and Monika Gerdes, all of Germany (collectively, ''Gerdes'').

On May 16, 2005, Stant filed a motion to terminate the investigation based on withdrawal of its complaint. Gerdes opposed Stant's motion for termination and further requested that, pursuant to rule 210.25(a)(2), the ALJ *sua sponte* impose sanctions on Stant for abuse of Commission process. The Commission's Investigative Attorney (''IA''), however, supported Stant's motion to terminate.

The ALJ granted Stant's motion to terminate the investigation based on withdrawal of the complaint on June 10, 2005, but declined to impose sanctions on Stant (ID, Order No. 10). Gerdes filed a Petition for Review of the ID on June 17, 2005. Stant filed a response to Gerdes's petition on June 24, 2005, and the IA filed a response on June 23, 2005.

Having considered the ALJ's rationale and the arguments made by the Parties, the Commission has determined not to review the ALJ's ID granting Complainant's motion to terminate the investigation on the basis of withdrawal of the complaint. Accordingly, the above-referenced investigation is hereby terminated.

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 sections 210.42 to 210.46 of the Commission's Rules of Practice and Procedure (19 CFR 210.42–210.46).

Issued: July 7, 2005.

By order of the Commission.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 05–13611 Filed 7–11–05; 8:45 am]

BILLING CODE 7020–02–M

DEPARTMENT OF JUSTICE

Antitrust Division

Public Comment and Response on Proposed Final Judgment

Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)–(h), the United States hereby publishes below the comment received on the proposed Final Judgment in *United States* v. *Bluefield Regional Medical Center, Inc. and Princeton Community Hospital Association, Inc.,* Civil Case No. 1:05–0234 (DAF), which was filed in the United States District Court for the Southern District of West Virginia, together with the United State's response to the comment, on June 30, 2005.

Copies of the comment and the response are available for inspection at the Department of Justice, Antitrust Division, 125 Seventh Street, NW., Room 200, Washington, DC 20530, (telephone (202) 514–2481), and at the Office of the Clerk of the United States District Court for the Southern District of West Virginia, 601 Federal Street, Room 2303, Bluefield, West Virginia 24701. Copies of any of these materials may be obtained upon request and payment of a copying fee.

J. Robert Kramer II,

Director of Operations, Antitrust Division.

United States District Court, for the Southern District of West Virginia, Bluefield Division.

United States of America, Plaintiff, Bluefield Regional Medical Center, Inc., and Princeton Community Hospital Association, Inc., Defendants.

Civil Action No. 1.05–0234.

Response to Competitive Impact Statement on Behalf of the West Virginia Health Care Authority

The West Virginia Health Care Authority (hereinafter ''Authority'') files this response to the Competitive Impact Statement published on April 7, 2005. The purpose of this response is to set forth the Authority's analysis of the state action doctrine and to clarify the statutory powers conferred upon the Authority by the West Virginia Legislature.

I. Statement of Facts

A. History of Bluefield Regional Medical Center and Princeton Community Hospital

Bluefield Regional Medical Center (hereinafter ''BRMC'') owns and operates a 265 bed acute care not-for-profit hospital in Bluefield, West Virginia. Princeton Community Hospital (hereinafter ''PCH'') owns and operates a 211 bed acute care not-for-profit hospital in Princeton, West Virginia. In addition to the Princeton facility, PCH also owns and operates St. Luke's Hospital, LLC, a 79 bed acute care hospital in Bluefield, West Virginia.

BRMC and PCH are located in close proximity to one another in Mercer County, Southern West Virginia. Mercer County ranks 15 out of 55 counties for the percentage of non-elderly adults without health insurance in the State of West Virginia.[1] Thus, a significant portion of the population of this county is rural and uninsured.

[1] Health Insurance in West Virginia: The Non-elderly Adult Report, July 2002 and reprinted May 2003 available at *http://www.wvhealthpolicy.org/reports_2002.htm.*

B. Overview of the West Virginia Health Care Authority, Its Cost Based Rate Review System and the Certificate of Need Program

By way of background, the Health Care Cost Review Authority (hereinafter ''HCCRA'') was created by the Legislature in 1983, as an autonomous agency within state government, W.Va. Code § 16–29B–5. The Authority, then known as HCCRA, is charged with the responsibility for collecting information on health care costs, developing a system of cost control, and ensuring accessibility to appropriate acute care beds. W.Va. Code § 16–29B–1, *et seq.*

This same legislation expanded the HCCRA's responsibilities to include the administration of two previously enacted cost containment programs: (1) the Certificate of Need (hereinafter ''CON'') program, which is codified at W.Va. Code §§ 16–2D–1, *et seq.;* and (2) the Health Care Financial Disclosure Act, which is codified at W.Va. Code §§ 16–5F–1, *et seq.* In 1997, the Legislature enacted a statute renaming the HCCRA as the West Virginia Health Care Authority. W.Va. Code § 16–29B–2.

The Authority's purpose is ''to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective quality health care services.'' W.Va. Code § 16–29B–1. This statute created a three member Board vested with the power to ''approve or disapprove hospital rates * * *.'' W.Va. Code §§ 16–29B–5 & 19.

The Authority establishes hospital rates for a group of payors termed ''nongovernmental payors'' or ''other payors.'' This group includes public and private insurers, persons who pay for their own hospital services and all other third party payors who are not government-related. W.Va. Code §§ 16–29B–1, *et seq.*; Hospital Cost Based Rate Review System, 65 C.S.R. §§ 5–1, *et seq.*

The Authority is also statutorily responsible for establishing the nongovernmental average charge per discharge for inpatient and outpatient services for acute care hospitals in the state. Accordingly, once a year, hospitals may file a rate application with the Authority seeking a rate increase pursuant to W.Va. Code § 16–29B–21. Ultimately, the Authority has the right to: (1) Approve a rate request, (2) modify a rate request, or (3) deny a rate request. W.Va. Code § 16–29B–19.

In evaluating rate applications, the Authority utilizes a hospital's rate application as the primary source of information in setting its rates. The

Authority also utilizes other documents on file with the Authority as additional sources of data, such as audited financial statements, Uniform Reporting System Financial Reports, Medicare Cost Reports, the hospital's trial balance and the Uniform Billing (hereinafter ''UB'') UB–92 discharge bills. The Authority then compares the rate application to the audited financial statements, the Uniform Financial Report and the Medicare Cost Report in order to determine whether the information in the rate application is consistent, in all material aspects, with the other filings. The UB–92 information is used to compare discharges and case mix indices. The case mix for each hospital is determined from diagnostic related groups (hereinafter ''DRG'') weights in effect during the hospital's fiscal year.

The Authority establishes several limits during the rate setting process and a hospital is expected to monitor each of these limits to ensure that it is in compliance with the Authority's established rates. W.Va. C.S.R. § 65–5–10.2. If a hospital exceeds its approved rates, then it has an overage. This overage may be justified through case mix, outliers, new service or other events which could not have reasonably been foreseen. W.Va. C.S.R, §§ 65–5–10.3–10.3.4. If any portion of the overage is not justified, then the hospital has an unjustified overage and is subject to penalties in subsequent years.

With respect to the CON program, the Authority's Board has been empowered by the Legislature to enact legislative rules, to develop the State Health Plan and to consider CON applications. W.Va. Code §§ 16–2D–3(b)(5); 16–2D–5. The law requires that a hospital obtain a CON prior to developing cardiac surgery or radiation therapy services.

With respect to the State Health Plan Cardiac Surgery Standards, the Authority has exhibited a preference for joint applicants seeking to provide cardiac surgery services. The Authority encouraged parties to work together to ensure that services were not duplicated in the various geographic areas in order to ensure the development of a quality open heart program. Several studies have shown a direct correlation between high volume programs and success rates. Therefore, the Authority determined that joint applications would produce greater volumes and therefore provide greater quality of service.

C. CON Applications Filed by BRMC for the Development of Cardiac Surgery Services and PCH for the Development of a Comprehensive Cancer Center

In 1999, BRMC submitted an application to offer cardiac surgery services. While a need appeared to exist in the area, the Authority denied this request because BRMC was not able to show that it would be able to attract a sufficient number of patients without working with other area hospitals, namely PCH. On January 23, 2003, BRMC, Charleston Area Medical Center, and PCH submitted a joint application for a CON to establish cardiac surgery services to be located at BRMC. This application was initially contested by Richard Lindsay, M.D., the West Virginia Consumer Advocate (hereinafter ''WVCA''), and the West Virginia Public Employees Insurance Agency (hereinafter ''WVPEIA''). WVCA and WVPEIA subsequently withdrew their requests for hearing and the Authority found that Richard D. Lindsay did not qualify as an affected party. On August 1, 2003, the applicants were granted a CON.

On July 15, 2003, PCH and BRMC filed a letter of intent to develop a freestanding Community Hospital Comprehensive Cancer Center facility to be located at PCH. PCH proposed acquiring existing radiation therapy equipment from BRMC and submitted a CON application on July 30, 2003. Several parties requested affected party status and requested that a hearing be conducted with respect to this application. This matter was scheduled for hearing and ultimately cancelled. To date, the matter has never been heard and is still on hold.

D. BRMC and PCH Entered Into Agreements Regarding Their CON Applications Which Were Subsequently Investigated by the Department of Justice

The Department of Justice (hereinafter ''DOJ'') sent letters to BRMC and PCH inquiring about agreements the hospitals entered into on January 30, 2003 (hereinafter called ''cardiac surgery and cancer center agreements''). The agreements applied to PCH's provision of certain cancer center services and the cardiac surgery agreement concerned BRMC's plan to establish and offer cardiac surgery services. The term of the agreements was for five years after the first cardiac surgery is performed at BRMC or the first cancer patient is treated at PCH, whichever is later. By their terms, the cardiac surgery and cancer center agreements applied to the following West Virginia counties: McDowell, Mercer, Monroe, Raleigh, Summers and Wyoming; and the following Virginia counties: Bland, Giles, and Tazwell.

The DOJ contends that the cardiac surgery and cancer center agreements violate Section 1 of the Sherman Act, 15 U.S.C. 1 and ''have the effect of unreasonably restraining competition and allocating markets for cancer and cardiac surgery services to the detriment of consumers.'' (Complaint filed by DOJ on March 21, 2005 at ¶ 1.) The DOJ requested the following relief in its complaint: that the Court declare the cardiac surgery and cancer center agreements violate Section 1 of the Sherman Act, 15 U.S.C. 1 and that the Court enjoin the defendants from enforcing the agreements and to further prohibit the parties from entering into additional agreements to allocate cancer or cardiac surgery services. (Complaint at ¶ 30.)

II. ANALYSIS OF LAW

A. Applicable Law

The United States Supreme Court case *Parker* v. *Brown*, 317 U.S. 341 (1943), serves as the legal foundation of the state action antitrust defense. This ''state action doctrine'' immunizes anticompetitve acts if taken pursuant to state policy. The Court later refined this doctrine in a series of cases.

For example, in *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum Inc.,* 445 U.S. 97 (1980) the United States Supreme Court articulated two criteria to be established before a party may qualify for immunity under the state action doctrine. First, there must be a clear articulation of the state policy in question. Second, the Court determined that the action in question must be actively supervised by the state.

With respect to the clear articulation prong, the Court held that a private party seeking Sherman Act immunity under the state action doctrine need not point to a specific detailed legislative authorization for its challenged conduct as long as the state clearly intends to displace competition in a particular field. *Southern Motor Carriers Rate Conference, Inc.* v. *United States,* 471 U.S. 48, 64 (1985). With respect to the active supervision prong, the Court has indicated that the state's supervision cannot be minimal. *Patrick* v. *Burget* 486 U.S. 94 (1988). Rather, the state officials must exercise ultimate control over the challenged anticompetitive conduct. *Id* at 101.

B. Application of Existing Law to BRMC and PCH

Courts have liberally applied the state action doctrine over the years.[2] This has caused both the FTC and DOJ to challenge the applicability of the state action doctrine. For example, in September 2003, the FTC issued a report analyzing the applicability of the state action doctrine.[3] This report concluded that ''overly broad interpretations of the state action doctrine could potentially impede national competition policy goals.'' *Id* at p. 2. Recently, the DOJ and FTC issued a report which criticized state CON programs as promoting anticompetitive markets.[4]

Based upon comments contained in the Competitive Impact Statement, it appears that the DOJ has attempted to re-define the criteria for determining when the state action doctrine applies. However, this Competitive Impact Statement does not negate approximately fifty years of United States Supreme Court precedent. Existing law clearly provides that the actions of BRMC and PCH should qualify for immunity under the state action doctrine.

With respect to the clear articulation prong of the two part test, the Authority was clearly created to control health care costs and to prevent the unnecessary duplication of services. W.Va Code § 16–29B–1. At their core, all CON programs control the development of services, or the health care market, in order to keep costs down.[5] This is especially important in West Virginia, which has a high rate of uninsured individuals who already face difficulties in accessing health care.

Therefore, the Authority controls the health care market by regulating entry into the market through its laws and regulations. W.Va. 16–2D–1, *et seq.*; 65 C.S.R. 7. For example, in order to be approved for a CON, the service must be needed and consistent with the State Health Plan. W.Va. Code § 16–2D–9(b); *Princeton Community Hospital* v. *State Health Planning and Development Agency*, 328 S.E.2d 164 (W.Va. 1985). In order to demonstrate the need for a service, a party often must conduct an analysis of the level of services being offered by existing providers and project the amount of services that will be needed in the future. If existing providers are not serving the population, then an unmet need exists. At a fundamental level this controls the market and allows only those providers that can establish need to enter the market. Thus, the West Virginia health care market is regulated and growth is controlled.

In addition, the Authority has determined that in order to have a high volume, quality cardiac surgery project in Southern West Virginia, hospitals must coordinate their efforts. In the newly revised State Health Plan cardiac Surgery Standards, the Authority gave preference to joint applicants in this geographic area. BRMC and PCH filed a joint application for the development of cardiac surgery services which was ultimately approved. Previously, an individual application filed by BRMC was denied. The recently newly approved joint application will allow residents in Southern West Virginia to benefit from a quality program in close proximity to their homes.

With respect to the active supervision prong, the Authority clearly has on-going supervision of West Virginia acute care hospitals. For example, the Authority establishes, on a yearly basis, the average charge per nongovernmental discharge that all acute care hospitals in the state may charge. The Authority has the power to impose significant penalties on those hospitals that do not comply with the Authority's established rates. The Authority has the power to collect financial disclosure from all covered entities, which includes acute care hospitals, in West Virginia on a yearly basis. In addition, the Authority has the right to approve or deny a CON for new institutional health services. The Authority's CON powers are very broad. Even after the CON is issued, parties must submit progress reports and request substantial compliance before a file may be closed. Further, the Authority retains oversight of a CON for at least three years after it is issued. In this regulatory environment, oversight clearly does exist.

Rather than contend with the total picture, the DOJ narrowed its focus to only the written cardiac surgery and cancer center agreements. Although the Authority does not have standing to enforce the actual agreements, these agreements served as the basis for the CON applications submitted and filed by both parties. The Authority certainly has the power to regulate the CON process as well as oversee the hospital's rates.

III. Conclusion

The Authority realizes that both PCH and BRMC have decided to enter into a consent decree to resolve the DOJ's investigation. The Authority's purpose in filing these comments is not to prevent this judgment from being entered, but rather is to clarify its statutory powers and set forth its opinion regarding the state action doctrine.

United States of America, Plaintiff, v. Bluefield Regional Medical Center, Inc., and Princeton Community Hospital Association, Inc., Defendants.

Civil Action No. 1:05–CV–00234.

Plaintiff United States Response to Public Comment

Pursuant to the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)–(h) (''APPA'' or ''Tunney Act''), the United States hereby responds to the one public comment received regarding the proposed Final Judgment in this case. After careful consideration of the comment, the United States continues to believe that the proposed Final Judgment will provide an effective and appropriate remedy for the antitrust violation alleged in the Complaint. The United States will move the Court for entry of the proposed Final Judgment after the public comment and this Response have been published in the **Federal Register**, pursuant to 15 U.S.C. 16(d).

On March 21, 2005, the United States filed a Complaint alleging that Bluefield Regional Medical Center, Inc., (BRMC) and Princeton Community Hospital Association, Inc., (PCH) violated section 1 of the Sherman Act (15 U.S.C. 1) by entering into two agreements on January 30, 2003, in which BRMC agreed not to offer many cancer services and PCH agreed not to offer cardiac-surgery services. At the same time the Complaint was filed, the United States also filed a proposed Final Judgment and a Stipulation signed by the United States and defendants consenting to the entry of the proposed Final Judgment after compliance with the requirements of the Tunney Act. Pursuant to those requirements, the United States filed a Competitive Impact Statement (''CIS'') with this Court on March 21, 2005; published the proposed Final Judgment, Stipulation, and CIS in the **Federal Register** on April 4, 2005, *see* 70 FR 17117 (2005); and published a summary of the terms of the proposed Final Judgments and CIS, together with directions for the submission of written

[2] *See e.g., Askew* v. *DCH Regional Healthcare Authority*, 995 F.2d 1033 (11th Cir. 1994) and *FTC* v. *Hospital Board of Directors of Lee County*, 38 F.3d 1184 (11th Cir. 1994).

[3] Report of the State Action Task Force (Sept. 2003) available at *http://www.ftc.gov/OS/2003/09/stateactionreport.pdf.*

[4] Improving Health Care: A Dose of Competition, (July, 2004) available at *http://www.ftc.gov/reports/healthcare/040723healthcarept.pdf.*

[5] W.Va. Code § 16–29B–26 provides state antitrust immunity for the actions of health care providers under the Authority's jurisdiction, when such actions are made in compliance with orders, directives, rules or regulations issued or promulgated by the Authority's Board.

comments relating to the proposed Final Judgment, in the Washington Post for seven days beginning on April 1, 2005 and continuing on consecutive days through April 7, 2005, and the Charleston Gazette, a newspaper of general circulation in the Southern District of West Virginia, beginning on April 4, 2005 and continuing on consecutive days through April 9, 2005, and on April 11, 2005. The 60-day period for public comments ended on June 5, 2005, and the United States received one comment as described below and attached hereto.

I. Background

As explained more fully in the Complaint and CIS, the defendants' cancer and open-heart agreements effectively allocated markets for cancer and cardiac-surgery services and restrained competition to the detriment of consumers in violation of section 1 of the Sherman Act. The proposed Final Judgment will restore competition by annulling the BRMC–PCH agreements and prohibiting BRMC and PCH from taking actions that would reduce competition between the two hospitals for patients needing cancer and cardiac-surgery services. 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. Legal Standard Governing the Court's Public Interest Determination

Upon the publication of the public comment and this Response, the United States will have fully complied with the Tunney Act and will move the Court for entry of the proposed Final Judgment as being ''in the public interest.'' [1] The Court, in making its public interest determination, shall consider:

(A) the competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration or 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.[2]

As the U.S. Court of Appeals for the District of Columbia Circuit has held, the Tunney Act permits a court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's complaint, whether the proposed Final Judgment is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the proposed Final Judgment may positively harm third parties.[3]

With respect to the adequacy of the relief secured by the proposed Final Judgment, courts have held that:

[t]he balancing of competing social and political interests affected by a proposed antitrust consent decree must be left, in the first instance, to the discretion of the Attorney General. The court's role in protecting the public interest is one of insuring that the government has not breached its duty to the public in consenting to the decree. The court is required to determine not whether a particular decree is the one that will best serve society, but whether the settlement is ''within the reaches of the public interest.'' More elaborate requirements might undermine the effectiveness of antitrust enforcement by consent decree.[4]

''[A] decree must be approved even if it falls short of the remedy the court would impose onits own, as long as it falls within the range of acceptability or is 'witnin the reaches of public interest.' '' [5] Furthermore,

[a]bsent a showing of corrupt failure of the government to discharge its duty, the Court, in making its public interest funding, should * * * carefully consider the explanations of the government in the competitive impact statement and its responses to comments in order to determine whether those explanations are reasonable under the circumstances.[6]

III. Summary of Public Comments and the United States' Response

During the 60-day public comment period, the United States received one comment, from the West Virginia Health Care Authority (WVHCA), which is attached hereto. The WVHCA, among other duties, is responsible for administering West Virginia's certificate of need (''CON'') program and establishing hospital rates for non-governmental payors, such as private insurers, in West Virginia.

The WVHCA does not seek to prevent entry of the proposed Final Judgment. Rather, the WVHCA states that its purpose is to ''set forth the Authority's analysis of the state action doctrine and to clarify the statutory powers conferred upon the Authroity by the West Virginia Legislature.'' (WVHCA Comment, p. 1). The state-action doctrine provides immunity from federal antitrust library when a defendant has satisfied a two-part test by first showing that the challenged restraint is one clearly articulated and affirmatively expressed as state policy and then showing that the restraint is actively supervised by the state.[7] The WVHCA believes that the defendants' actions qualify for immunity under the state-action doctrine. (WVHCA Comment, p. 8).

As an initial matter, the Court need not rule on whether the state-action doctrine provides federal antitrust immunity to the challenged agreements. The Court's role under the Tunney Act is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its Complaint. The Tunney Act does not authorize the Court to construct a ''hypothetical case adn then evaluate the decree against that case.'' Microsoft, 56 F.3d at 1459. Indeed, the WVHCA does not argue that the proposed Final Judgment is not ''within the reaches of public interest'' or that the remedy secured does not fit the violations alleged. Nor does the WVHCA assert that any public or private interest would be harmed by the entry of the judgment, or that the judgment inadequately or improperly preserves the role of competition in the relevant markets within the regulatory framework established by the Commonwealth of

[1] 15 U.S.C. 16(e).

[2] 15 U.S.C. 16(e)(1).

[3] *See United States* v. *Microsoft Corp.*, 56 F.3d 1448, 1458–62 (D.C. Cir. 1995).

[4] *Bechtel Corp.*, 648 F.2d 660, 666 (9th Cir. 1981) (emphasis added) (citations omitted). *Cf. United States* v. *BNS Inc.*, 858 F.2d 456, 464 (9th Cir. 1988) (holding that the court's ''ultimate authority under the [Tunney Act] is limited to approving or disapproving the consent decree''); *United States* v. *Gillette Co.*, 406 F. Supp. 713, 716 (D. Mass. 1975) (noting that, in this way, the court is constrained to ''look at the overall picture not hypercritically, nor with a microscope, but with an artist's reducing glass''); *see generally Microsoft*, 56 F.3d at 1461 (discussing whether ''the remedies [obtained in the decree are] so inconsonant with the allegations charged as to fall outside of the 'reaches of the public interest' '').

[5] *United States* v. *AT&T Corp.*, 552 F. Supp. 131, 151 (D.D.C. 1982) (citations omitted)(quoting *Gillette,* 406 F. Supp. at 716), *aff'd sub nom. Maryland* v. *United States,* 460 U.S. 1001 (1983); *see also United States* v. *Alcan Aluminum Ltd.*, 605 F. Supp. 619, 622 (W.D. Ky. 1985) (approving the consent judgment even though the court would have imposed a greater remedy).

[6] *United States* v. *Mid-America Dairymen, Inc.*, 1977–1 Trade Cas. (CCH) ¶ 61,508, at ¶ 71,980 (W.D. Mo. 1977).

[7] *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum,* 445 U.S. 97, 105 (1980).

West Virginia.[8] In short, the WVHCA has provided no argument against entry of the proposed Final Judgment and does not object to its entry. Consequently, the WVHCA's comment does not support disapproving the proposed Final Judgment.

Even if the Court were to consider the applicability of the state action doctrine, the WVHCA's comment does not demonstrate that the doctrine should apply in this case. With regard to the first part of the state-action test, the comment discusses the WVHCA's powers over West Virginia's CON program. (WVHCA Comment, pp. 8–10). But the comment does not discuss whether those powers allow the WVHCA to authorize market-allocation agreements between private parties such as the ones challenged in the Complaint. In fact, the WVHCA's CON powers do not allow it to authorize such agreements.[9] Rather the West Virginia legislature empowered the WVHCA to administer West Virginia's CON program only according to legislatively established procedures, consisting principally of granting or denying CONs to firms wishing to compete.[10] Because the West Virginia legislature did not empower the WVHCA to authorize private market-allocation agreements, the defendants' cancer and open-heart agreements do not qualify for state-action immunity.

With regard to the second part of the state-action test, the comment states that the WVHCA ''clearly has on-going supervision of West Virginia acute care hospitals'' through West Virginia's CON program and regulation of hospital rates for non-governmental payors. (WVHCA Comment, p. 10). However, the active-supervision requirement of the state-action doctrine requires that the State actively supervise and exercise ultimate control over the challenged anticompetitive conduct.[11] So the relevant question for determining whether state-action immunity exists is not whether the WVHCA actively supervises some aspects of hospital regulation in West Virginia, but whether the WVHCA is empowered to supervise and has actively supervised the defendants' agreements.

The WVHCA does not have such powers and has not actively supervised the defendants' agreements. The West Virginia legislature has not empowered the WVHCA to require parties to private agreements to maintain, alter, or abandon their agreements. Thus, the WVHCA has no power to exercise active supervision or control over private agreements such as the cancer and open-heart agreements. Moreover, the WVHCA has not purported to actively supervise the cancer and open-heart agreements, as it did not (1) develop a factual record concerning the initial or ongoing nature and effect of the agreements, (2) issue a written decision approving the agreements, or (3) assess whether the agreements further criteria established by the West Virginia legislatures.[12]

The WVHCA's rate-regulation responsibilities do not satisfy the active-supervision requirement because the challenged anticompetitive conduct in this matter is not the prices charged by the hospitals to non-governmental payors, but rather the terms of the cancer and open-heart agreements. the WVHCA's rice regulation activities do not directly address market-allocation issues or the potential anticompetitive effects of such allocations as rate regulation may fail to ensure that the hospitals charge rates equal to those rates that would have prevailed in a competitive market and fails to address decreases in quality of service, innovation, and consumer choice that result from an agreement not to compete.

The WVHCA comment also does not address the fact that the defendants' agreements allocated markets for cancer and cardiac surgery in the three Virginia counties. As the WVHCA is not vested with any power concerning matters in the Commonwealth of Virginia, the powers and actions of the WVHCA cannot create state-action immunity for an agreement not to complete in Virginia.

IV. Conclusion

After careful consideration of the WVHCA comment, the United States still concludes that entry of the proposed Final Judgment will provide an effective and appropriate remedy for the antitrust violation alleged in the Complaint and is, therefore, in the public interest. Pursuant to Section 16(d) of the Tunney Act, the United States is submitting the public comments and its Response to the **Federal Register** for publication. After the comments and its Response are published in the **Federal Register**, the United States will move this court to enter the proposed Final Judgment.

Dated: June ____, 2005

Respectfully submitted,

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[8] The question of state-action immunity may not properly be before the Court. State-action immunity is essentially an affirmative defense with the party claiming state-action immunity bearing the burden of proof in establishing the defense. *Ticor Title,* 504 U.S. at 625; *town of Hallie* v. *City of Eau Claire,* 471 U.S. 34, 37–39 (1985); *Yeager's Fuel* v. *Pennsylvania Power & Light,* 22 F.3d 1260, 1267 (3d Cir. 1994); *Nugget Hydroelectric, L.P.* v. *Pacific Gas & Elec. Co.,* 981 F.2d 429, 434 (9th Cir. 1992). In the present matter, the defendants have chosen not to assert a state-action defense but instead to stipulate that the Court may enter the proposed Final Judgement.

[9] *See* W. Va. Code § 16–2D–1 *et seq.*, W. Va. Code St. R. § 65–7–1 *et seq.,* W. Va. Code § 16–29b–1 *et seq.*

[10] W. Va. Code § 16–2D–1 *et seq.*, W. Va. Code St. R. § 65–7–1 *et seq.*, W. Va. Code § 16–29B–1 *et seq. See also* CIS, pp. 8–10.

[11] *Midcal*, 445 U.S. at 105, *Patrick* v. *Burget*, 486 U.S. 94, 100–101 (1988).

[12] *See FTC* v. *Ticor Title Ins. Co.*, 504 U.S. 621, 637–639 (1992).

NATIONAL SCIENCE FOUNDATION

Agency Information Collection Activities: Comment Request

AGENCY: National Science Foundation.

ACTION: Submission for OMB review; comment request.

SUMMARY: Under the Paperwork Reduction Act of 1995, Pub. L. 104–13 (44 U.S.C. 3501 *et seq.*), and as part of its continuing effort to reduce paperwork and respondent burden, the National Science Foundation (NSF) is inviting the general public and other Federal agencies to comment on this proposed continuing information collection. This is the second notice for public comment; the first was published in the **Federal Register** at 70 FR 19508 and one comment was received. NSF is forwarding the proposed submission to the Office of Management and Budget (OMB) for clearance simultaneously with the publication of this second notice.

DATES: Comments regarding these information collections are best assured of having their full effect if received by OMB within 30 days of publication in the **Federal Register**.

ADDRESSES: Written comments regarding (a) whether the collection of information is necessary for the proper performance of the functions of NSF, including whether the information will have practical utility; (b) the accuracy of