Regional's rivals. Section IV.B prohibits United Regional from taking any retaliatory actions against an insurer that enters (or seeks to enter) into an agreement with a rival health-care provider.

In addition to prohibiting United Regional from conditioning its discounts on exclusivity, Section IV.C prohibits United Regional from offering other types of "conditional volume discounts" that could have the same anticompetitive effects as the challenged conduct. "Conditional volume discounts" are prices, discounts, or rebates offered to a commercial health insurer *on condition* that the volume of that insurer's purchases from United Regional meets or exceeds a specified threshold. For example, United Regional may not offer discounts that are applied retroactively when a customer reaches a specified threshold (sometimes referred to as "first-dollar" discounts). The retroactive nature of these discounts can disguise below-cost pricing that excludes equally-efficient competitors and smaller entrants, resulting in a loss of competition and harm to consumers. Similarly, United Regional may not offer market-share discounts, *i.e.* discounts conditioned on an insurer's purchases at United Regional meeting a specified percentage of that insurer's total purchases, whether they apply retroactively or not, because such discounts can also be a form of anticompetitive pricing. By contrast, as explained further below, United Regional may offer incremental discounts that apply solely to purchases above a specified threshold if those discounts are above cost.[5]

[5] As specified in Section II.F, however, an incremental volume discount may not be a market-share discount.

Finally, United Regional may not use provisions in its insurance contracts that discourage insurers from offering products that encourage members to use other in-network providers (besides United Regional). Although United Regional did not include these types of provisions in the contracts at issue in this case, this section of the proposed Final Judgment is designed to make the proposed remedy more effective.

B. Permissible Conduct

To ensure that United Regional can engage in procompetitive discounting and other pricing practices, Section V.A(1) of the proposed Final Judgment allows United Regional to sell its hospital services at any price or discount, provided that such prices or discounts do not violate the prohibitions in Section IV. United Regional may still offer different prices to different commercial health insurers, and it may consider an insurer's previous or anticipated overall size or volume when negotiating prices or discounts.

Section V.A(2) allows United Regional to offer above-cost incremental volume discounts, a certain type of conditional volume discount that is unlikely to cause anticompetitive harm. By permitting above-cost incremental volume discounts, the Final Judgment ensures that United Regional can engage in procompetitive efforts to compete for additional patient volume, while preventing United Regional from offering discounts that have the potential to exclude an equally-efficient competitor. Furthermore, unlike other kinds of conditional discounts, it is feasible to determine whether an incremental volume discount is above cost simply by comparing the incremental prices with the incremental costs without also having to determine the magnitude of the contestable volume.

Under the terms of the proposed Final Judgment, an incremental volume discount is deemed above cost if the discounted prices for each service line, expressed as a percentage of billed charges, are greater than United Regional's Cost-to-Charge Ratio, defined as the ratio of total costs (for all services) to total charges, as reported to the Centers for Medicare and Medicaid Services. For example, United Regional may offer to accept payments equal to 75% of billed charges for the first $10 million of gross charges from a particular insurer, and 40% of billed charges for any charges in excess of $10 million. In 2009, United Regional reported total charges of approximately $807 million, and total costs of approximately $207 million, implying a Cost-to-Charge Ratio of approximately 26%. Because the discounted prices for each service line (40% of billed charges) exceed the hospital's Cost-to-Charge Ratio (26% of billed charges), this offer would be above cost and permitted under the proposed Final Judgment.

Section V.D allows United Regional to renegotiate or terminate its contracts according to the provisions in those contracts. However, United Regional may not terminate a contract because an insurer contracted with another health-care facility, and, as required in VI.B, United Regional must honor the discounts conditioned on exclusivity—regardless of whether an insurer contracts with another health-care facility—unless or until United Regional's existing contracts are renegotiated or terminated. If United Regional notifies the insurer of its intent to renegotiate, United Regional is not required to provide that discount for more than 270 days after the notice is given.

C. Required Conduct

Section VI.A requires United Regional to (1) notify in writing each commercial health insurer that has an agreement with United Regional that the Final Judgment has been entered, and (2) send each of these insurers a copy of the Final Judgment.

As discussed above, Section VI.B requires United Regional to honor its current discounts conditioned on exclusivity unless or until such contracts are renegotiated or terminated. For example, if, when the Complaint is filed, an agreement allowed for a 25% discount with exclusivity and a 5% discount without exclusivity, United Regional must offer its services to that insurer at the 25% discount—even if the insurer contracts with other health-care facilities—until the agreement is renegotiated or terminated. However, as explained above, if United Regional notifies the insurer of its intent to renegotiate, United Regional is not required to provide the discount for longer than 270 days after the notice is given.

D. Compliance

Section VII of the proposed Final Judgment contains several provisions to ensure United Regional's compliance with the proposed Final Judgment. First, under Section VII.A, United Regional is required to designate an antitrust compliance officer. That officer is required to provide a copy of the Final Judgment to key United Regional personnel and develop procedures to ensure United Regional's compliance with the Final Judgment.

Second, to facilitate monitoring of United Regional's compliance with the proposed Final Judgment, Section VII grants the United States and the State of Texas

access, upon reasonable notice, to United Regional's records and documents relating to matters contained in the proposed Final Judgment. Within 270 days after the entry of the Final Judgment, United Regional is required to submit a written report explaining the actions it has taken to comply with the Final Judgment, including the status and results of its negotiations with commercial health insurers. Furthermore, for one year after entry of the Final Judgment, United Regional must provide the Department of Justice and the State of Texas copies of all new or revised agreements with insurers within fourteen days of such agreements being executed. United Regional must make its employees available for interviews or depositions about such matters. Moreover, upon request, United Regional must answer interrogatories and prepare written reports relating to matters contained in the proposed Final Judgment.

IV.
REMEDIES AVAILABLE TO POTENTIAL 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 the person has suffered, as well as costs and reasonable attorneys' fees. Entry of the proposed Final Judgment will neither impair nor assist the bringing of any private antitrust damage action. Under the provisions of Section 5(a) of the Clayton Act, 15 U.S.C. § 16(a), the proposed Final Judgment has no prima facie effect in any subsequent private lawsuit that may be brought against Defendants.

V.
PROCEDURES AVAILABLE FOR MODIFICATION OF THE PROPOSED FINAL JUDGMENT

The United States, the State of Texas, and United Regional have stipulated that the proposed Final Judgment may be entered by the Court after compliance with the provisions of the APPA, provided that the United States has not withdrawn its consent. The APPA conditions entry upon the Court's determination that the proposed Final Judgment is in the public interest.

The APPA provides a period of at least sixty days preceding the effective date of the proposed Final Judgment within which any person may submit to the United States written comments regarding the proposed Final Judgment. Any person who wishes to comment should do so within sixty days of the date of publication of this Competitive Impact Statement in the Federal Register, or the last date of publication in a newspaper of the summary of this Competitive Impact Statement, whichever is later. All comments received during this period will be considered by the United States Department of Justice, which remains free to withdraw its consent to the proposed Final Judgment at any time before the Court's entry of judgment. The comments and the response of the United States will be filed with the Court and published in the Federal Register.

Written comments should be submitted to:

Joshua H. Soven
Chief, Litigation I Section
Antitrust Division
United States Department of Justice
450 Fifth Street, NW, Suite 4100
Washington, DC 20530

The proposed Final Judgment provides that the Court retains jurisdiction over this action, and the parties may apply to the Court for any order necessary or appropriate for the modification, interpretation, or enforcement of the Final Judgment.

VI.
ALTERNATIVES TO THE PROPOSED FINAL JUDGMENT

As an alternative to the proposed Final Judgment, the United States considered proceeding to a full trial on the merits against United Regional. The United States is satisfied, however, that the prohibitions and requirements contained in the proposed Final Judgment will fully address the competitive concerns set forth in the Complaint against United Regional. The proposed Final Judgment achieves all or substantially all of the relief the United States would have obtained through litigation against United Regional and avoids the time, expense, and uncertainty of a full trial on the merits of the Complaint.

VII.
STANDARD OF REVIEW UNDER THE APPA FOR THE PROPOSED FINAL JUDGMENT

The Clayton Act, as amended by the APPA, requires that proposed consent judgments in antitrust cases brought by the United States be subject to a sixty-day comment period, after which the court shall determine whether entry of the proposed Final Judgment "is in the public interest." 15 U.S.C. § 16(e)(1). In making that determination, the court, in accordance with the statute as amended in 2004, is required to consider:

> (A) the competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration of relief sought, anticipated effects of alternative remedies actually considered, whether its terms are ambiguous, and any other competitive considerations bearing upon the adequacy of such judgment that the court deems necessary to a determination of whether the consent judgment is in the public interest; and
>
> (B) the impact of entry of such judgment upon competition in the relevant market or markets, upon the public generally and individuals alleging specific injury from the violations set forth in the complaint including consideration of the public benefit, if any, to be derived from a determination of the issues at trial.

15 U.S.C. § 16(e)(1)(A) & (B). In considering these statutory factors, the court's inquiry is necessarily a limited one as the government is entitled to "broad discretion to settle with the defendant within the reaches of the public interest." *United States v. Microsoft Corp.*, 56 F.3d 1448, 1461 (D.C. Cir. 1995); *see also United States v. SBC Commc'ns, Inc.*, 489 F. Supp. 2d 1 (D.D.C. 2007) (assessing public-interest standard under the Tunney Act); *United States v. InBev N.V./S.A.*, No. 08-1965 (JR), 2009 U.S. Dist. LEXIS 84787, at *3 (D.D.C. Aug. 11, 2009) (noting that the court's review of a consent judgment is limited and only inquires "into whether the government's determination that the proposed remedies will cure the antitrust violations alleged in the complaint was reasonable, and whether the mechanisms to enforce the final judgment are clear and manageable.").[6]

As the United States Court of Appeals for the District of Columbia Circuit has held, a court considers under the APPA, among other things, the relationship between the remedy secured and the specific allegations set forth in the United States' complaint,

[6] The 2004 amendments substituted "shall" for "may" in directing relevant factors for courts to consider and amended the list of factors to focus on competitive considerations and to address potentially ambiguous judgment terms. *Compare* 15 U.S.C. § 16(e) (2004), *with* 15 U.S.C. § 16(e)(1) (2006); *see also SBC Commc'ns*, 489 F. Supp. 2d at 11 (concluding that the 2004 amendments "effected minimal changes" to Tunney Act review).

whether the decree is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the decree may positively harm third parties. *See Microsoft*, 56 F.3d at 1458–62. With respect to the adequacy of the relief secured by the decree, a court may not "engage in an unrestricted evaluation of what relief would best serve the public." *United States v. BNS Inc.*, 858 F.2d 456, 462 (9th Cir. 1988) (citing *United States v. Bechtel Corp.*, 648 F.2d 660, 666 (9th Cir. 1981)); *see also Microsoft*, 56 F.3d at 1460–62; *InBev*, 2009 U.S. Dist. LEXIS 84787, at *3; *United States v. Alcoa, Inc.*, 152 F. Supp. 2d 37, 40 (D.D.C. 2001). Courts have held that:

> [t]he balancing of competing social and political interests affected by a proposed antitrust consent decree must be left, in the first instance, to the discretion of the Attorney General. The court's role in protecting the public interest is one of insuring that the government has not breached its duty to the public in consenting to the decree. The court 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.

Bechtel, 648 F.2d at 666 (emphasis added) (citations omitted).[7] In determining whether a proposed settlement is in the public interest, a district court "must accord deference to the government's predictions about the efficacy of its remedies, and may not require that the remedies perfectly match the alleged violations." *SBC Commc'ns*, 489 F. Supp. 2d at 17; *see also Microsoft*, 56 F.3d at 1461 (noting the need for courts to be "deferential to the government's predictions as to the effect of the proposed remedies"); *United States v.*

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[7] *Cf. BNS*, 858 F.2d at 464 (holding that the court's "ultimate authority under the [APPA] is limited to approving or disapproving the consent decree"); *United States v. Gillette Co.*, 406 F. Supp. 713, 716 (D. Mass. 1975) (noting that, in this way, the court is constrained to "look at the overall picture not hypercritically, nor with a microscope, but with an artist's reducing glass"); *see generally Microsoft*, 56 F.3d at 1461 (discussing whether "the remedies [obtained in the decree are] so inconsonant with the allegations charged as to fall outside of the 'reaches of the public interest'").

Archer-Daniels-Midland Co., 272 F. Supp. 2d 1, 6 (D.D.C. 2003) (noting that the court should grant due respect to the United States' "prediction as to the effect of proposed remedies, its perception of the market structure, and its views of the nature of the case").

Courts have greater flexibility in approving proposed consent decrees than in crafting their own decrees following a finding of liability in a litigated matter. "[A] proposed decree must be approved even if it falls short of the remedy the court would impose on its own, as long as it falls within the range of acceptability or is 'within the reaches of public interest.'" *United States v. Am. Tel. & Tel. Co.*, 552 F. Supp. 131, 151 (D.D.C. 1982) (citations omitted) (quoting *United States v. Gillette Co.*, 406 F. Supp. 713, 716 (D. Mass. 1975)), *aff'd sub nom. Maryland v. United States*, 460 U.S. 1001 (1983); *see also United States v. Alcan Aluminum Ltd.*, 605 F. Supp. 619, 622 (W.D. Ky. 1985) (approving the consent decree even though the court would have imposed a greater remedy). To meet this standard, the United States "need only provide a factual basis for concluding that the settlements are reasonably adequate remedies for the alleged harms." *SBC Commc'ns*, 489 F. Supp. 2d at 17.

Moreover, the court's role under the APPA is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its complaint, and does not authorize the court to "construct [its] own hypothetical case and then evaluate the decree against that case." *Microsoft*, 56 F.3d at 1459; *see also InBev*, 2009 U.S. Dist. LEXIS 84787, at *20 ("the 'public interest' is not to be measured by comparing the violations alleged in the complaint against those the court believes could have, or even should have, been alleged"). Because the "court's authority to review the decree depends entirely on the government's exercising its prosecutorial discretion by bringing a case in

the first place," it follows that "the court is only authorized to review the decree itself," and not to "effectively redraft the complaint" to inquire into other matters that the United States did not pursue. *Microsoft*, 56 F.3d at 1459–60. As the United States District Court for the District of Columbia recently confirmed in *SBC Communications*, courts "cannot look beyond the complaint in making the public interest determination unless the complaint is drafted so narrowly as to make a mockery of judicial power." *SBC Commc'ns*, 489 F. Supp. 2d at 15.

In its 2004 amendments, Congress made clear its intent to preserve the practical benefits of using consent decrees in antitrust enforcement, adding the unambiguous instruction that "[n]othing in this section shall be construed to require the court to conduct an evidentiary hearing or to require the court to permit anyone to intervene." 15 U.S.C. § 16(e)(2). This language effectuates what Congress intended when it enacted the Tunney Act in 1974. As Senator Tunney explained: "[t]he court is nowhere compelled to go to trial or to engage in extended proceedings which might have the effect of vitiating the benefits of prompt and less costly settlement through the consent decree process." 119 Cong. Rec. 24,598 (1973) (statement of Senator Tunney). Rather, the procedure for the public-interest determination is left to the discretion of the court, with the recognition that the court's "scope of review remains sharply proscribed by precedent and the nature of Tunney Act proceedings." *SBC Commc'ns*, 489 F. Supp. 2d at 11.[8]

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[8] *See United States v. Enova Corp.*, 107 F. Supp. 2d 10, 17 (D.D.C. 2000) (noting that the "Tunney Act expressly allows the court to make its public interest determination on the basis of the competitive impact statement and response to comments alone"); *United States v. Mid-Am. Dairymen, Inc.*, 1977-1 Trade Cas. (CCH) ¶ 61,508, at 71,980 (W.D. Mo. 1977) ("Absent a showing of corrupt failure of the government to discharge its duty, the Court, in making its public interest finding, should . . . carefully consider the explanations of the government in the competitive impact statement and its responses to comments in order to determine whether those explanations are reasonable under the circumstances."); S. Rep. No. 93-298 at 6 (1973) ("Where

VIII.
DETERMINATIVE DOCUMENTS

There are no determinative materials or documents within the meaning of the APPA that were considered by the United States in formulating the proposed Final Judgment.

Respectfully submitted,

s/ Scott I. Fitzgerald

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Dated: February 25, 2011

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the public interest can be meaningfully evaluated simply on the basis of briefs and oral arguments, that is the approach that should be utilized.").

CERTIFICATE OF SERVICE

On February 25, 2011, I, Scott I. Fitzgerald, electronically submitted a copy of the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system for the court. I hereby certify that I caused a copy of the foregoing document to be served upon Defendant United Regional Health Care System electronically or by another means authorized by the Court of the Federal Rules of Civil Procedure.

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