handbook_on_electronic_filing.pdf). Persons with questions regarding filing should contact the Secretary (202–205–2000).

Any person desiring to submit a document to the Commission in confidence must request confidential treatment. All such requests should be directed to the Secretary to the Commission and must include a full statement of the reasons why the Commission should grant such treatment. *See* 19 CFR 201.6. Documents for which confidential treatment by the Commission is properly sought will be treated accordingly. All information, including confidential business information and documents for which confidential treatment is properly sought, submitted to the Commission for purposes of this Investigation may be disclosed to and used: (i) By the Commission, its employees and Offices, and contract personnel (a) for developing or maintaining the records of this or a related proceeding, or (b) in internal investigations, audits, reviews, and evaluations relating to the programs, personnel, and operations of the Commission including under 5 U.S.C. Appendix 3; or (ii) by U.S. government employees and contract personnel, solely for cybersecurity purposes (all contract personnel will sign appropriate nondisclosure agreements). All nonconfidential written submissions will be available for public inspection at the Office of the Secretary and on EDIS.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in Part 210 of the Commission's Rules of Practice and Procedure (19 CFR part 210).

By order of the Commission.
Issued: December 4, 2018.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2018–26740 Filed 12–10–18; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[USITC SE–18–058]

Sunshine Act Meetings

TIME AND DATE: December 14, 2018 at 11:00 a.m.

PLACE: Room 101, 500 E Street SW, Washington, DC 20436, Telephone: (202) 205–2000.

STATUS: Open to the public.

MATTERS TO BE CONSIDERED:

1. Agendas for future meetings: None.
2. Minutes.
3. Ratification List.
4. Vote on Inv. Nos. 701–TA–598 and 731–TA–1408 (Final)(Rubber Bands from China). The Commission is currently scheduled to complete and file its determinations and views of the Commission by December 27, 2018.
5. Outstanding action jackets: None.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carried over to the agenda of the following meeting.

By order of the Commission.
Issued: December 7, 2018.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2018–26925 Filed 12–7–18; 4:15 pm]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Antitrust Division

United States et al. v. The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System; Proposed Final Judgment and Competitive Impact Statement

Notice is hereby given pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)–(h), that a proposed Final Judgment, Stipulation, and Competitive Impact Statement have been filed with the United States District Court for the Western District of North Carolina in *United States and State of North Carolina.* v. *The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System,* Civil Action No. 3:16–cv–00311–RJC–DCK. On June 6, 2016, the United States and the State of North Carolina filed a Complaint alleging that The Charlotte-Mecklenburg Hospital Authority formerly known as Carolinas HealthCare System (or CHS) and now doing business as Atrium Health (''Atrium'') included provisions in its contracts with health insurers that restricted insurers from steering their members to lower-cost, high-quality providers, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. The proposed Final Judgment, filed November 15, 2018, enjoins Atrium from (1) enforcing provisions in its current insurer contracts that restrict steering and transparency; (2) having contract provisions with an insurer that would prohibit, prevent or significantly restrain the insurer from using certain steering methods or providing transparency; and (3) penalizing, or threatening to penalize, any insurer for its use of certain steering methods and transparency.

Copies of the Complaint, proposed Final Judgment, and Competitive Impact Statement are available for inspection on the Antitrust Division's website at *http://www.justice.gov/atr* and at the Office of the Clerk of the United States District Court for the Western District of North Carolina. Copies of these materials may be obtained from the Antitrust Division upon request and payment of the copying fee set by Department of Justice regulations.

Public comment is invited within 60 days of the date of this notice. Such comments, including the name of the submitter, and responses thereto, will be posted on the Antitrust Division's website, filed with the Court, and, under certain circumstances, published in the **Federal Register**. Comments should be directed to Peter J. Mucchetti, Chief, Healthcare and Consumer Products Section, Antitrust Division, Department of Justice, 450 Fifth Street NW, Suite 4100, Washington, DC 20530 (telephone: 202–307–0001).

Patricia A. Brink,

Director of Civil Enforcement.

United States District Court for the Western District of North Carolina Charlotte Division

United States of America and the State of North Carolina, Plaintiffs, v. *The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System,* Defendant.

Case No. 3:16–cv–00311–RJC–DCK
Judge Robert J. Conrad, Jr.

COMPLAINT

The United States of America and the State of North Carolina bring this civil antitrust action to enjoin Defendant, The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System (''CHS''), from using unlawful contract restrictions that prohibit commercial health insurers in the Charlotte area from offering patients financial benefits to use less-expensive healthcare services offered by CHS's competitors. These steering restrictions reduce competition resulting in harm to Charlotte area consumers, employers, and insurers.

I. CHS AND ITS UNLAWFUL STEERING RESTRICTIONS

1. CHS is a North Carolina not-for-profit corporation providing healthcare services with its principal place of business in Charlotte. Its flagship facility is Carolinas Medical Center, a large general acute-care hospital located in downtown Charlotte. It also operates nine other general acute-care hospitals in the Charlotte area.

2. CHS is the dominant hospital system in the Charlotte area, with approximately a 50 percent share of the relevant market, and 2014 revenue of approximately $8.7 billion. Its closest competitor by size is Novant, which owns five general acute care hospitals in the Charlotte area and has less than half

of CHS's revenue. After Novant, the next-largest hospital in the Charlotte area is CaroMont Regional Medical Center, which has less than one tenth of CHS's revenue.

3. CHS exerts market power in its dealings with commercial health insurers (''insurers''). CHS's market power results from its large size, the comprehensive range of healthcare services that it offers, its high market share, and insurers' need to include access to CHS's hospitals–as well as its other facilities and providers–in at least some of their provider networks in insurance plans that cover people in the Charlotte area. CHS's market power is further evidenced by its ability to profitably charge prices to insurers that are higher than competitive levels across a range of services, and to impose on insurers restrictions that reduce competition.

4. CHS's market power has enabled it to negotiate high prices (in the form of high ''reimbursement rates'') for treating insured patients. CHS has long had a reputation for being a high-priced healthcare provider. In a 2013 presentation, CHS's internal strategy group recognized that CHS ''has enjoyed years of annual reimbursement rate increases that are premium to the market, with those increases being applied to rates that are also premium to the market.''

5. Steering is a method by which insurers offer consumers of healthcare services options to reduce some of their healthcare expenses. Steering typically occurs when an insurer offers consumers a financial incentive to use a lower-cost provider or lower-cost provider network, in order to lower their healthcare expenses.

6. Steering–and the competition from lower-priced healthcare providers that steering animates–threatens CHS's high prices and revenues. In 2013, CHS's internal strategy group surveyed a dozen of CHS's senior leaders, asking them to list the ''biggest risks to CHS revenue streams.'' Nine of the twelve leaders polled identified the steering of patients away from CHS as one of the biggest risks to CHS's revenues.

7. To protect itself against steering that would induce price competition and potentially require CHS to lower its high prices, CHS has imposed steering restrictions in its contracts with insurers. These restrictions impede insurers from providing financial incentives to patients to encourage them to consider utilizing lower-cost but comparable or higher-quality alternative healthcare providers.

8. Tiered networks are a popular type of steering that insurers use in healthcare markets. Typically, insurers using tiered networks place healthcare providers that offer better value healthcare services (lower cost, higher quality) in top tiers. Patients who use top-tier providers pay lower out-of-pocket costs. For example, for a procedure costing $10,000, a patient might be responsible for paying $3,600 in coinsurance at a lower-tier hospital, but only $1,800 coinsurance to have the same procedure performed at a top-tier hospital.

9. Narrow-network insurance plans are another popular steering tool. Typically, narrow networks consist of a subset of all the healthcare providers that participate in an insurer's conventional network. A consumer who chooses a narrow-network insurance plan typically pays lower premiums, and lower out-of-pocket expenses than a conventional broad-network insurance plan as long as the consumer is willing to choose from the smaller network of providers for his or her healthcare needs.

10. Providers are motivated to have insurers steer towards them, including through an insurer's narrow or tiered network, because of the increased patient volume that accompanies steering. Thus, the ability of insurers to steer gives providers a powerful incentive to be as efficient as possible, maintain low prices, and offer high quality and innovative services. By doing so, providers induce insurers to steer patient volume to them. Individuals and employers that provide health insurance to their employees benefit tremendously from this because they can lower their healthcare expenses.

11. CHS has gained patient volume from insurers steering towards CHS, and has obtained higher revenues as a result. CHS encourages insurers to steer patients toward itself by offering health insurers modest concessions on its market-power driven, premium prices.

12. However, CHS forbids insurers from allowing CHS's competitors to do the same. CHS prevents insurers from offering tiered networks that feature hospitals that compete with CHS in the top tiers, and prevents insurers from offering narrow networks that include only CHS's competitors. By restricting its competitors from competing for–and benefitting from–steered arrangements, CHS uses its market power to impede insurers from negotiating lower prices with its competitors and offering lower-premium plans.

13. CHS also imposes restrictions in its contracts with insurers that impede insurers from providing truthful information to consumers about the value (cost and quality) of CHS's healthcare services compared to CHS's competitors. CHS's restrictions on insurers' price and quality transparency are an indirect restriction on steering, because they prevent patients from accessing information that would allow them to make healthcare choices based on available price and quality information.

14. Because CHS's steering restrictions prevent its competitors from attracting more patients through lower prices, CHS's competitors have less incentive to remain lower priced and to continue to become more efficient. As a result, CHS's restrictions reduce the competition that CHS faces in the marketplace. In the instances in which insurers have steered in other markets and in the few instances in which insurers have steered in the Charlotte area despite CHS's restrictions, insurers have reduced health insurance costs for consumers.

15. Four insurers provide coverage to more than 85 percent of the commerically-insured residents of the Charlotte area. They are: Aetna Health of the Carolinas, Inc., Blue Cross Blue Shield of North Carolina, Cigna Healthcare of North Carolina, Inc., and United Healthcare of North Carolina, Inc.

16. CHS maintains and enforces steering restrictions in its contracts with all four of these insurers. In some instances, the contract language prohibits steering outright. For example, CHS secured a contractual obligation from one insurer that it ''shall not directly or indirectly steer business away from'' CHS. In other instances, the contract language gives CHS the right to terminate its agreement with the insurer if the insurer engages in steering, providing CHS the ability to deny the insurer and its enrollees access to its dominant hospital system unless the steering ends. Although the contractual language that CHS has imposed varies with each insurer, it consistently creates disincentives that deter insurers from providing to their enrollees truthful information about their healthcare options and the benefits of price and quality competition among healthcare providers that the insurers could offer if they had full freedom to steer.

II. RELEVANT MARKET AND COMPETITIVE EFFECTS

17. The sale of general acute care inpatient hospital services to insurers (''acute inpatient hospital services'') is a relevant product market. The market includes sales of such services to insurers' individual, group, fully-insured and self-funded health plans.

18. The relevant market does not include sales of acute inpatient hospital services to government payers, *e.g.,* Medicare (covering the elderly and disabled), Medicaid (covering low-income persons), and TRICARE (covering military personnel and families) because a healthcare provider's negotiations with an insurer are separate from the process used to determine the rates paid by government payers.

19. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other (*e.g.,* obstetrics is not a substitute for cardiac services), insurers typically contract for the various individual acute inpatient hospital services as a bundle, and CHS's steering restrictions have an adverse impact on the sale of all acute inpatient hospital services. Therefore, acute inpatient hospital services can be aggregated for analytical convenience.

20. There are no reasonable substitutes or alternatives to acute inpatient hospital services. Consequently, a hypothetical monopolist of acute inpatient hospital services would likely profitably impose a small but significant price increase for those services over a sustained period of time.

21. The relevant geographic market is no larger than the Charlotte area. In this Complaint, the Charlotte area means the Charlotte Combined Statistical Area, as defined by the U.S. Office of Management and Budget, which consists of Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina, and Chester, Lancaster, and York counties in South Carolina. The Charlotte area has a population of about 2.6 million people.

22. Insurers contract to purchase acute inpatient hospital services from hospitals

within the geographic area where their enrollees are likely to seek medical care. Such hospitals are typically close to their enrollees' homes or workplaces. Insurers who seek to sell insurance plans to individuals and employers in the Charlotte area must include Charlotte area hospitals in their provider networks because people who live and work in the Charlotte area strongly prefer to obtain acute inpatient hospital services in the Charlotte area. Charlotte area consumers have little or no willingness to enroll in an insurance plan that provides no network access to hospitals located in the Charlotte area.

23. For these reasons, it is not a viable alternative for insurers that sell health insurance plans to consumers in the Charlotte area to purchase acute inpatient hospital services from providers outside the Charlotte area. Consequently, competition from providers of acute inpatient hospital services located outside the Charlotte area would not likely be sufficient to prevent a hypothetical monopolist provider of acute inpatient hospital services located in the Charlotte area from profitably imposing small but significant price increases for those services over a sustained period of time.

24. An insurer selling health insurance plans to individuals and employers in the Charlotte area must have CHS as a participant in at least some of its provider networks, in order to have a viable health insurance business in the Charlotte area. This gives CHS the ability to impose steering restrictions in its contracts with insurers. When CHS negotiates with insurers for CHS's network participation, CHS typically negotiates the prices and terms of participation for acute inpatient hospital services and other healthcare services, such as outpatient, ancillary, and physician services, at the same time, including services that are located outside the Charlotte area. As a result, CHS's anticompetitive steering restrictions typically apply to all the negotiated services.

25. CHS's maintenance and enforcement of its steering restrictions lessen competition between CHS and the other providers of acute inpatient hospital services in the Charlotte area that would, in the absence of the restrictions, likely reduce the prices paid for such services by insurers. Thus, the restrictions help to insulate CHS from competition, by limiting the ability of CHS's competitors to win more commercially-insured business by offering lower prices.

26. Insurers want to steer towards lower-cost providers and to offer innovative insurance plans that steer. For years, insurers have tried to negotiate the removal of steering restrictions from their contracts with CHS, but cannot because of CHS's market power. In the absence of the steering restrictions, insurers would likely steer consumers to lower-cost providers more than their current contracts with CHS presently permit.

27. As a result of this reduced competition due to CHS's steering restrictions, individuals and employers in the Charlotte area pay higher prices for health insurance coverage, have fewer insurance plans from which to choose, and are denied access to consumer comparison shopping and other cost-saving innovative and more efficient health plans that would be possible if insurers could steer freely. Deprived of the option to benefit from choosing more cost-efficient providers, Charlotte area patients incur higher out-of-pocket costs for their healthcare. Insurers are directly harmed by CHS's imposition of steering restrictions.

28. CHS restricts steering to help insulate itself from price competition, which enables CHS to maintain high prices and preserve its dominant position, and not for any procompetitive purpose. Indeed, when asked under oath whether CHS should limit the ability of insurers to offer tiered networks or narrow networks that exclude CHS, Carol Lovin, CHS's Chief Strategy Officer, said that CHS should not. And when asked her view about the possibility of eliminating CHS's steering restrictions, she testified, ''Would I personally be okay with getting rid of them? Yes, I would.'' CHS's steering restrictions do not have any procompetitive effects. CHS can seek to avoid losses of revenues and market share from lower cost competitors by competing to offer lower prices and better value than its competitors, rather than imposing rules on insurers that reduce the benefit to its rivals from competing on price.

III. JURISDICTION, VENUE AND INTERSTATE COMMERCE

29. The Court has subject-matter jurisdiction over this action under Section 4 of the Sherman Act, 15 U.S.C. § 4 (as to the claim by the United States); Section 16 of the Clayton Act, 15 U.S.C. § 26 (as to the claim by the State of North Carolina); and 28 U.S.C. §§ 1331, 1337(a), and 1345.

30. The Court has personal jurisdiction over CHS under Section 12 of the Clayton Act, 15 U.S.C. § 22. CHS maintains its principal place of business and transacts business in this District.

31. Venue is proper under 28 U.S.C. § 1391 and Section 12 of the Clayton Act, 15 U.S.C. § 22. CHS transacts business and resides in this District and the events giving rise to the claims occurred in this District.

32. CHS engages in interstate commerce and in activities substantially affecting interstate commerce. CHS provides healthcare services for which employers, insurers, and individual patients remit payments across state lines. CHS also purchases supplies and equipment that are shipped across state lines, and it otherwise participates in interstate commerce.

IV. CHS'S VIOLATION OF SECTION 1 OF THE SHERMAN ACT

33. Plaintiffs incorporate paragraphs 1 through 32 of this Complaint.

34. CHS has market power in the sale of acute inpatient hospital services in the Charlotte area.

35. CHS has and likely will continue to negotiate and enforce contracts containing steering restrictions with insurers in the Charlotte area. The contracts containing the steering restrictions are contracts, combinations, and conspiracies within the meaning of Section 1 of the Sherman Act, 15 U.S.C. § 1.

36. These steering restrictions have had, and will likely to continue to have, the following substantial anticompetitive effects in the relevant product and geographic market, among others:

a. protecting CHS's market power and enabling CHS to maintain at supracompetitive levels the prices of acute inpatient hospital services;

b. substantially lessening competition among providers in their sale of acute inpatient hospital services;

c. restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services;

d. reducing consumers' incentives to seek acute inpatient hospital services from more cost-effective providers; and

e. depriving insurers and their enrollees of the benefits of a competitive market for their purchase of acute inpatient hospital services.

37. Entry or expansion by other hospitals in the Charlotte area has not counteracted the actual and likely competitive harms resulting from CHS's steering restrictions. And in the future, such entry or expansion is unlikely to be rapid enough and sufficient in scope and scale to counteract these harms to competition. Building a hospital with a strong reputation that is capable of attracting physicians and patients is difficult, time-consuming, and expensive. Additionally, new facilities and programs, and typically the expansion of existing facilities and programs, are subject to lengthy licensing requirements, and in North Carolina, to certificate-of-need laws.

38. CHS did not devise its strategy of using steering restrictions for any procompetitive purpose. Nor do the steering restrictions have any procompetitive effects. Any arguable benefits of CHS's steering restrictions are outweighed by their actual and likely anticompetitive effects.

39. The challenged steering restrictions unreasonably restrain trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

V. REQUEST FOR RELIEF

40. The United States and the State of North Carolina request that the Court:

a. adjudge that all of the steering restrictions in the contracts between CHS and any insurer violate Section 1 of the Sherman Act, 15 U.S.C. § 1;

b. enjoin CHS, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts an insurer from engaging, or attempting to engage, in steering towards any healthcare provider;

c. enjoin CHS from retaliating, or threatening to retaliate, against any insurer for engaging or attempting to engage in steering; and

d. award Plaintiffs their costs in this action and such other relief as the Court may deem just and proper.

Dated: June 9, 2016

Respectfully Submitted,

FOR PLAINTIFF UNITED STATES OF AMERICA

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Deputy Assistant Attorney General.

Patricia A. Brink,
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United States District Court for the Western District of North Carolina Charlotte Division

United States of America and State of North Carolina, Plaintiffs, v. *The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System,* Defendant.

Case No. 3:16–cv–00311–RJC–DCK
Judge Robert J. Conrad, Jr.

[PROPOSED] FINAL JUDGMENT

WHEREAS, Plaintiffs, the United States of America and the State of North Carolina (collectively ''Plaintiffs''), filed their Complaint on June 9, 2016; Plaintiffs and Defendant The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System (collectively the ''Parties''), by their respective attorneys, have consented to the entry of this Final Judgment without trial or adjudication of any issue of fact or law;

AND WHEREAS, this Final Judgment does not constitute any evidence against or admission by any party regarding any issue of fact or law;

AND WHEREAS, the Plaintiffs and Defendant agree to be bound by the provisions of this Final Judgment pending its approval by this Court;

AND WHEREAS, the essence of this Final Judgment is to enjoin Defendant from prohibiting, preventing, or penalizing steering as defined in this Final Judgment;

NOW THEREFORE, before any testimony is taken, without trial or adjudication of any issue of fact or law, and upon consent of the parties, it is ORDERED, ADJUDGED, AND DECREED:

I. JURISDICTION

The Court has jurisdiction over the subject matter of and each of the Parties to this action. The Complaint states a claim upon which relief may be granted against Defendant under Section 1 of the Sherman Act, as amended, 15 U.S.C. § 1.

II. DEFINITIONS

For purposes of this Final Judgment, the following definitions apply:

A. ''Benefit Plan'' means a specific set of health care benefits and Healthcare Services that is made available to members through a health plan underwritten by an Insurer, a self-funded benefit plan, or Medicare Part C plans. The term ''Benefit Plan'' does not include workers' compensation programs, Medicare (except Medicare Part C plans), Medicaid, or uninsured discount plans.

B. ''Carve-out'' means an arrangement by which an Insurer unilaterally removes all or substantially all of a particular Healthcare Service from coverage in a Benefit Plan during the performance of a network-participation agreement.

C. ''Center of Excellence'' means a feature of a Benefit Plan that designates Providers of certain Healthcare Services based on objective quality or quality-and-price criteria in order to encourage patients to obtain such Healthcare Services from those designated Providers.

D. ''Charlotte Area'' means Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina and Chester, Lancaster, and York counties in South Carolina.

E. ''Co-Branded Plan'' means a Benefit Plan, such as Blue Local with Carolinas HealthCare System, arising from a joint venture, partnership, or a similar formal type of alliance or affiliation beyond that present in broad network agreements involving value-based arrangements between an Insurer and Defendant in any portion of the Charlotte Area whereby both Defendant's and Insurer's brands or logos appear on marketing materials.

F. ''Defendant'' means The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System, a North Carolina hospital authority with its headquarters in Charlotte, North Carolina; and its directors, commissioners, officers, managers, agents, and employees; its successors and assigns; and any controlled subsidiaries (including Managed Health Resources), divisions, partnerships, and joint ventures, and their directors, commissioners, officers, managers, agents, and employees; and any Person on whose behalf Defendant negotiates contracts with, or consults in the negotiation of contracts with, Insurers. For purposes of this Final Judgment, an entity is controlled by Defendant if Defendant holds 50% or more of the entity's voting securities, has the right to 50% or more of the entity's profits, has the right to 50% or more of the entity's assets on dissolution, or has the contractual power to designate 50% or more of the directors or trustees of the entity. Also for purposes of this Final Judgment, the term ''Defendant'' excludes MedCost LLC and MedCost Benefits Services LLC, but it does not exclude any Atrium Health director, commissioner, officer, manager, agent, or employee who may also serve as a director, member, officer, manager, agent, or employee of MedCost LLC or MedCost Benefit Services LLC when such director, commissioner, officer, manager, agent, or employee is acting within the course of his or her duties for Atrium Health. MedCostLLC and MedCost Benefits Services LLC will remain excluded from the definition of ''Defendant'' as long as Atrium does not acquire any greater ownership interest in these entities than it has at the time that this Final Judgment is lodged with the Court.

G. ''Healthcare Provider'' or ''Provider'' means any Person delivering any Healthcare Service.

H. ''Healthcare Services'' means all inpatient services (*i.e.,* acute-care diagnostic and therapeutic inpatient hospital services), outpatient services (*i.e.,* acute-care diagnostic and therapeutic outpatient services, including but not limited to ambulatory surgery and radiology services), and professional services (*i.e.,* medical services provided by physicians or other licensed medical professionals) to the extent offered by Defendant and within the scope of services covered on an in-network basis pursuant to a contract between Defendant and an Insurer. ''Healthcare Services'' does not mean management of patient care, such as through population health programs or employee or group wellness programs.

I. ''Insurer'' means any Person providing commercial health insurance or access to Healthcare Provider networks, including but not limited to managed-care organizations, and rental networks (*i.e.,* entities that lease, rent, or otherwise provide direct or indirect access to a proprietary network of Healthcare Providers), regardless of whether that entity bears any risk or makes any payment relating to the provision of healthcare. The term ''Insurer'' includes Persons that provide Medicare Part C plans, but does not include Medicare (except Medicare Part C plans), Medicaid, or TRICARE, or entities that otherwise contract on their behalf.

J. ''Narrow Network'' means a network composed of a significantly limited number of Healthcare Providers that offers a range of Healthcare Services to an Insurer's members for which all Providers that are not included in the network are out of network.

K. ''Penalize'' or ''Penalty'' is broader than ''prohibit'' or ''prevent'' and is intended to include any contract term or action with the likely effect of significantly restraining steering through Steered Plans or Transparency. In determining whether any contract provision or action ''Penalizes'' or is a ''Penalty,'' factors that may be considered include: the facts and circumstances relating to the contract provision or action; its economic impact; and the extent to which the contract provision or action has potential or actual procompetitive effects in the Charlotte Area.

L. ''Person'' means any natural person, corporation, company, partnership, joint

venture, firm, association, proprietorship, agency, board, authority, commission, office, or other business or legal entity.

M. ''Reference-Based Pricing'' means a feature of a Benefit Plan by which an Insurer pays up to a uniformly-applied defined contribution, based on an external price selected by the Insurer, toward covering the full price charged for a Healthcare Service, with the member being required to pay the remainder. For avoidance of doubt, a Benefit Plan with Reference-Based Pricing as a feature may permit an Insurer to pay a portion of this remainder.

N. ''Steered Plan'' means any Narrow Network Benefit Plan, Tiered Network Benefit Plan, or any Benefit Plan with Reference-Based Pricing or a Center of Excellence as a component.

O. ''Tiered Network'' means a network of Healthcare Providers for which (i) an Insurer divides the in-network Providers into different sub-groups based on objective price, access, and/or quality criteria; and (ii) members receive different levels of benefits when they utilize Healthcare Services from Providers in different sub-groups.

P. ''Transparency'' means communication of any price, cost, quality, or patient experience information directly or indirectly by an Insurer to a client, member, or consumer.

III. APPLICABILITY

This Final Judgment applies to Defendant, as defined above, and all other Persons in active concert with, or participation with, Defendant who receive actual notice of this Final Judgment by personal service or otherwise.

IV. PROHIBITED CONDUCT

A. The contract language reproduced in Exhibit A is void, and Defendant shall not enforce or attempt to enforce it. The contract language reproduced in Exhibit B shall not be used to prohibit, prevent, or penalize Steered Plans or Transparency, but could remain enforceable for protection against Carve-outs. For the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and Defendant's wholly-owned subsidiary Managed Health Resources, effective January 1, 2014, as amended, Defendant shall exclude from the calculation of total cumulative impact pursuant to Section 6.14 of that agreement any impact to Defendant resulting from Blue Cross and Blue Shield of North Carolina disfavoring Defendant through Transparency or through the use of any Steered Plan.

B. For Healthcare Services in the Charlotte Area, Defendant will not seek or obtain any contract provision which would prohibit, prevent, or penalize Steered Plans or Transparency including:

1. express prohibitions on Steered Plans or Transparency;

2. requirements of prior approval for the introduction of new benefit plans (except in the case of Co-Branded Plans); and

3. requirements that Defendant be included in the most-preferred tier of Benefit Plans (except in the case of Co-Branded Plans). However, notwithstanding this Paragraph IV(B)(3), Defendant may enter into a contract with an Insurer that provides Defendant with the right to participate in the most-preferred tier of a Benefit Plan under the same terms and conditions as any other Charlotte Area Provider, provided that if Defendant declines to participate in the most-preferred tier of that Benefit Plan, then Defendant must participate in that Benefit Plan on terms and conditions that are substantially the same as any terms and conditions of any then-existing broad-network Benefit Plan (*e.g.,* PPO plan) in which Defendant participates with that Insurer. Additionally, notwithstanding Paragraph IV(B)(3), nothing in this Final Judgment prohibits Defendant from obtaining any criteria used by the Insurer to (i) assign Charlotte Area Providers to each tier in any Tiered Network; and/or (ii) designate Charlotte Area Providers as a Center of Excellence.

C. Defendant will not take any actions that penalize, or threaten to penalize, an Insurer for (i) providing (or planning to provide) Transparency, or (ii) designing, offering, expanding, or marketing (or planning to design, offer, expand, or market) a Steered Plan.

I. PERMITTED CONDUCT

A. Defendant may exercise any contractual right it has, provided it does not engage in any Prohibited Conduct as set forth above.

B. For any Co-Branded Plan or Narrow Network in which Defendant is the most-prominently featured Provider, Defendant may restrict steerage within that Co-Branded Plan or Narrow Network. For example, Defendant may restrict an Insurer from including at inception or later adding other Providers to any (i) Narrow Network in which Defendant is the most-prominently featured Provider, or (ii) any Co-Branded Plan.

C. With regard to information communicated as part of any Transparency effort, nothing in this Final Judgment prohibits Defendant from reviewing its information to be disseminated, provided such review does not delay the dissemination of the information. Furthermore, Defendant may challenge inaccurate information or seek appropriate legal remedies relating to inaccurate information disseminated by third parties. Also, for an Insurer's dissemination of price or cost information (other than communication of an individual consumer's or member's actual or estimated out-of-pocket expense), nothing in the Final Judgment will prevent or impair Defendant from enforcing current or future provisions, including but not limited to confidentiality provisions, that (i) prohibit an Insurer from disseminating price or cost information to Defendant's competitors, other Insurers, or the general public; and/or (ii) require an Insurer to obtain a covenant from any third party that receives such price or cost information that such third party will not disclose that information to Defendant's competitors, another Insurer, the general public, or any other third party lacking a reasonable need to obtain such competitively sensitive information. Defendant may seek all appropriate remedies (including injunctive relief) in the event that dissemination of such information occurs.

V. REQUIRED CONDUCT

Within fifteen (15) business days of entry of this Final Judgment, Defendant, through its designated counsel, must notify in writing Aetna, Blue Cross and Blue Shield of North Carolina, Cigna, MedCost, and UnitedHealthcare, that:

A. This Final Judgment has been entered (enclosing a copy of this Final Judgment) and that it prohibits Defendant from entering into or enforcing any contract term that would prohibit, prevent, or penalize Steered Plans or Transparency, or taking any other action that violates this Final Judgment; and

B. For the term of this Final Judgment Defendant waives any right to enforce any provision listed in Exhibit A and further waives the right to enforce any provision listed in Exhibit B to prohibit, prevent, or penalize Steered Plans and Transparency.

VII. COMPLIANCE

A. It shall be the responsibility of the Defendant's designated counsel to undertake the following:

1. within fifteen (15) calendar days of entry of this Final Judgment, provide a copy of this Final Judgment to each of Defendant's commissioners and officers, and to each employee whose job responsibilities include negotiating or approving agreements with Insurers for the purchase of Healthcare Services, including personnel within the Managed Health Resources subsidiary (or any successor organization) of Defendant;

2. distribute in a timely manner a copy of this Final Judgment to any person who succeeds to, or subsequently holds, a position of commissioner, officer, or other position for which the job responsibilities include negotiating or approving agreements with Insurers for the purchase of Healthcare Services, including personnel within the Managed Health Resources subsidiary (or any successor organization) of Defendant; and

3. within sixty (60) calendar days of entry of this Final Judgment, develop and implement procedures necessary to ensure Defendant's compliance with this Final Judgment. Such procedures shall ensure that questions from any of Defendant's commissioners, officers, or employees about this Final Judgment can be answered by counsel (which may be outside counsel) as the need arises. Paragraph 21.1 of the Amended Protective Order Regarding Confidentiality shall not be interpreted to prohibit outside counsel from answering such questions.

B. For the purposes of determining or securing compliance with this Final Judgment, or any related orders, or determining whether the Final Judgment should be modified or vacated, and subject to any legally-recognized privilege, from time to time authorized representatives of the United States or the State of North Carolina, including agents and consultants retained by the United States or the State of North Carolina, shall, upon written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General for the State of North Carolina, and on reasonable notice to Defendant, be permitted:

1. access during Defendant's office hours to inspect and copy, or at the option of the

United States, to require Defendant to provide electronic copies of all books, ledgers, accounts, records, data, and documents in the possession, custody, or control of Defendant, relating to any matters contained in this Final Judgment; and

2. to interview, either informally or on the record, Defendant's officers, employees, or agents, who may have their individual counsel present, regarding such matters. The interviews shall be subject to the reasonable convenience of the interviewee and without restraint or interference by Defendant.

C. Within 270 calendar days of entry of this Final Judgment, Defendant must submit to the United States and the State of North Carolina a written report setting forth its actions to comply with this Final Judgment, specifically describing (1) the status of all negotiations between Managed Health Resources (or any successor organization) and an Insurer relating to contracts that cover Healthcare Services rendered in the Charlotte Area since the entry of the Final Judgment, and (2) the compliance procedures adopted under Paragraph VII(A)(3) of this Final Judgment.

D. Upon the written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General for the State of North Carolina, Defendant shall submit written reports or responses to written interrogatories, under oath if requested, relating to any of the matters contained in this Final Judgment as may be requested.

E. The United States may share information or documents obtained under Paragraph VII with the State of North Carolina subject to appropriate confidentiality protections. The State of North Carolina shall keep all such information or documents confidential.

F. No information or documents obtained by the means provided in Paragraph VII shall be divulged by the United States or the State of North Carolina to any Person other than an authorized representative of (1) the executive branch of the United States or (2) the Office of the North Carolina Attorney General, except in the course of legal proceedings to which the United States or the State of North Carolina is a party (including grand jury proceedings), for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

G. If at the time that Defendant furnishes information or documents to the United States or the State of North Carolina, Defendant represents and identifies in writing the material in any such information or documents to which a claim of protection may be asserted under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure, and Defendant marks each pertinent page of such material, ''Subject to claim of protection under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure,'' the United States and the State of North Carolina shall give Defendant ten (10) calendar days' notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding).

H. For the duration of this Final Judgment, Defendant must provide to the United States and the State of North Carolina a copy of each contract and each amendment to a contract that covers Healthcare Services in the Charlotte Area that it negotiates with any Insurer within thirty (30) calendar days of execution of such contract or amendment. Defendant must also notify the United States and the State of North Carolina within thirty (30) calendar days of having reason to believe that a Provider which Defendant controls has a contract with any Insurer with a provision that prohibits, prevents, or penalizes any Steered Plans or Transparency.

VIII. Retention of Jurisdiction

The Court retains jurisdiction to enable any Party to this Final Judgment to apply to the Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify any of its provisions, to enforce compliance, and to punish violations of its provisions.

IX. Enforcement of Final Judgment

A. The United States retains and reserves all rights to enforce the provisions of this Final Judgment, including the right to seek an order of contempt from the Court. Defendant agrees that in any civil contempt action, any motion to show cause, or any similar action brought by the United States regarding an alleged violation of this Final Judgment, the United States may establish a violation of the decree and the appropriateness of any remedy therefor by a preponderance of the evidence, and Defendant waives any argument that a different standard of proof should apply.

B. The Final Judgment should be interpreted to give full effect to the procompetitive purposes of the antitrust laws and to restore all competition Plaintiffs alleged was harmed by the challenged conduct. Defendant agrees that it may be held in contempt of, and that the Court may enforce, any provision of this Final Judgment that, as interpreted by the Court in light of these procompetitive principles and applying ordinary tools of interpretation, is stated specifically and in reasonable detail, whether or not it is clear and unambiguous on its face. In any such interpretation, the terms of this Final Judgment should not be construed against either Party as the drafter.

C. In any enforcement proceeding in which the Court finds that Defendant has violated this Final Judgment, the United States may apply to the Court for a one-time extension of this Final Judgment, together with such other relief as may be appropriate. In connection with any successful effort by the United States to enforce this Final Judgment against Defendant, whether litigated or resolved prior to litigation, Defendant agrees to reimburse the United States for the fees and expenses of its attorneys, as well as any other costs including experts' fees, incurred in connection with that enforcement effort, including in the investigation of the potential violation.

X. Expiration of Final Judgment

Unless the Court grants an extension, this Final Judgment shall expire ten (10) years from the date of its entry, except that after five (5) years from the date of its entry, this Final Judgment may be terminated upon notice by the United States to the Court and Defendant that the continuation of the Final Judgment is no longer necessary or in the public interest.

XI. Public Interest Determination

Entry of this Final Judgment is in the public interest. The Parties have complied with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16, including making copies available to the public of this Final Judgment, the Competitive Impact Statement, any comments thereon, and the United States' responses to comments. Based upon the record before the Court, which includes the Competitive Impact Statement and any comments and responses to comments filed with the Court, entry of this Final Judgment is in the public interest.

Date: _____

[Court approval subject to procedures of Antitrust Procedures and Penalties Act, 15 U.S.C. § 16]

Robert J. Conrad, Jr.
United States District Judge.

Exhibit A

Aetna

Section 2.8 of the Physician Hospital Organization Agreement between and among Aetna Health of the Carolinas, Inc., Aetna Life Insurance Company, Aetna Health Management, LLC, and Defendant states in part:

''Company may not . . . steer Members away from Participating PHO Providers other than instances where services are not deemed to be clinically appropriate, subject to the terms of Section 4.1.3 of this Agreement.''

In addition, Section 2.11 of the above-referenced agreement states in part:

''Company reserves the right to introduce in new Plans . . . and products during the term of this Agreement and will provide PHO with ninety (90) days written notice of such new Plans, Specialty Programs and products. . . . For purposes under (c) and (d) above, Company commits that Participating PHO Providers will be in-network Participating Providers in Company Plans and products as listed on the Product Participation Schedule. If Company introduces new products or benefit designs in PHO's market that have the effect of placing Participating PHO Providers in a non-preferred position, PHO will have the option to terminate this Agreement in accordance with Section 6.3. Notwithstanding the foregoing, if Company introduces an Aexcel performance network in PHO Provider's service area, all PHO Providers will be placed in the most preferred benefit level. As long as such Plans or products do not directly or indirectly steer Members away from a Participating PHO Provider to an alternative Participating Provider for the same service in the same level of care or same setting, the termination provision would not apply.''

Blue Cross and Blue Shield of North Carolina

The Benefit Plan Exhibit to the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and

Defendant (originally effective January 1, 2014), as replaced by the Fifth Amendment, states in part:

''After meeting and conferring, if parties cannot reach agreement, then, notwithstanding Section 5.1, this Agreement will be considered to be beyond the initial term, and you may terminate this Agreement upon not less than 90 days' prior Written Notice to us, pursuant to Section 5.2.''

Cigna

Section II.G.5 of the Managed Care Alliance Agreement between Cigna HealthCare of North Carolina, Inc. and Defendant states in part:

''All MHR entities as defined in Schedule 1 will be represented in the most preferred benefit level for any and all CIGNA products for all services provided under this Agreement unless CIGNA obtains prior written consent from MHR to exclude any MHR entities from representation in the most preferred benefit level for any CIGNA product. . . . As a MHR Participating Provider, CIGNA will not steer business away from MHR Participating Providers.''

Medcost

Section 3.6 of the Participating Physician Hospital Organization agreement between Medcost, LLC and Defendant states in part:

''Plans shall not directly or indirectly steer patients away from MHR Participating Providers.''

UnitedHealthcare

Section 2 of the Hospital Participation Agreement between UnitedHealthcare of North Carolina, Inc. and Defendant states in part:

''As a Participating Provider, Plan shall not directly or indirectly steer business away from Hospital.''

Exhibit B

Cigna

Section II.G.5 of the Managed Care Alliance Agreement between Cigna HealthCare of North Carolina, Inc. and Defendant states in part:

''CIGNA may not exclude a MHR Participating Provider as a network provider for any product or Covered Service that MHR Participating Provider has the capability to provide except those carve-out services as outlined in Exhibit E attached hereto, unless CIGNA obtains prior written consent from MHR to exclude MHR Participating Provider as a network provider for such Covered Services.''

UnitedHealthcare

Section 2 of the Hospital Participation Agreement between UnitedHealthcare of North Carolina, Inc. and Defendant states in part:

''Plan may not exclude Hospital as a network provider for any Health Service that Hospital is qualified and has the capability to provide and for which Plan and Hospital have established a fee schedule or fixed rate, as applicable, unless mutually agreed to in writing by Plan and Hospital to exclude Hospital as a network provider for such Health Service.''

In addition, Section 3.6 of the above-referenced agreement states in part:

''During the term of this Agreement, including any renewal terms, if Plan creates new or additional products, which product otherwise is or could be a Product Line as defined in this Agreement, Hospital shall be given the opportunity to participate with respect to such new Product Line.''

United States District Court for the Western District of North Carolina Charlotte Division

United States of America and the State of North Carolina, Plaintiffs, v. *The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System,* Defendant.

Case No. 3:16–cv–00311–RJC–DCK
Judge Robert J. Conrad, Jr.

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 June 9, 2016, the United States and the State of North Carolina filed a civil antitrust lawsuit against The Charlotte-Mecklenburg Hospital Authority, formerly known as Carolinas HealthCare System and now doing business as Atrium Health (''Atrium''), to enjoin it from using steering restrictions in its agreements with health insurers in the Charlotte, North Carolina area. The Complaint alleges that Atrium's steering restrictions are anticompetitive and violate Section 1 of the Sherman Act, 15 U.S.C. § 1, because the restrictions have detrimental effects on competition among healthcare providers in the Charlotte area.

Healthcare providers charge health insurers a wide variety of prices for the same service, but insurers have generally not passed these price differences on to consumers because most commercial health plans offer coverage that is the same no matter which provider a patient chooses. This weakens the connection between price and quantity that is the essence of competition because it allows a provider to charge a high price without losing business to rivals. To control escalating healthcare costs, insurers have developed health plans and plan features that ''steer'' members by providing financial incentives that enable members to share savings by choosing more cost-effective providers, which stimulates competition between providers. To enable patients to choose more cost-effective providers, insurers also provide members with transparency about the prices, quality, patient experience, or anticipated out-of-pocket costs at different healthcare providers.

Atrium is the largest health system in the Charlotte area. For an insurer to maintain a competitive health insurance business in the Charlotte area, it needs to have a contractual relationship with Atrium that gives employers and consumers the option of purchasing insurance that covers care there.

Atrium has used its dominant position to demand contractual restrictions on steering and transparency that interfere with the competitive process. Insurers that contract with Atrium are prohibited from providing financial incentives or information that would encourage consumers to obtain healthcare services from competing providers. These contract provisions significantly reduce the number of additional patients that Atrium's competitors can hope to attract by agreeing to lower prices or otherwise providing greater value. These restrictions have been in Atrium's contracts for years, and remain to this day.

Atrium's steering restrictions reduce the competitive incentive that Atrium's competitors would otherwise have to lower prices in order to win more business. This interference in the competitive process has reduced competition between Atrium and other healthcare providers in the Charlotte area. In addition, because many of the most innovative healthcare plans in the country today are based on steering to more efficient providers, Atrium's steering restrictions have also curbed the introduction of such plans, and reduced choices for Charlotte-area consumers.

Plaintiffs and Atrium have entered into a Stipulation and proposed Final Judgment. The proposed Final Judgment enjoins Atrium from (1) enforcing provisions in its current insurer contracts that restrict steering and transparency; (2) seeking or obtaining contract provisions with an insurer that would prohibit, prevent, or penalize the insurer from using popular steering methods or providing transparency; and (3) penalizing, or threatening to penalize, any insurer for its use of these popular steering methods and transparency. The proposed Final Judgment is described in detail beginning with Section III below. In the Stipulation, Atrium agrees to abide by the injunctive provisions of the proposed Final Judgment while awaiting its entry by the Court.

The United States (unless it has withdrawn its consent), the State of North Carolina, and Atrium have stipulated that the Court may enter the proposed Final Judgment at any time after compliance with the APPA. 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 ALLEGED VIOLATION

A. Atrium and other Charlotte-Area Hospitals

Atrium is the largest healthcare system in North Carolina and one of the largest not-for-profit healthcare systems in the United States. It is the dominant hospital system in the Charlotte area. Its flagship facility is Carolinas Medical Center, a general acute-care hospital located near downtown Charlotte and the largest hospital in North Carolina. Atrium also operates nine additional general acute-care hospitals in the Charlotte area. Atrium owns, manages, or has strategic affiliations with over 40 hospitals in the Carolinas, and sells healthcare services throughout the Carolinas, including in

freestanding emergency departments, urgent care centers, physician practices, outpatient surgery centers, imaging centers, nursing homes, and laboratories. In 2017, Atrium's owned, managed, and affiliated hospitals and other healthcare providers earned net operating revenue of close to $10 billion.

In addition to Atrium's ten Charlotte-area hospitals, there are eleven other general acute-care hospitals in the Charlotte area. The next largest hospital system, Novant Health (''Novant''), owns five general acute-care hospitals located in that area and had operating revenue of approximately $4.6 billion in 2017, making Novant less than half the size of Atrium. Novant's largest hospital in the Charlotte area is Novant Presbyterian Medical Center, which is the second-largest hospital in Charlotte. After Novant, the next-largest hospital in the Charlotte area is CaroMont Regional Medical Center. CaroMont Regional Medical Center is a 370-bed hospital in Gastonia, North Carolina, and is owned and operated by CaroMont Health, an independent community hospital system. In 2016, CaroMont Health had net operating revenue of approximately $529 million. The remaining hospitals in the Charlotte area are operated by Community Health Systems, Inc., Tenet Healthcare Corporation, and Iredell Health System.

B. The Relevant Market

The Complaint alleges that Atrium has market power in a relevant market for the sale of general acute care inpatient hospital services sold to commercial health insurers (''GAC inpatient hospital services'') in the Charlotte area. GAC inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that includes a patient's overnight stay in the hospital. Although individual GAC inpatient hospital services are not substitutes for each other (*e.g.,* a patient who needs heart surgery cannot elect instead to have her knee replaced), GAC inpatient hospital services can be aggregated for analytical convenience because the competitive conditions for each of the individual services is largely the same.

The relevant geographic market for the sale of GAC inpatient hospital services is no larger than the Charlotte area.[1] Insurers contract to purchase GAC inpatient hospital services from hospitals within the geographic area where their members are likely to seek medical care because consumers prefer to seek medical care near the places where they work and live. As a result, insurers doing business in the Charlotte area must include in their provider networks hospitals located in the Charlotte area. Charlotte-area consumers have little or no willingness to enroll in an insurance plan that provides no network access to hospitals located in the Charlotte area. For these reasons, it is not a viable alternative for insurers that sell health plans to consumers in the Charlotte area to contract for GAC inpatient hospital services from providers outside the Charlotte area.

C. Anticompetitive Effects of the Steering Restrictions

1. Atrium is the dominant hospital system in the Charlotte area

Atrium is the dominant seller of GAC inpatient hospital services in the Charlotte area. Atrium has market power in this market. The market for GAC inpatient hospital services in the Charlotte area is highly concentrated, and Atrium's market share is more than 55 percent. By comparison, Atrium's largest rival, Novant Health, has approximately 17 percent of the licensed hospital beds in the Charlotte area. Without an attractive broad-network plan that includes Atrium, insurers would not be viable in the Charlotte area because they would not be able to attract the business of employers. Atrium's size and breadth give it significant market power because it can decline to participate in an insurer's network unless it obtains high prices and advantageous contract terms.

As a result of its market power, Atrium has been able to secure from insurers high prices relative to other hospital systems in the Charlotte area and relative to other advanced medical centers in North Carolina. These higher prices are not explained by any measure of relative high-quality. Because of high provider prices, patients' out-of-pocket healthcare costs in the Charlotte area are among the highest in North Carolina.

2. Steering is part of the competitive process

Employers in Charlotte and elsewhere around the country have approached health insurers about ways to address rising healthcare costs. One approach of increasing interest is the introduction of steering mechanisms into the health plans that employers offer. Steering can be one way of fostering competition among hospitals.

Steering can be accomplished in several ways. Popular types of steering in healthcare are narrow networks and tiered networks, reference-based pricing, and centers of excellence.[2] Transparency into hospitals' or physicians' relative prices and quality is also important to help effectuate steering.

a. Narrow networks and tiered networks

In addition to offering the broad-network plans that are most popular with employers, insurers in Charlotte want to introduce narrow network and tiered insurance options. Narrow networks are formed by using cost and/or quality criteria to select and contract with a subset of healthcare providers in an area. For example, a health plan sold in the Charlotte area that consists of hospitals and physicians only at Novant, CaroMont, and Community Health Systems would be a narrow-network plan. Because using an in-network provider costs a member less than using an out-of-network provider, a consumer that enrolls in a narrow-network plan is choosing to be steered to participating providers. The likely increase in patient volume realized by providers in the narrow network can help the insurer to negotiate lower prices, and then to pass those savings along in the form of lower premiums.

Tiered networks are typically created by designating network providers into different levels (or tiers) based mostly on quality and price. Tiered networks typically have two or more tiers of in-network providers: a preferred tier and one or more secondary in-network tiers. There may also be providers that remain out-of-network. In tiered networks, members are free to use any of the providers, but receive the most substantial benefits when they choose a provider in the preferred tier. This tier typically includes the providers with the best mix of quality and price. Tiered and narrow network plans are increasingly popular with employers and consumers. For example, in 2017, 19 percent of large employers that offered healthcare coverage provided a narrow-network plan to their employees and 31 percent offered a tiered plan.[3] A large majority of the plans offered on the individual healthcare exchanges are narrow network plans. Narrow and tiered networks can effectively reduce healthcare costs and make insurance more affordable.

b. Reference-based pricing and centers of excellence

Reference-based pricing and centers of excellence are forms of steering that can be used as a feature of a health benefit plan. For reference-based pricing, the insurer establishes a market-wide standard, or ''reference,'' price for a service. The reference price can be established by drawing from average local prices or from other sources such as the reimbursement amounts established by Medicare rules. The benefit plan covers the member's expenses up to the ''reference price.'' Reference-based pricing steers members towards the providers that have prices at or below the reference price. This gives higher-priced providers an incentive to reduce their prices to be closer to the reference price.[4]

A center of excellence is a designation that an insurer applies to a provider for its quality and/or cost efficiency in delivering a particular healthcare service. The insurer often provides a financial incentive to consumers to select the center of excellence. For example, an insurer may designate a particular hospital in a metropolitan area as

[1] As used in this case, the Charlotte area means the Charlotte Combined Statistical Area, as defined by the U.S. Office of Management and Budget, which consists of Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina, and Chester, Lancaster, and York counties in South Carolina.

[2] The proposed Final Judgment defines narrow networks, tiered networks, and health plans with reference-based pricing or centers of excellence as ''Steered Plans.''

[3] Kaiser Family Foundation, *2017 Employer Health Benefits Survey,* 213–214, *http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.*

[4] The California Public Employees' Retirement System (''CalPERS'') has successfully used reference-based pricing to lower expenses on hip and knee replacements. A study of the first year after implementation of the reference-based pricing program indicates that surgical volumes at low-price facilities increased while volumes at high-price facilities decreased. Prices declined at both high and low price facilities. As a result CalPERS and its employees saved approximately $3 million. James C. Robinson and Timothy T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce hospital Prices for Orthopedic Surgery, 32 Health Affairs* 1392, 1394–97 (2013).

its center of excellence in bariatric surgery because the hospital has superior expertise or is particularly cost effective. To incent members to obtain bariatric surgery there, the insurer may reduce or eliminate out-of-pocket expenses for members who choose that hospital. Members remain free to obtain bariatric surgery elsewhere and pay the out-of-pocket expenses prescribed under the plan. Members are steered towards a center of excellence by virtue of the designation and the cost savings.

c. Transparency

Transparency is the communication of price, cost, quality, or patient experience information to a member. Transparency makes steered plans more effective by providing consumers with information to enable them to comparison shop before selecting a provider. Transparency may also be a form of steering even in the absence of differential benefits because information that identifies one provider as more cost effective than another provider may prompt consumers to choose the more cost-effective provider.

3. To insulate itself from competition, Atrium required that steering restrictions be included in its insurer contracts

To protect its dominant share and high prices and insulate itself from competition, Atrium has used its market power to require every major insurer in the Charlotte area—Aetna Health of the Carolinas, Inc. (''Aetna''), Blue Cross and Blue Shield of North Carolina (''BCBS–NC''), Cigna Healthcare of North Carolina, Inc. (''Cigna''), and United Healthcare of North Carolina, Inc. (''UnitedHealthcare'') [5]— to accept contract terms that restrict the insurers from steering their members to Atrium's lower-cost competitors.

Atrium's contracts with each of these insurers contain steering restrictions that either expressly prohibit the insurer from steering their members away from Atrium, or impede steering through other means, such as by imposing a financial penalty on any steering against Atrium that exceeds a specified amount or by allowing Atrium to promptly terminate the insurer's contract if the insurer steers against Atrium. Atrium used its market power to require that insurers agree to these contract provisions that restrict steering, and thereby restrict competition.

Atrium's steering restrictions restrain insurers from offering consumers the choice of narrow-network plans that do not include Atrium, and tiered-network plans that do not place Atrium in the most favorable tier. Atrium's steering restrictions also prevent insurers from offering reference-based pricing because if the reference price for a service is lower than the price that Atrium charges for that service, members will be steered away from Atrium. Insurers are also prevented from offering financial incentives for members to obtain services at non-Atrium providers that are designated centers of excellence.

These restrictions also prevent insurers from providing members transparency into the price, quality, patient experience, and anticipated out-of-pocket costs of Atrium's healthcare services compared to Atrium's competitors. Atrium's restrictions on transparency indirectly restrict steering because they inhibit consumers from accessing information that would allow them to make better-informed healthcare provider choices.

Deprived of any mechanism to reward low prices with more patient volume, insurers cannot create incentives for Atrium's rivals to compete on price. Atrium's steering restrictions, therefore, reduce competition for GAC inpatient hospital services in the Charlotte area by impeding its competitors' ability to attract patients by offering lower prices to insurers and their members. The steering restrictions prevent consumers from benefitting from lower prices, so they protect Atrium from losing patient volume in response to high prices. This reduction in competition causes prices to be higher than they would be in the absence of Atrium's steering restrictions.

III. EXPLANATION OF THE PROPOSED FINAL JUDGMENT

The purpose of the proposed Final Judgment is to prevent Atrium from impeding insurers' steered plans and transparency, and to restore competition among healthcare providers in the Charlotte area. The proposed Final Judgment will accomplish this objective through injunctive, compliance, and enforcement provisions.

Atrium has market power in GAC inpatient hospital services, but the proposed Final Judgment applies to the broad range of healthcare services that Atrium provides and to which its steering restrictions apply. The additional healthcare services covered by the proposed Final Judgment include outpatient services (such as ambulatory surgeries and radiological services), professional services rendered by physicians, and ancillary services such as imaging and lab services. The full scope of services covered by the proposed Final Judgment falls within the proposed Final Judgment's definition of ''Healthcare Services.'' Because Atrium uses its market power to restrict steering away from it for any healthcare service, the proposed Final Judgment provides relief that is broader than the set of services in the relevant market.

The proposed Final Judgment also applies to a broad range of benefit plans. This includes health insurance policies sold to individuals, fully-insured and self-funded health plans sold to employers and other groups, and Medicare Advantage plans.

A. Prohibited Conduct

The proposed Final Judgment seeks to restore competition by prohibiting Atrium from engaging in specific conduct. There are three main provisions. The first stops Atrium from enforcing the current contract provisions at issue in this suit. The second stops Atrium from enforcing similar or new contractual provisions that would restrict steering in the Charlotte area. The third stops Atrium from retaliating against insurers for steering in the Charlotte area.

1. Eliminating the anticompetitive contract provisions

The proposed Final Judgment eliminates the contractual language that Plaintiffs alleged is anticompetitive. The proposed Final Judgment voids the contractual provisions listed in Exhibit A to the proposed Final Judgment that expressly prevent steering. For example, a provision stating that an insurer ''will not steer business away from'' Atrium is voided from that insurer's contract. Additionally, a part of a contract between Atrium and an insurer that required the insurer to give Atrium 90 days' notice before bringing a plan to market that would steer patients away from Atrium is also voided. Further, the proposed Final Judgment eliminates a provision in one insurer's contract that allows Atrium to terminate the contract on 90 days' notice if the insurer offers a plan that would steer away from Atrium.

In addition, Atrium's contracts with commercial insurers contain other provisions that require the insurer to include Atrium in all of its benefit plans. Each such provision prevents the insurer from creating narrow networks that feature Atrium's rivals, but exclude Atrium. The proposed Final Judgment lists that language in Exhibit B, and prohibits Atrium from enforcing or attempting to enforce such contractual provisions to prevent, prohibit, or penalize steered plans and transparency.[6]

Finally, the proposed Final Judgment prevents Atrium from enforcing a ''material impact'' provision in its contract with BCBS–NC in a manner that reduces BCBS–NC's incentives to steer to more efficient providers.

2. Preventing new contractual provisions that harm steering

The proposed Final Judgment also prevents Atrium from seeking or obtaining similar or new contract provisions that would prohibit, prevent, or penalize steering through steered plans or transparency in the Charlotte area.

Paragraph IV(B) of the proposed Final Judgment identifies three types of contractual provisions that, among others, would prohibit, prevent, or penalize steering through steered plans and would thus violate the terms of the proposed Final Judgment. First, Atrium may not expressly prohibit

[5] These four major insurers cover over 90 percent of the commercially-insured residents of the Charlotte area. MedCost is the next-largest health plan in the Charlotte area. MedCost provides administrative services and access to its healthcare provider networks to employers that self-fund their employees' healthcare benefits. Employers that are self-funded pay the healthcare benefit claims from the assets of their business, rather than purchase health insurance policies for the benefit of their employees. Atrium owns 50 percent of MedCost.

[6] The contract provisions appearing in Exhibit B could remain enforceable to prevent insurers from ''carving out'' certain Atrium procedures from their benefits plans. A ''carve-out'' is an industry term defined in the proposed Final Judgment as an arrangement by which an insurer unilaterally removes all or substantially all of a particular healthcare service from coverage in a benefit plan during the performance of a network-participation agreement. Insurers are free to negotiate carve-outs as part of a contract, but Atrium may prohibit insurers from carving additional services out of a contract after it is signed.

steered plans or transparency. Second, Atrium may not require prior approval of new benefit plans. Third, Atrium may not demand to be included in the most-preferred tier of benefit plans regardless of price.

The Final Judgment's injunction against steering restrictions also reaches beyond these three existing provisions to include any contract provision that prohibits, prevents, or penalizes steering. ''Penalize'' is a term in the proposed Final Judgment that includes within its definition anything that would significantly restrain an insurer's steering. Because steering away from Atrium necessarily reduces its volume and revenues, terms that punish such reductions with higher prices or other detrimental consequences may be penalties. Whether a provision or action is likely to significantly restrain steering depends on the facts and circumstances, including but not limited to its economic impact, and any procompetitive effects that would tend to lower healthcare costs or otherwise benefit consumers in the Charlotte area.

3. Atrium may not retaliate against steering

Under the terms of the proposed Final Judgment Atrium also may not seek or obtain any contract provision, or take any other action that would penalize an insurer for steering away from Atrium through steered plans or transparency. For example, Atrium may not threaten to terminate its participation in an insurer's healthcare networks because the insurer was planning to introduce a tiered-network plan that steered away from Atrium.

B. Conduct That is Not Prohibited by the Final Judgment

Paragraph V of the proposed Final Judgment sets forth conduct that Atrium may undertake without violating the terms of the proposed Final Judgment. Paragraph V(A) makes clear that nothing in the proposed Final Judgment prohibits Atrium from exercising any of its contractual rights provided it does not engage in any conduct that would violate the terms of the proposed Final Judgment.

If Atrium is the most-prominently featured provider in a narrow-network plan or co-branded plan,[7] Paragraph V(B) of the proposed Final Judgment allows Atrium to restrict an insurer from steering away from Atrium in that plan. Such restrictions may help narrow networks and co-branded plans be more effective, and this provision allows Atrium to participate in plans that steer towards it.

Paragraph V(C) makes clear that the proposed Final Judgment does not prohibit Atrium from negotiating with insurers for the ability to review the information about Atrium that an insurer disseminates through transparency, as long as any provision for review does not delay dissemination of the information. The proposed Final Judgment does not prevent Atrium from challenging information that it believes is inaccurate, including pursuing legal remedies available to it.

Paragraph V(C) also makes clear that the proposed Final Judgment does not prohibit Atrium from seeking certain safeguards regarding the insurer's dissemination of the prices Atrium has negotiated with insurers. Atrium may seek contractual provisions with an insurer prohibiting the insurer from disseminating Atrium's negotiated prices to Atrium's competitors, other insurers, or the general public. Atrium may also seek contractual provisions with an insurer requiring the insurer to obtain a covenant from any third party receiving Atrium's negotiated prices that such third party will not disclose that information to Atrium's competitors, another insurer, the general public, or another third party lacking a reasonable need to know such information. Atrium may also seek all appropriate remedies in the event that dissemination of such information occurs.

C. Required Conduct

The proposed Final Judgment also prescribes conduct that Atrium is required to undertake in order to facilitate prompt and effective relief. Paragraph VI of the proposed Final Judgment requires Atrium to provide Aetna, BCBS–NC, Cigna, MedCost and UnitedHealthcare with a copy of the Final Judgment and notify them in writing within 15 business days of the Court's entry of the proposed Final Judgment that (1) the Final Judgment has been entered; (2) the Final Judgment prohibits Atrium from entering into or enforcing any agreement provision that violates the Final Judgment; (3) Atrium waives the right to enforce any contract language reproduced in Exhibit A; and (4) Atrium waives the right to enforce any contract language reproduced in Exhibit B to the extent such language prohibits, prevents, or penalizes steered plans or transparency.

D. Compliance

Under Paragraph VII of the proposed Final Judgment, within 15 calendar days of the entry of the Final Judgment, Atrium must provide a copy of the Final Judgment to each of its commissioners and officers as well as each employee who has responsibility to negotiate or approve contracts with insurers. Within 60 calendar days of the entry of the proposed Final Judgment, Atrium must develop and implement procedures necessary to ensure Atrium's compliance with the proposed Final Judgment, including procedures to answer questions from Atrium's commissioners and employees about abiding by the terms of the proposed Final Judgment.

Within 270 calendar days of entry of the proposed Final Judgment, Atrium must submit to the United States and the State of North Carolina a written report setting forth its actions to comply with the proposed Final Judgment. Atrium must also submit to the United States and the State of North Carolina a copy of any new or revised agreement or amendment to any agreement with any insurer that is executed during the term of the proposed Final Judgment no later than 30 calendar days after the date the agreement or amendment is executed.

Atrium must also notify the United States and the State of North Carolina within 30 calendar days of having reason to believe that a provider which Atrium controls has a contract with any insurer with a provision that prohibits, prevents, or penalizes transparency or any steered plan.

To facilitate monitoring Atrium's compliance with the proposed Final Judgment, Paragraphs VII(B) and VII(D) of the proposed Final Judgment require Atrium to grant the United States access, upon reasonable notice, to Atrium's records and documents relating to matters contained in the proposed Final Judgment. In addition Atrium must make its employees available for interviews or depositions and answer interrogatories and prepare written reports relating to matters contained in the proposed Final Judgment upon request.

The proposed Final Judgment also contains provisions that promote compliance and make the enforcement of the proposed Final Judgment as effective as possible. Paragraph IX(A) provides that the United States retains and reserves all rights to enforce the provisions of the proposed Final Judgment, including its rights to seek an order of contempt from the Court. Under the terms of this Paragraph, Atrium has agreed that in any civil contempt action, any motion to show cause, or any similar action brought by the United States regarding an alleged violation of the proposed Final Judgment, the United States may establish the violation and the appropriateness of any remedy by a preponderance of the evidence and that Atrium has waived any argument that a different standard of proof should apply. This provision aligns the standard for compliance obligations with the standard of proof that applies to the underlying offense that the compliance commitments address.

Paragraph IX(B) sets forth the parties' agreed-upon rules for interpreting the proposed Final Judgment's provisions. Because consent decrees share many attributes with ordinary contracts, they should be construed as contracts for purposes of enforcement. *See Anita's New Mexico Style Mexican Food* v. *Anita's Mexican Foods Corp.,* 201 F.3d 314, 319 (4th Cir. 2000) (quoting *United States* v. *ITT Continental Baking Co.,* 420 U.S. 223, 236–37 (1975)). The parties have agreed that the Court should employ ordinary tools of interpretation to enforce the proposed Final Judgment. In Paragraph IX(B), the parties make clear the purpose of the proposed Final Judgment that can be used as an interpretive tool. The proposed Final Judgment was drafted with the purpose of resolving this litigation and restoring all competition that Plaintiffs alleged was harmed by the challenged conduct. Paragraph IX(B) says that the provisions of the proposed Final Judgment are to be interpreted to give effect to the procompetitive purpose of the federal antitrust laws, and to restore this lost competition.

Atrium also agrees that the Court may enforce any provision of the proposed Final Judgment that is stated specifically and in reasonable detail, *see* Fed.R.Civ.P. 65(d) (requiring specific terms and ''reasonable detail''), even if the provision is not clear and

[7] A co-branded plan is a benefit plan created by a formal and substantial level of alliance or affiliation, such as a partnership or joint venture, between a provider and an insurer. A co-branded plan has the logos of both the insurer and provider on the plan's marketing materials.

unambiguous on its face, by applying these procompetitive principles and ordinary tools of interpretation. *See Martin's Herend Imports, Inc.* v. *Diamond & Gem Trading,* 195 F.3d 765, 771 (5th Cir. 1999) (''The mere fact that interpretation is necessary does not render the injunction so vague and ambiguous that a party cannot know what is expected of him.'' (internal citation and quotation omitted)). When interpreting the proposed Final Judgment, the Court should not construe the language of the proposed Final Judgment against either party as the drafter.

Paragraph IX(C) of the proposed Final Judgment provides that should the Court find in an enforcement proceeding that Atrium has violated the proposed Final Judgment, the United States may apply to the Court for a one-time extension of the proposed Final Judgment, together with such other relief as may be appropriate. In addition, in order to compensate American taxpayers for any costs associated with the investigation and enforcement of violations of the proposed Final Judgment, Paragraph IX(C) further provides that in any successful effort by the United States to enforce the proposed Final Judgment against Atrium, whether litigated or resolved prior to litigation, Atrium agrees to reimburse the United States for attorneys' fees, experts' fees, or costs incurred in connection with any enforcement effort, including the investigation of the potential violation.

Finally, Paragraph X of the proposed Final Judgment provides that the proposed Final Judgment shall expire ten years from the date of its entry, except that after five years from the date of its entry, the proposed Final Judgment may be terminated upon notice by the United States to the Court and Atrium that the continuation of the proposed Final Judgment is no longer necessary or in the public interest.

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 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 Atrium.

V. PROCEDURES AVAILABLE FOR MODIFICATION OF THE PROPOSED FINAL JUDGMENT

The United States, the State of North Carolina, and Atrium 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 60 calendar 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 60 calendar 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 entry of the proposed Final Judgment at any time prior to the Court's entry of the judgment. The comments and the response of the United States will be filed with the Court. In addition, comments will be posted on the U.S. Department of Justice, Antitrust Division's internet website and, under certain circumstances, published in the **Federal Register**.

Written comments should be submitted to:

Peter J. Mucchetti
Chief, Healthcare and Consumer Products 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 proposed Final Judgment.

VI. ALTERNATIVES TO THE PROPOSED FINAL JUDGMENT

As an alternative to the proposed Final Judgment, the United States considered continuing this litigation, and proceeding to trial in May 2019 against Atrium. While the proposed Final Judgment represents a negotiated resolution to the action that necessitated compromises by Plaintiffs and Atrium, the United States is satisfied that the relief contained in the proposed Final Judgment will remedy the anticompetitive conduct identified in the Complaint. The proposed Final Judgment would achieve all or substantially all of the relief the United States would have obtained through litigation but avoids the time, expense, and uncertainty of a full trial on the merits.

VII. APPA's STANDARD OF REVIEW 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 60-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 generally 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. *U.S. Airways Group, Inc.,* 38 F. Supp. 3d 69, 75 (D.D.C. 2014) (explaining that the ''court's inquiry is limited'' in Tunney Act settlements).

As the United States Court of Appeals for the District of Columbia Circuit has held, under the APPA a court considers, among other things, the relationship between the remedy secured and the specific allegations in the government's complaint, whether the decree is sufficiently clear, whether its 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) (quoting *United States* v. *Bechtel Corp.,* 648 F.2d 660, 666 (9th Cir. 1981)); *see also Microsoft,* 56 F.3d at 1460–62; *United States* v. *Alcoa, Inc.,* 152 F. Supp. 2d 37, 40 (D.D.C. 2001). Instead:

[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).[8]

In determining whether a proposed settlement is in the public interest, a district

[8] *See also 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'').

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 U.S. Airways,* 38 F. Supp. 3d at 74–75 (noting that a court should not reject the proposed remedies because it believes others are preferable and that room must be made for the government to grant concessions in the negotiation process for settlements); *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. *Archer-Daniels-Midland Co.,* 272 F. Supp. 2d 1, 6 (D.D.C. 2003) (noting that the court should grant ''due respect to the government's prediction as to the effect of proposed remedies, its perception of the market structure, and its views of the nature of the case''). The ultimate question is 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.''' *Microsoft,* 56 F.3d at 1461. 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, a 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 a court to ''construct [its] own hypothetical case and then evaluate the decree against that case.'' *Microsoft,* 56 F.3d at 1459; *see also U.S. Airways,* 38 F. Supp. 3d at 75 (noting that the court must simply determine whether there is a factual foundation for the government's decisions such that its conclusions regarding the proposed settlements are reasonable). 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 court 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,[9] Congress made clear its intent to preserve the practical benefits of utilizing 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); *see also U.S. Airways,* 38 F. Supp. 3d at 76 (indicating that a court is not required to hold an evidentiary hearing or to permit intervenors as part of its review under the Tunney Act). This language explicitly wrote into the statute what Congress intended when it first 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 Sen. 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. A court can make its public interest determination based on the competitive impact statement and response to public comments alone. *U.S. Airways,* 38 F. Supp. 3d at 76. *See also 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''); S. Rep. No. 93–298 93d Cong., 1st Sess., at 6 (1973) (''Where the public interest can be meaningfully evaluated simply on the basis of briefs and oral arguments, that is the approach that should be utilized.'').

[9] The 2004 amendments substituted ''shall'' for ''may'' in directing relevant factors for a court 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).

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,

Dated: December 4, 2018

FOR PLAINTIFF UNITED STATES OF AMERICA:

John R. Read
Karl D. Knutsen
Natalie Melada
Catherine R. Reilly
David Stolzfus
Paul Torzilli

Antitrust Division, U.S. Department of Justice, 450 Fifth Street NW, Suite 4100, Washington, D.C. 20530, (p) 202/307.0468, John.Read@usdoj.gov.

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BILLING CODE 4410–11–P

NATIONAL SCIENCE FOUNDATION

Request for Information on National Strategic Overview for Quantum Information Science

AGENCY: National Science Foundation.

ACTION: Notice of request for information.

SUMMARY: The National Science and Technology Council (NSTC) Subcommittee on Quantum Information Science (SCQIS) release of the ''National Strategic Overview for Quantum Information Science'' (hereafter ''Strategic Overview'') calls upon agencies to develop plans to address six key policy areas to enable continued American leadership in quantum information science. The National Science Foundation (NSF), working with the NSTC, is requesting information from the research and development community around quantum information science (QIS) to inform the subcommittee as the Government develops potential means of addressing specific policy recommendations.

DATES: Interested persons are invited to submit comments on or before 11:59 p.m. (ET) on January 25, 2019.

ADDRESSES: Comments submitted in response to this notice may be sent by either of the following methods:

- *Email: nsfscqis@nsf.gov.* Email submissions should be machine-readable and not be copyright-protected. Submissions should include ''RFI Response: National Strategic Overview for Quantum Information Science'' in the subject line of the message.
- *Direct input to the website: http://www.nsfscqis.org*

Instructions: Response to this RFI is voluntary. Each individual or institution is requested to submit only one response. Submissions must not exceed the equivalent of one page for each question, or eight pages total, in 12 point or larger font, with a page number provided on each page. Responses should include the name of the person(s) or organization(s) filing the comment.

Responses to this RFI may be posted online as discussions proceed. Therefore, we request that no business proprietary information, copyrighted information, or personally identifiable information be submitted in response to this RFI.

In accordance with FAR 15.202(3), responses to this notice are not offers and cannot be accepted by the Government to form a binding contract. Responders are solely responsible for all expenses associated with responding to this RFI.

FOR FURTHER INFORMATION CONTACT: C. Denise Caldwell at (703)-292–7371 or *nsfscqis@nsf.gov.* Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

SUPPLEMENTARY INFORMATION: The National Science and Technology