the amount of $10.5 million in accordance with bond requirements at six non-owned sites.

The Department of Justice will receive, for a period of fifteen days from the date of this publication, comments relating to the Non-Owned Site Settlement Agreement. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either emailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *In re Motors Liquidation Corp., et al.,* D.J. Ref. 90–11–3–09754. Commenters may request an opportunity for a public meeting in the affected area, in accordance with Section 7003(d) of RCRA, 42 U.S.C. 6973(d).

The Non-Owned Site Settlement Agreement may be examined at the Office of the United States Attorney, 86 Chambers Street, 3rd Floor, New York, New York 10007, and at the U.S. Environmental Protection Agency, Ariel Rios Building, 1200 Pennsylvania Avenue, NW., Washington, DC 20460. During the public comment period, the Non-Owned Site Settlement Agreement may also be examined on the following Department of Justice Web site, *http://www.usdoj.gov/enrd/Consent_Decrees.html.* Copies of the Non-Owned Site Settlement Agreement may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $6.75 (25 cents per page reproduction cost) payable to the U.S. Treasury or, if by e-mail or fax, please forward a check in that amount to the Consent Decree Library at the stated address.

Maureen Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 2011–5445 Filed 3–9–11; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Antitrust Division

United States and State of Texas v. United Regional Health Care 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 Northern District of Texas, Wichita Falls Division, in *United States of America and State of Texas* v. *United Regional Health Care System,* Civil Action No. 7:11–cv–00030–O. On February 25, 2011, the United States filed a Complaint alleging that United Regional Health Care System has entered, maintained, and enforced exclusionary contracts with commercial insurers that effectively prevent those insurers from contracting with United Regional's competitors in violation of Section 2 of the Sherman Act, 15 U.S.C. 2. The proposed Final Judgment, filed at the same time as the Complaint, prohibits United Regional from using agreements with commercial health insurers that improperly inhibit insurers from contracting with United Regional's competitors.

Copies of the Complaint, proposed Final Judgment, and Competitive Impact Statement are available for inspection at the Department of Justice, Antitrust Division, Antitrust Documents Group, 450 Fifth Street, NW., Suite 1010, Washington, DC 20530 (*telephone:* 202–514–2481), on the Department of Justice's Web site at *http://www.usdoj.gov/atr,* and at the Office of the Clerk of the United States District Court for the Northern District of Texas, Wichita Falls Division. 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, and responses thereto, will be published in the **Federal Register** and filed with the Court. Comments should be directed to Joshua H. Soven, Chief, Litigation I Section, Antitrust Division, U.S. Department of Justice, 450 Fifth Street, NW., Suite 4100, Washington, DC 20530 (*telephone:* 202–307–0827).

Patricia A. Brink,

Director of Civil Enforcement.

In the United States District Court for the Northern District of Texas, Wichita Falls Division

United States of America and State of Texas, Plaintiffs, v. United Regional Health Care System, Defendant.

Case No.: 7:11–cv–00030.
Judge: Reed C. O'Connor.
Filed: Feb. 25, 2011.
Description: Antitrust.

Complaint

The United States of America, acting under the direction of the Attorney General of the United States, and the State of Texas, by and through the Texas Attorney General, bring this civil antitrust action to enjoin defendant United Regional Health Care System ("United Regional") from entering into, maintaining, or enforcing contracts with commercial health insurers that effectively prevent those insurers from contracting with United Regional's competitors, in violation of Section 2 of the Sherman Act, 15 U.S.C. 2, and to remedy the effects of its unlawful conduct. Plaintiffs allege as follows:

I. Nature of the Action

1. United Regional has monopoly power in two relevant product markets in Wichita Falls, Texas and the surrounding area: (1) The sale of general acute-care inpatient hospital services ("inpatient hospital services") to commercial health insurers, and (2) the sale of outpatient surgical services to commercial health insurers. United Regional has an approximately 90% share of the market for inpatient hospital services sold to commercial insurers and a greater than 65% share of the market for outpatient surgical services sold to commercial insurers. All health insurance companies in the relevant geographic market consider United Regional a "must-have" hospital for health plans because it is by far the largest hospital in the region and the only local provider of certain essential services.

2. United Regional has maintained its monopoly power in the relevant markets by entering into contracts with commercial health insurers that exclude United Regional's competitors in the Wichita Falls area from the insurers' health-care provider networks ("exclusionary contracts"). These exclusionary contracts effectively prevent insurers from contracting with hospitals and other health-care facilities

that compete with United Regional by requiring the insurers to pay a substantial pricing penalty if they also contract with United Regional's competitors. Most commercial health insurers must pay United Regional 13% to 27% more for its services if they do not use United Regional exclusively. The effects of this pricing penalty are to make the cost of including a competing hospital or other health-care facility in an insurer's network prohibitively expensive and not commercially viable, and to exclude equally-efficient rivals.

3. United Regional's exclusionary contracts have reduced competition and enabled United Regional to maintain its monopoly power in the provision of inpatient hospital services and outpatient surgical services. They have done so by (1) Delaying and preventing the expansion and entry of United Regional's competitors, likely leading to higher health-care costs and higher health insurance premiums; (2) limiting price competition for price-sensitive patients, likely leading to higher health-care costs for those patients; and (3) reducing quality competition between United Regional and its competitors. In this case, there is no valid procompetitive business justification for United Regional's exclusionary contracts.

4. United Regional's exclusionary contracts unlawfully maintain United Regional's monopoly power in the relevant markets in violation of Section 2 of the Sherman Act, 15 U.S.C. 2.

II. Defendant, Jurisdiction, Venue, and Interstate Commerce

5. United Regional is a nonprofit corporation organized and existing under the laws of the State of Texas, with its principal place of business in Wichita Falls, Texas.

6. Plaintiff United States brings this action pursuant to Section 4 of the Sherman Act, 15 U.S.C. 4, and plaintiff State of Texas brings this action pursuant to Section 16 of the Clayton Act, 15 U.S.C. 26, to prevent and restrain United Regional's violations of Section 2 of the Sherman Act, 15 U.S.C. 2.

7. This Court has subject matter jurisdiction over this action under Section 4 of the Sherman Act, 15 U.S.C. 4; Section 16 of the Clayton Act, 15 U.S.C. 26; and 28 U.S.C. 1331, 1337(a), and 1345.

8. United Regional maintains its principal place of business and transacts business in this District. United Regional entered into the agreements at issue in this District, and committed the acts complained of in this District. United Regional's conduct has had anticompetitive effects and will continue to have anticompetitive effects in this District. Consequently, this Court has personal jurisdiction over the defendant, and venue is proper in this District under Section 12 of the Clayton Act, 15 U.S.C. 22, and 28 U.S.C. 1391.

9. United Regional is engaged in, and its activities substantially affect, interstate trade and commerce. It contracts with providers of commercial health insurance located outside of Texas to be included in their provider networks. These providers of commercial health insurance make substantial payments to United Regional in interstate commerce.

III. Relevant Markets

A. Relevant Product Markets

(1) The Sale of Inpatient Hospital Services to Commercial Health Insurers

10. The sale of inpatient hospital services to commercial health insurers is a relevant product market.

11. Inpatient hospital services are a broad group of medical and surgical diagnostic and treatment services that include an overnight stay in the hospital by the patient. Inpatient hospital services *exclude* (1) Services at hospitals that serve solely children, military personnel or veterans; (2) services at outpatient facilities that provide same-day service only; and (3) psychiatric, substance abuse, and rehabilitation services. Although individual inpatient hospital services are not substitutes for each other (*e.g.,* obstetrics and cardiac services are not substitutes for each other), the various individual inpatient hospital services can be aggregated for analytic convenience.

12. The market for the sale of inpatient hospital services to commercial health insurers excludes outpatient services because health plans and patients would not substitute outpatient services for inpatient services in response to a sustained price increase. There are no other reasonably interchangeable services for inpatient hospital services.

13. Commercial health insurers include managed-care organizations (such as Blue Cross Blue Shield, Aetna, United Healthcare, CIGNA, Accountable, or other HMOs or PPOs), rental networks (such as Beech Street, Texas True Choice, Multiplan, and PHCS), and self-funded plans. Rental networks serve as a secondary network used by health insurance companies looking for network coverage or discounts outside of their own networks or by self-insured employers; they are used by small and mid-sized health insurance companies to offer clients national coverage. Self-funded plans may access provider networks through managed-care organizations or rental networks. Although not all of these are risk-bearing entities, they can be referred to collectively as "commercial health insurers." Commercial health insurers *do not* include government payers (Medicare, Medicaid, and TRICARE).

14. The market for the sale of inpatient hospital services to commercial health insurers *excludes* sales of such services to government payers. The primary government payers are the federal government's Medicare program (coverage for the elderly and disabled), the joint federal and state Medicaid programs (coverage for low-income persons), and the federal government's TRICARE program (coverage for military personnel and families). The federal government sets the rates and schedules at which the government pays health-care providers for services provided to individuals covered by Medicare, Medicaid, and TRICARE. These rates are not subject to negotiation.

15. In contrast, commercial health insurers negotiate rates with health-care providers and sell health insurance policies to organizations and individuals, who pay premiums for the policies. Generally, the rates that commercial health insurers pay health-care providers are substantially higher than those paid by government payers (Medicare, Medicaid, and TRICARE).

16. There are no reasonable substitutes or alternatives to inpatient hospital services sold to commercial health insurers. A health-care provider's negotiations with commercial health insurers are separate from the process used to determine the rates paid by government payers, and health-care providers could, therefore, target a price increase just to commercial health insurers. Commercial health insurers cannot shift to government rates in response to an increase in rates for inpatient hospital services sold to commercial health insurers, and patients who are ineligible for Medicare, Medicaid, or TRICARE cannot substitute those programs for commercial health insurance in response to a price increase for commercial health insurance. Consequently, a hypothetical monopolist provider of inpatient hospital services sold to commercial health insurers could profitably maintain supracompetitive prices for those services over a sustained period of time.

(2) The Sale of Outpatient Surgical Services to Commercial Health Insurers

17. The sale of outpatient surgical services to commercial health insurers is a relevant product market.

18. Outpatient surgical services are a broad group of surgical diagnostic and surgical treatment services that do not require an overnight stay in a hospital. Outpatient surgical services are typically performed in a hospital or other specialized facility, such as a free-standing ambulatory surgery center that is licensed to perform outpatient surgery. Outpatient surgical services are distinct from procedures routinely performed in a doctor's office. Outpatient surgical services *exclude* services at hospitals or other facilities that serve solely children, military personnel, or veterans. Although individual outpatient surgical services are not substitutes for each other (*e.g.,* orthopedic and gastroenterological surgical services are not substitutes for one another), the various individual outpatient surgical services can be aggregated for analytic convenience.

19. The market for the sale of outpatient surgical services to commercial health insurers excludes inpatient hospital services; because health plans and patients would not substitute inpatient care for outpatient surgical services in response to a sustained price increase. There are no other reasonably interchangeable services for outpatient surgical services.

20. There are no reasonable substitutes or alternatives to outpatient surgical services sold to commercial health insurers. A health-care provider's negotiations with commercial health insurers are separate from the process used to determine the rates paid by government payers, and health-care providers could, therefore, target a price increase just to commercial health insurers. Commercial health insurers cannot shift to government rates in response to an increase in rates for outpatient surgical services sold to commercial health insurers, and patients who are ineligible for Medicare, Medicaid, or TRICARE cannot substitute those programs for commercial health insurance in response to a price increase for commercial health insurance. Consequently, a hypothetical monopolist provider of outpatient surgical services sold to commercial health insurers could profitably maintain supracompetitive prices for those services over a sustained period of time.

B. Relevant Geographic Market

21. The relevant geographic market for each of the relevant product markets alleged above is no larger than the Wichita Falls Metropolitan Statistical Area ("MSA"). The Wichita Falls MSA is comprised of Archer, Clay, and Wichita counties. MSAs are geographic areas defined by the U.S. Office of Management and Budget for use in Federal statistical activities.

22. Wichita Falls is the largest city in the Wichita Falls MSA. According to the 2008 estimates of the Census Bureau, the Wichita Falls MSA has a population of about 150,000. About 100,000 of these people reside in the city of Wichita Falls, which is located in Wichita County near the border of the three counties that compose the Wichita Falls MSA. Wichita Falls is in north central Texas, about a two-hour drive from the nearest metropolitan areas: Dallas-Fort Worth, Texas, and Oklahoma City, Oklahoma.

23. Commercial health insurers contract to purchase inpatient hospital services and outpatient surgical services in the geographic area in which their health plan beneficiaries are likely to seek medical care. Health plan beneficiaries typically seek medical care close to their homes or workplaces. Very few plan beneficiaries who live in the Wichita Falls MSA travel outside its borders to seek inpatient hospital services or outpatient surgical services. For example, in 2008, only about 10% of inpatient discharges of residents of the Wichita Falls MSA were from hospitals not located in the Wichita Falls MSA. Commercial health insurers that sell policies to beneficiaries in the Wichita Falls MSA cannot reasonably purchase inpatient hospital services or outpatient surgical services outside the Wichita Falls MSA as an alternative to serve those beneficiaries. Consequently, hospitals and health-care facilities outside the Wichita Falls MSA do not compete with health-care providers located in the Wichita Falls MSA for the sale of the relevant products in a manner that would constrain the pricing or other behavior of Wichita Falls health-care providers.

24. Competition for the sale of inpatient hospital services to commercial health insurers from providers located outside the Wichita Falls MSA would not be sufficient to prevent a hypothetical monopolist provider of inpatient hospital services to commercial health insurers located in the Wichita Falls MSA from profitably maintaining supracompetitive prices for those services over a sustained period of time.

25. Competition for the sale of outpatient surgical services to commercial health insurers from providers located outside the Wichita Falls MSA would not be sufficient to prevent a hypothetical monopolist provider of outpatient surgical services to commercial health insurers located in the Wichita Falls MSA from profitably maintaining supracompetitive prices for those services over a sustained period of time.

IV. Hospitals and Outpatient Surgical Facilities in the Wichita Falls MSA

A. Acute-Care Hospitals

26. There are two general acute-care hospitals in Wichita Falls—United Regional and Kell West Regional Hospital ("Kell West"). Two additional hospitals, Electra Memorial Hospital ("Electra Memorial") and Clay County Memorial Hospital ("Clay Memorial"), are outside Wichita Falls, but within the Wichita Falls MSA.

(1) United Regional

27. United Regional is a 369-bed general acute-care hospital that offers a wide range of inpatient and outpatient services. United Regional has 14 operating rooms, a laboratory, a 24-hour emergency department, and a Level III trauma center, among other facilities. It offers comprehensive cardiac care and has a childbirth center. United Regional is a private nonprofit hospital, not a public hospital. Its net patient revenues for 2009 were approximately $265 million.

28. Commercial health insurers that offer health insurance within the Wichita Falls MSA consider United Regional a "must have" hospital because it is by far the largest hospital in the region and the only provider of some essential services, such as cardiac surgery, obstetrics, and high-level trauma care.

29. United Regional was formed in October 1997 by the merger of what were then the only two general acute-care hospitals in Wichita Falls—Wichita General Hospital ("Wichita General") and Bethania Regional Health Care Center ("Bethania"). To complete the 1997 merger, Wichita General and Bethania sought and obtained an antitrust exemption from the Texas Legislature. The Legislature enacted Tex. Health & Safety Code Ann. § 265.037(d), which provides that a county-city hospital board "existing in a county with a population of more than 100,000 and a municipality with a population of more than 75,000 * * * may purchase, construct, receive, lease, or otherwise acquire hospital facilities,

including the sublease of one or more hospital facilities, regardless of whether the action might be considered anticompetitive under the antitrust laws of the United States or this state." In an attempt to qualify for the antitrust exemption enacted by the legislature, Wichita General and Bethania Regional entered into a leasing arrangement that involved the Wichita County-City of Wichita Falls, Texas Hospital Board ("County-City Board").

(2) Kell West

30. Kell West Regional is a 41-bed general acute-care hospital that opened in January 1999, partially as a competitive response to the merger that created United Regional. Kell West provides a wide range of inpatient and outpatient surgical and medical treatments. Kell West has eleven operating rooms, a laboratory, four intensive care beds, and a 24-hour emergency department. Kell West currently does not provide several services that United Regional provides, including, in particular, cardiac surgery and obstetrics. However, United Regional considers Kell West to be a significant competitor.

(3) Other Inpatient Facilities

31. Electra Memorial is a 22-bed hospital located in Electra, Texas, more than 30 miles west of Wichita Falls. Electra Memorial offers a much narrower range of inpatient hospital services and outpatient surgical services than either United Regional or Kell West. United Regional does not consider Electra Memorial to be a significant competitor, but instead as a source of referrals.

32. Clay Memorial is a 25-bed hospital located in Henrietta, Texas, more than 15 miles east of Wichita Falls. Clay Memorial offers a much narrower range of inpatient hospital services and outpatient surgical services than either United Regional or Kell West. United Regional does not consider Clay Memorial to be a significant competitor, but instead as a source of referrals.

B. Outpatient Surgical Facilities

33. United Regional, Kell West, Electra Memorial, and Clay Memorial all provide outpatient surgical services, although those provided by Electra Memorial and Clay Memorial are more limited than those provided by United Regional and Kell West. Maplewood Ambulatory Surgery Center ("Maplewood") provides outpatient surgical services focusing solely on surgical procedures for pain remediation. Texoma Outpatient Surgery Center only performs eye surgeries. The North Texas Surgi-Center provided some outpatient surgical services in Wichita Falls from 1985 to 2008. It was excluded from some commercial health insurers' networks by United Regional's exclusionary contracts. The Surgi-Center closed in December 2008.

34. There are no other providers of outpatient surgical services in the Wichita Falls MSA.

C. Potential Expansion by Competitors

35. Both Kell West and Maplewood have significant excess capacity. Kell West has the capacity to more than double the number of total patients it serves without any additional physical expansion. In addition, Kell West was intended by its owners to become a full-service hospital. To this end, Kell West has devoted most of its surplus funds to expansion projects. In 2002, Kell West nearly tripled in size, expanding from 15 to 41 beds. In 2005, it added two emergency exam rooms; in 2007, a four-bed intensive care unit; in 2008, an on-site laundry facility; and in 2009, four additional operating rooms.

36. Kell West's owners originally intended to expand Kell West into a 70-bed hospital with an intensive care unit, OB suite, and cardiology department. Today, Kell West has 41 beds. As alleged below, likely because of United Regional's exclusionary contracts, it has not been able to expand into several service lines that it has considered opening, including obstetrics, pediatrics, oncology, industrial medicine, and neurology. Doctors in the Wichita Falls community have expressed interest in treating additional patients at Kell West if it could expand into new services.

37. Maplewood currently operates its outpatient surgery center only three days per week and could easily add at least one day more per week to its schedule to accommodate additional patients.

V. United Regional's Monopoly Power

A. United Regional has monopoly power in the two relevant product markets in the Wichita Falls MSA: (1) The sale of inpatient hospital services to commercial health insurers and (2) the sale of outpatient surgical services to commercial health insurers. Since the 1997 merger between Wichita General and Bethania, United Regional has dominated both product markets in the Wichita Falls MSA, and its prices have climbed. It is currently one of the most expensive hospitals in Texas.

B. Inpatient Hospital Services

38. United Regional is by far the largest provider of inpatient hospital services in the Wichita Falls MSA. United Regional's share of inpatient hospital services sold to commercial health insurers is approximately 90% (based on admissions) in the Wichita Falls MSA.

39. An analysis prepared for United Regional by a major insurer concluded that the payments from commercial health insurers for inpatient hospital services in Wichita Falls are at least 50% higher than the average amounts paid in seven other comparable cities in Texas. Another commercial health insurer estimated that it pays United Regional almost 70% more than what it pays hospitals in the Dallas-Fort Worth area for inpatient hospital services. This insurer's analysis found that the "inpatient allowed per day adjusted for case mix" (a measure that adjusts for differences in the type and severity of services performed) was $4,143 on average in Wichita Falls, compared to $3,254 in Dallas-Fort Worth. The analysis also found that hospital prices in Wichita Falls are, on average, significantly higher for inpatient services than prices in five other comparable MSAs in Texas. United Regional is also significantly more expensive than Kell West, its primary competitor in Wichita Falls. For services that are offered by both hospitals, United Regional's average per-day rate for inpatient services sold to commercial health insurers is about 70% higher than Kell West's.

C. Outpatient Surgical Services

40. United Regional is also by far the largest provider of outpatient surgical services in the Wichita Falls MSA. United Regional's share of outpatient surgical services sold to commercial health insurers is more than 65% (based on visits) in the Wichita Falls MSA.

41. United Regional's prices for outpatient surgical services are also among the highest in Texas. One

commercial health insurer calculated that United Regional's prices for all outpatient services were in the top 10% of the 279 Texas hospitals that submitted outpatient claims to that insurer. Of the 100 Texas hospitals submitting the largest number of outpatient claims to that insurer in 2007, the insurer found that United Regional was the fourth most expensive outpatient provider in the state. Another analysis by a commercial health insurer shows that hospital prices in Wichita Falls are, on average, significantly higher for outpatient services than prices in five other comparable MSAs in Texas. Maplewood, a nearby competitor, charges much lower prices for outpatient surgical services than United Regional charges for the same services. Prices at the North Texas Surgi-Center, an ambulatory surgery center in Wichita Falls that performed a wide range of outpatient surgical services but closed in December 2008, were also significantly lower than prices charged by United Regional for identical procedures.

42. In the Wichita Falls MSA, significant barriers to the entry of new hospital and outpatient facilities as well as barriers to the expansion of existing facilities help preserve United Regional's monopoly power. For hospitals, barriers to entry include the expense and difficulty of building a hospital, recruiting and hiring qualified staff and physicians, building a reputation in the community, and gaining accreditation from relevant accrediting organizations. For outpatient facilities, the same barriers exist, but to a lesser extent. For both hospital and outpatient facilities, the barriers to entry are substantial when combined with the additional entry barriers imposed by United Regional's exclusionary contracts.

VI. United Regional Has Willfully Maintained Its Monopoly Power Through the Use of Anticompetitive Exclusionary Contracts

A. The Exclusionary Contracts and Their Terms

43. All of United Regional's exclusionary contracts share the same anticompetitive feature: a pricing penalty ranging from 13% to 27% if an insurer contracts with Kell West or other competing facilities. Specifically, the contracts provide for a higher discount off billed charges (*e.g.,* 25%) if United Regional is the only local hospital or outpatient surgical provider in the insurer's network. The contracts provide for a much smaller discount (*e.g.,* 5% off billed charges) if the commercial health insurer adds another competing local health-care facility, such as Kell West or Maplewood. A penalty that reduces an insurer's discount from 25% to 5% (for adding a rival facility) increases the insurer's price from 75% to 95% of billed charges—a 27% increase over the discounted price.

44. The 13% to 27% pricing penalty applies if an insurer contracts with competing facilities within a specific geographic area delineated by each contract. Though the scope of the geographic limitation differs between contracts, every exclusionary contract designates an area that is no larger than Wichita County, and prevents commercial health insurers from contracting with competing facilities within that area. For example, one contract prevents the commercial health insurer from contracting with competing facilities within ten miles of the City of Wichita Falls. Two contracts describe the geographic limitation as within 15 miles of the City of Wichita Falls. One contract designates certain zip codes located within Wichita County, and three contracts designate Wichita County in its entirety. In every case, Kell West, Maplewood, and the now-closed Surgi-Center fall within the geographic zone of exclusion defined by the contracts.

45. United Regional adopted the exclusionary contracts in direct response to the competitive threat presented by Kell West, the North Texas Surgi-Center, and other local outpatient surgical facilities to United Regional's monopoly position in the Wichita Falls MSA. United Regional began considering the possibility of moving to exclusionary contracts at around the time Kell West began operations. Shortly thereafter, United Regional began entering contracts with commercial health insurers that effectively prevented them from contracting with Kell West and other local health-care facilities for both inpatient and outpatient services.

46. By 1999, within three months after Kell West opened for business, United Regional had obtained exclusionary contracts from five commercial health insurers. United Regional has continued to enter into exclusionary contracts with insurers up to the present day. As of 2010, United Regional had entered into exclusionary contracts with a total of eight commercial health insurers. In each instance, it was United Regional that required the exclusionary provisions in the contract—not the insurer.

47. One of the earlier contracts provides as follows:

Exclusive Agreement. The rates set forth in Exhibit A [80% of billed charges] are contingent upon [INSURER] not entering into another agreement with an acute care facility, hospital or ambulatory surgery center, directly or indirectly, for the provision of inpatient services and/or outpatient services in Wichita Falls, Texas or within ten miles of Wichita Falls, Texas. If [INSURER] enters into another agreement with an acute care facility, hospital, or ambulatory surgery Center for the provision of inpatient services and/or outpatient services in Wichita Falls, Texas or within a ten mile radius of Wichita Falls, Texas, Clients shall immediately and automatically begin reimbursing Hospital, for Covered Services rendered by Hospital to Participants, one hundred percent (100%) of Hospital's billed charges . * * *

48. A more recent agreement between United Regional and another insurer describes a similar arrangement:

At this time, [INSURER] elects the Tier 1 Option (defined below). Hospital shall be compensated at seventy-five percent (75%) of billed charges for covered services. However, upon the Effective Date and during the term of this Agreement, if [INSURER] elects to enter into a new contract with another general acute care facility, ambulatory surgery center or radiology center in [a] 15 mile radius of United Regional Health Care System ("Hospital") located at 1600 11th St., Wichita Falls, Texas, [INSURER] shall notify Hospital thirty (30) days in advance of the effective date of such new contract. On the effective date of such contract, the Tier 1 Option Hospital Reimbursement Schedule shall be void and the reimbursement rates will revert to 95% of billed charges for all inpatient and outpatient services at United Regional Health Care System, its affiliates, and joint ventures [] where United Regional has a majority ownership interest.

1. Tier One Option: Hospital is the sole in-network facility (including only general acute care facilities, ambulatory surgery centers or radiology center[s]) within a 15 mile radius of Hospital located at 1600 11th St., Wichita Falls, Texas and Hospital shall be compensated at seventy-five percent (75%) of billed charges for covered services. Payor will deduct any applicable Copayments, Deductibles, or Coinsurance from payment due to Hospital.

2. Tier 2 Option: Hospital is not the sole in-network facility for general acute care, ambulatory surgery center or radiology center within a 15 mile radius of Hospital located at 1600 11th St., Wichita Falls, Texas and Hospital shall be compensated at ninety-five percent (95%) of billed charges for covered services. Payor will deduct any applicable Copayment, Deductibles, or Coinsurance from payment due to Hospital.

49. United Regional has broadened the scope of the exclusionary provisions over time. All eight of the exclusionary contracts effectively prevent the commercial health insurer from contracting with hospital competitors (for inpatient or outpatient services) within a certain geographic proximity to United Regional. Seven of the eight

exclusionary contracts also effectively prevent the commercial health insurer from contracting with outpatient surgery centers. United Regional added provisions excluding additional outpatient facilities such as radiology centers to five of the more recent contracts.

50. Although the earlier contracts (signed before 2001) describe the pricing in these agreements in terms of "exclusivity" or an "exclusive agreement," more recent contracts use the phrase "tiered compensation schedule." Regardless of the label, the contracts share the same anticompetitive feature; they impose a significant pricing penalty if an insurer does not enter into an exclusive arrangement with United Regional.

51. Every commercial health insurer that has entered into one of United Regional's exclusionary contracts would prefer an open network in which its customers have a choice of hospitals and outpatient surgical facilities. Most, if not all, of these insurers have sought to add Kell West or another outpatient provider to their networks. In every case, United Regional has threatened the insurer with prices so high that the insurer would not be able to compete with other health insurers offering insurance in the Wichita Falls area. As a result, notwithstanding their preferences, each health insurer contracted exclusively with United Regional because the insurer could not offer a commercially viable product if it paid the higher prices that United Regional would charge if the insurer chose to include in its network one or more of United Regional's competitors. One national commercial health insurer, for example, agreed to enter into an exclusionary contract in 2010 because it determined that it could not otherwise offer a commercially viable product in the Wichita Falls MSA.

52. United Regional has entered into exclusionary contracts with most commercial health insurers currently providing health insurance to residents of the Wichita Falls area. For more than twelve years, the only major insurer without an exclusionary contract has been Blue Cross Blue Shield of Texas ("Blue Cross"), the largest commercial health insurer in Wichita Falls and in Texas. For two rental networks, which combined account for less than 5% of the commercially insured lives in Wichita Falls, United Regional offered only the higher nonexclusive rates without an exclusive provision. In late 2010, after plaintiffs began their investigation, one other rental network switched from an exclusive agreement with United Regional to a non-exclusive arrangement.

53. All exclusionary contracts entered into between 1998 and 2010 are still in force and are essentially "evergreen" contracts, automatically renewed yearly unless terminated by one of the parties.

B. United Regional's Exclusionary Contracts Foreclosed Its Rivals From the Most Profitable Health-Insurance Contracts

54. United Regional has effectively foreclosed its rivals from many of the most profitable health-insurance contracts in Wichita Falls—contracts that are crucial for its rivals to effectively compete.

55. Inclusion in health insurer networks is critical because patients generally seek health-care services from "in-network" providers and thereby incur substantially lower out-of-pocket costs than if the patients use out-of-network providers. Patients do so because, typically, a health insurer charges a member substantially lower co-payments or other charges when the member uses an in-network provider.

56. By effectively denying its competitors critical in-network status, United Regional likely substantially reduces the number of patients who would otherwise use Kell West and other United Regional competitors. More importantly, United Regional's contracts effectively deny access to a substantial percentage of the most profitable patients—those with commercial health insurance.

57. It is substantially more profitable for hospitals to serve patients with commercial health insurance than Medicare, Medicaid, or TRICARE patients, because government plans pay significantly less than commercial health insurers. This is true in the Wichita Falls MSA. All commercial health plans in the Wichita Falls MSA pay United Regional at least *double* the Medicare payment rate, and all but one insurer (Blue Cross) pay United Regional more than *triple* the Medicare payment rate.

58. Consequently, patients covered by government plans are not adequate substitutes for commercially insured patients. In fact, United Regional, like many other hospitals, depends on payments from commercial health insurers to compensate for the comparatively low payments it receives from government payers. The low payment rates from government payers provide little or no contribution margin to offset United Regional's overhead expenses.

59. By 2010, the insurers that had exclusionary contracts with United Regional accounted for approximately 35% to 40% of all payments that United Regional received from commercial health insurers.

60. Most of the remaining commercial payments are attributable to a single commercial health insurer—Blue Cross—which has a 55% to 65% share of the commercially insured lives in the Wichita Falls MSA. In the relevant market, serving Blue Cross patients is far less profitable than serving patients covered by other commercial health insurers. Because of its size, Blue Cross negotiates the deepest discounts; thus, it pays United Regional and other providers in the relevant market substantially less than other commercial health insurers.

61. Because the insurers that have exclusionary contracts with United Regional pay the highest rates, these insurers account for a substantial share of the profits that would otherwise be available to competing health-care providers. In particular, these insurers account for approximately 30% to 35% of the profits that United Regional earns from *all* payers—including government payers such as Medicare, Medicaid, and TRICARE—even though they account for only about 8% of United Regional's total patient volume.

62. If the commercial health insurers that have exclusionary contracts with United Regional added Kell West and other health-care providers to their networks, these providers would earn substantially higher profits than they do now. For example, if only 10% of these insurers' patients switched from United Regional to Kell West, and these insurers paid Kell West 30% less than they currently pay United Regional, Kell West's profits would still likely increase by more than 40%.

C. United Regional's Exclusionary Contracts Likely Have Caused Substantial Anticompetitive Effects

63. United Regional's exclusionary contracts have reduced competition and enabled United Regional to maintain its monopoly power in the provision of inpatient hospital services and outpatient surgical services. By effectively preventing most commercial health insurers from including in their networks other inpatient and outpatient facilities, such as Kell West, the North Texas Surgi-Center, Maplewood, and others, United Regional has (1) delayed and prevented the expansion and entry of United Regional's competitors, likely leading to higher health-care costs and higher health insurance premiums; (2) limited price competition for price-sensitive patients, likely leading to higher health-care costs for those

patients; and (3) reduced quality competition between United Regional and its competitors.

(1) The Exclusionary Contracts Likely Delayed and Prevented Expansion and Entry

64. The exclusionary contracts have likely delayed and prevented competitors from expanding in or entering the relevant markets, leading to higher health-care costs and higher health-insurance premiums. As alleged above, United Regional's exclusionary contracts effectively prevent virtually all commercial health insurers from contracting with many of United Regional's competitors, including Kell West. If United Regional had not imposed its exclusionary contracts, these insurers likely would have contracted with Kell West, Maplewood, and other competitors in the Wichita Falls MSA (and with providers that otherwise might have entered the market), giving the competitors in-network access to the patients covered by commercial health insurers—the patients that are the most profitable to health-care providers.

65. Furthermore, physicians treating patients covered by commercial health insurers that have been effectively prevented from contracting with United Regional's competitors would likely have referred more patients to these competitors, and more patients would likely have chosen to use them. In addition to referrals of patients insured by commercial health insurers with exclusionary contracts, such referrals would have likely included additional referrals of Blue Cross patients and patients covered by Medicare, Medicaid, and TRICARE. Many doctors engage in "block-booking," finding it most efficient to perform all of a given day's surgeries and other procedures at the same facility. This, in turn, would have given United Regional's competitors higher patient volumes and utilization, increased revenues, and substantially higher profits.

66. The higher volumes and profits obtained from serving additional patients insured by commercial health insurers—the patients that are the most profitable to health-care providers—as well as additional Blue Cross patients and additional Medicare, Medicaid or TRICARE patients, likely would have allowed Kell West and other competitors to expand. This expansion would enable the competitors to compete more effectively with United Regional, likely resulting in more competition and lower health-care costs.

67. Kell West likely would have expanded sooner into certain services, and would also likely have added more beds and additional services, such as additional intensive care capabilities, cardiology services, and obstetric services. Kell West has considered expansion into these additional services on numerous occasions, but has been limited in its ability to expand due to its lack of in-network access to commercially insured patients. Kell West also would likely fill its significant excess capacity for the services it already provides if it had access to the commercial health insurers that currently have exclusionary contracts with United Regional.

68. If Maplewood had similar in-network access to those commercial health insurers, it would likely add one or more days to its schedule in order to serve additional patients. Maplewood currently operates only three days a week.

69. The lack of in-network access to commercially insured patients also likely has delayed and prevented Kell West from expanding by attracting an outside investor or buyer. For example, with in-network access to commercial health insurance contracts, Kell West would be more attractive to a larger hospital system, which would invest in the expansion of Kell West's services. As a physician-owned hospital, Kell West became subject in March 2010 to certain restrictions on expansion imposed by federal health-care reform legislation, *see* 42 U.S.C. 1395nn(i)(1)(B), that would not apply if Kell West were acquired by a non-physician investor. The existence of the exclusionary contracts makes such an acquisition less likely.

70. United Regional's exclusionary contracts also inhibit new providers from entering the market. Potential entrants are dissuaded from entering the market because they cannot obtain contracts with many of the commercial health insurers who have customers in that market. At least one potential entrant that is considering entering the outpatient surgical services market believes that it will not be able to do so without contracts with virtually all area commercial health insurers. United Regional's exclusionary contracts currently prevent such access.

71. By limiting the expansion or entry of competitors, United Regional's exclusionary contracts have helped it to maintain its monopoly and likely increased the cost of providing medical care to residents in the Wichita Falls area. Because the exclusionary contracts likely limited competitors' expansion and entry, and thereby reduced insurers' bargaining leverage with United Regional, the contracts likely have enabled United Regional to continue to demand higher prices from commercial health insurers free from competitive discipline.

72. The costs of medical care are typically 80% or more of an insurer's costs, and hospital costs are a substantial portion of medical care costs. The price of hospital services at individual hospitals directly affects health insurance premiums for the customers that use those hospitals. Accordingly, insurers' hospital costs are an important element of insurers' ability to offer competitive prices.

73. The higher payment rates demanded by United Regional from commercial health insurers are borne in part by Wichita Falls employers and residents in the form of higher insurance premiums. Insurance premiums in Wichita Falls are among the highest in Texas. Blue Cross's premiums in Wichita Falls exceed its premiums anywhere else in the state, including Dallas, and its employee premium rate in Wichita Falls is significantly higher than in Amarillo and Odessa, two cities similar in size to Wichita Falls.

(2) The Exclusionary Contracts Likely Have Limited Price Competition for Price-Sensitive Patients

74. United Regional's contracts have also likely reduced competition for price-sensitive patients in the relevant markets. Certain patients select a hospital based on price because the prices charged can affect the patient's out-of-pocket costs. For example, in 2008, United Regional lowered its list price for gynecological surgeries because it was concerned that too many price-sensitive patients were choosing Kell West or the North Texas Surgi-Center for these surgeries to avoid United Regional's high prices. Exclusionary contracts that effectively prevent insurers from including providers such as Kell West in commercial health insurers' networks make it less likely that a commercially insured patient would switch to Kell West in response to a price increase by United Regional, and hence reduce this constraint on United Regional's prices. Consequently, the exclusionary contracts likely enable United Regional to charge higher prices for many services.

(3) The Exclusionary Contracts Likely Have Reduced Quality Competition Between United Regional and Its Competitors

75. Patients and physicians often choose among hospitals and other health-care providers based on the

provider's quality and reputation, including quality of care (reflected in past performance on clinical measures such as mortality rates) and quality of service (reflected in non-clinical characteristics that may appeal to patients, including amenities such as physical surroundings, staff hospitality, and other services). Because there is a financial penalty for using out-of-network providers, patients with health insurance provided by insurers with exclusionary contracts are less likely to choose out-of-network providers, even if the patient believes the out-of-network provider offers superior quality to United Regional.

76. If United Regional's competitors became in-network providers for more commercially insured patients, each of those competitors would have the incentive to make additional improvements in quality to attract those patients to its facility. United Regional, in turn, would also have the incentive to improve its quality in order to keep patients from choosing Kell West or another competitor. Therefore, without the exclusionary contracts, United Regional and its competitors would have increased incentives to make additional quality improvements, and the overall level of quality of health care in the Wichita Falls area likely would be higher. Moreover, such quality improvements would benefit all patients, not just those with commercial health insurance.

D. United Regional's Exclusionary Contracts Have the Potential To Exclude Equally-Efficient Competitors

77. United Regional's exclusionary contracts have likely excluded equally-efficient competitors. When the entire "discount" that a commercial health insurer receives in exchange for agreeing to exclusivity is allocated to the patient volume that United Regional would likely lose to a competitor in the absence of the exclusionary contracts (the "contestable patient volume"), it is clear that United Regional is selling services to commercial health insurers for the contestable volume at a price below its own marginal costs. A competing hospital, therefore, would need to offer a price below United Regional's marginal cost to induce a commercial health insurer to turn down exclusivity.

78. Put differently, because the contestable patient volume is likely a small portion of a commercial health insurer's total volume at United Regional and because the pricing penalty in United Regional's contracts is so large, a commercial health insurer would not find it commercially reasonable to enter into a contract with a competing hospital in the Wichita Falls area, unless that hospital were to offer a price below United Regional's marginal cost. As a result, United Regional's exclusionary contracts likely exclude equally-efficient competitors.

E. The Exclusionary Contracts Lack a Valid Procompetitive Business Justification

79. In this case, there is no valid procompetitive business justification for United Regional's exclusionary contracts. United Regional did not use the contracts to achieve any economies of scale or other efficiencies as a result of any additional patient volume that it obtained from the contracts. Moreover, as alleged above, United Regional's contracts set prices for the contestable patient volume at a level below its own incremental costs, which (1) illustrates that the contracts are not simply lower prices in exchange for volume, and (2) cannot be justified by economies of scale in any event.

VII. Violations Alleged

Monopolization in Violation of Sherman Act § 2

80. Plaintiffs repeat and reallege the allegations of paragraphs 1 through 80 above with the same force and effect as though said paragraphs were set forth here in full.

81. United Regional possesses monopoly power in the relevant product markets in the Wichita Falls MSA.

82. United Regional has willfully maintained and abused its monopoly power in the relevant markets through its exclusionary contracts with commercial health insurers.

83. Each exclusionary contract between United Regional and a commercial health insurer constitutes an act by which United Regional willfully exploits and maintains its monopoly power in the relevant product markets in the Wichita Falls MSA.

84. In this case, there is no valid procompetitive business justification for United Regional's use of the exclusionary contracts described above.

85. United Regional's exclusionary contracts violate Section 2 of the Sherman Act, 15 U.S.C. 2.

VIII. Request For Relief

Wherefore, Plaintiffs request:

(a) That the Court adjudge and decree that United Regional acted unlawfully to maintain a monopoly in violation of Section 2 of the Sherman Act, 15 U.S.C. 2;

(b) That the Court permanently enjoin United Regional, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, negotiating for, agreeing to, continuing, maintaining, renewing, using, or enforcing, or attempting to enforce exclusionary contracts with health insurance companies and others;

(c) That the Court reform existing contracts to remove the exclusionary provisions; and

(d) That Plaintiffs be awarded the costs of this action and such other relief as may be appropriate and as the Court may deem just and proper.

Dated: February 25, 2011.

Respectfully submitted,

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In the United States District Court for the Northern District of Texas, Wichita Falls Division

United States of America and State of Texas, *Plaintiffs, v.* United Regional Health Care System, *Defendant.*

Case No.: 7:11–cv–00030.

Judge: Reed C. O'Connor.

Filed: Feb. 25, 2011.

Description: Antitrust.

Competitive Impact Statement

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

I. Nature and Purpose of the Proceeding

On February 25, 2011, the United States and the State of Texas filed a civil antitrust lawsuit against Defendant United Regional Health Care System ("United Regional") challenging United Regional's contracts with commercial health insurers that effectively prevent insurers from contracting with United Regional's competitors ("exclusionary contracts"). The Complaint alleges that United Regional has unlawfully used these contracts to maintain its monopoly for hospital services, in violation of Section 2 of the Sherman Act, 15 U.S.C. 2.

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

II. Description of the Events Giving Rise to the Alleged Violation

A. The Defendant and the Challenged Conduct

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

United Regional was formed in October 1997 by the merger of Wichita General Hospital and Bethania Regional Health Care Center. At the time of that merger, there were no other general acute-care hospitals in Wichita Falls and only one small outpatient surgery center. Soon after the merger, however, a group of doctors began planning for a competing hospital called Kell West Regional Hospital ("Kell West"). Kell West opened in January 1999 and is now a 41-bed general acute-care hospital, located about six miles from United Regional. Kell West provides a wide range of inpatient and outpatient procedures, but does not provide some key services offered by United Regional such as cardiac surgery and obstetrics.

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

Within three months after Kell West opened in January 1999, United Regional had entered into exclusionary contracts with five commercial health insurers, and by 2010, it had exclusionary contracts with eight insurers. In each instance, it was United Regional that required the exclusionary provisions in the contract—not the insurer. The only major insurer that did not sign an exclusionary contract with United Regional was Blue Cross Blue Shield of Texas ("Blue Cross"), by far the largest insurer in Wichita Falls and in Texas.

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

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

B. The Relevant Markets

The Complaint alleges two distinct relevant product markets: (1) the market for general acute-care inpatient hospital services ("inpatient hospital services") sold to commercial health insurers, and (2) the market for outpatient surgical services sold to commercial health insurers. In each case, the relevant geographic market is no larger than the Wichita Falls Metropolitan Statistical Area ("MSA").

1. The Sale of Inpatient Hospital Services to Commercial Health Insurers

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

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

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

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

third-party payers—Medicare, Medicaid, and TRICARE.

There is a key difference between the government plans and commercial health insurers. The government unilaterally sets the rates that it pays for Medicare, Medicaid, and TRICARE beneficiaries—rates that are non-negotiable. In contrast, commercial health insurers negotiate their rates with individual health-care providers. Therefore, health-care providers can target a price increase to commercial health insurers, and these insurers cannot avoid the price increase by shifting to government rates. Furthermore, patients who are ineligible for Medicare, Medicaid, or TRICARE cannot substitute into those programs in response to a price increase for commercial health insurance. Thus, a hypothetical monopolist provider of inpatient hospital services sold to commercial health insurers could profitably maintain supracompetitive prices for those services over a sustained period of time.

2. The Sale of Outpatient Surgical Services to Commercial Health Insurers

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

3. Relevant Geographic Market: No Larger Than the Wichita Falls MSA

The relevant geographic market for both inpatient hospital services and outpatient surgical services is no larger than the Wichita Falls MSA, which comprises three counties in north central Texas: Archer, Clay, and Wichita. Wichita Falls—the largest city in the MSA, with a population of about 100,000—is more than a two-hour drive and at least 100 miles from the nearest metropolitan areas: Dallas-Ft. Worth, Texas, and Oklahoma City, Oklahoma. Because patients typically seek medical care close to their homes or workplaces, very few patients who live in the Wichita Falls MSA travel outside its borders to seek inpatient hospital services or outpatient surgical services; and providers of those services located outside the Wichita Falls MSA do not compete to any substantial degree in the Wichita Falls MSA for the sale of those services. Thus, as the Complaint alleges, competition for the sale of inpatient hospital services and outpatient surgical services to commercial health insurers from providers located outside the Wichita Falls MSA would not be sufficient to prevent a hypothetical monopolist provider of those services in the Wichita Falls MSA from profitably maintaining supracompetitive prices for those services over a sustained period of time.

C. Monopoly Power

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

Monopoly power may be established by evidence that a firm has profitably raised prices above the competitive level. *See United States* v. *Microsoft Corp.,* 253 F.3d 34, 51 (D.C. Cir. 2001). In the absence of such direct proof, monopoly power may be inferred from circumstantial evidence, including "a firm's possession of a dominant share of a relevant market that is protected by entry barriers." *Id.* When evaluating monopoly power, relying on current market share alone can sometimes be misleading. But generally, evidence of dominant market share, without countervailing evidence of the possibility of competition from new entrants, is sufficient to show monopoly power. *Id.*

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

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

D. Exclusionary Conduct

Possessing monopoly power does not by itself constitute "monopolization." *See Grinnell,* 384 U.S. at 570–71. Rather, Section 2 of the Sherman Act makes it unlawful to *maintain* monopoly power through exclusionary conduct. *See Verizon Commc'ns, Inc.* v. *Law Offices of Curtis V. Trinko, LLP,* 540 U.S. 398, 407 (2004); *Microsoft,* 253 F.3d at 58.

The general test for exclusionary conduct is set forth in *United States* v. *Microsoft Corp.* First, a plaintiff must show that a monopolist's conduct has had an "anticompetitive effect." *Id.* Second, if a plaintiff proves an anticompetitive effect, the monopolist may proffer a non-pretextual "procompetitive justification" for its conduct. *Id.* at 59. Third, if the monopolist's procompetitive justification is unrebutted, the plaintiff "must demonstrate that the anticompetitive harm of the conduct outweighs the procompetitive benefit." *Id.*

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

1. The Exclusionary Contracts Likely Caused Anticompetitive Effects by Foreclosing United Regional's Rivals From the Most Profitable Health-Insurance Contracts

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

But as the Complaint explains, profits from the government plans are not an adequate substitute for the lost profits from the excluded insurers, making the excluded insurers "significant sources of input or distribution." *Id.* Commercial health insurers pay hospitals and other health-care providers substantially more than the government plans: in the Wichita Falls MSA, all commercial health insurers pay United Regional at least *double* the Medicare payment rate, and all but one insurer (Blue Cross) pay United Regional more than *triple* the Medicare payment rate. Consequently, to simply calculate the percentage of the total commercial and public-payer lives that the exclusionary contracts deny United Regional's competitors is not an accurate method to assess the contracts' effect on competition. Rather, a more appropriate approach is to assess the degree to which the contracts have foreclosed access to payments for commercially insured patients and account for the foreclosed percentage of profits from all payers.

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

Because the excluded insurers pay the highest rates, these insurers account for a substantial share of the profits that would otherwise be available to competing health-care providers. In particular, these insurers account for approximately 30% to 35% of the profits that United Regional earns from *all* payers—including the government payers—even though they account for only about 8% of United Regional's total patient volume. The Complaint alleges that if the excluded insurers added Kell West and other health-care providers to their networks, these providers would earn substantially higher profits than they do now, increasing their ability to compete against United Regional. For example, if only 10% of these insurers' patients switched from United Regional to Kell West, and these insurers paid Kell West 30% less than they currently pay United Regional, Kell West's profits would still likely increase by more than 40%.

2. The Exclusionary Contracts Have Led to Higher Prices and Reduced Quality Competition in the Relevant Markets

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

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

Second, the exclusionary contracts have likely limited price competition for price-sensitive patients. Even with the exclusionary contracts, some price competition has already occurred. For example, in 2008 United Regional lowered its list price for gynecological surgeries because it was concerned that too many price-sensitive patients were choosing Kell West and the North Texas Surgi-Center to avoid United Regional's high prices. But because insured patients generally avoid obtaining health-care services from out-of-network providers, the exclusionary contracts make it less likely that many commercially insured patients would switch to another provider in response to a price increase by United Regional. In the absence of the exclusionary contracts—with the risk that United Regional would lose some of its most profitable patients—this type of price competition would likely increase.

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

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

exclusionary contracts, United Regional and its competitors would have increased incentives to make additional quality improvements, and the overall level of quality of health care in the Wichita Falls area likely would be higher.

3. The Exclusionary Contracts Fail an Appropriate Price-Cost Test

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

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

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

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

Though measuring the contestable volume may in some cases be impractical, here the contestable volume can be estimated by examining patient usage patterns from Blue Cross and Medicare, two major payers that are not subject to exclusivity. Based on the share of patient volume that United Regional receives from Blue Cross and Medicare, the likely contestable volume is approximately 10% of the patient volume that United Regional receives from the payers that have signed exclusionary contracts. This is partly because competing providers offer a more limited portfolio of services, and partly because, as usage patterns from Blue Cross and Medicare patients suggest, many patients are likely to choose care at United Regional even for services that competing providers offer.

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

4. The Exclusionary Contracts Lack a Valid Procompetitive Business Justification

As stated above, "even if a company exerts monopoly power, it may defend its practices by establishing a business justification." *Dentsply,* 399 F.3d at 196. The plaintiff bears the burden of establishing that "the monopolist's conduct * * * has the requisite anticompetitive effect"; when that burden is met, it shifts to the defendant to "proffer a 'procompetitive justification' for its conduct." *Microsoft,* 253 F.3d at 58–59. A business justification will not be accepted where it is pretextual, *see, e.g., Eastman Kodak Co.* v. *Image Technical Servs., Inc.,* 504 U.S. 451, 484 (1992), nor is the fact that the action was taken "in furtherance of [the company's] economic interests" sufficient to meet this burden, *see, e.g., LePage's Inc.* v. *3M,* 324 F.3d 141, 163 (3d Cir. 2003) (en banc).

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

III. Explanation of the Proposed Final Judgment

The prohibitions and required conduct in the proposed Final Judgment

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

achieve all the relief sought from United Regional in the Complaint, and thus fully resolve the competitive concerns raised by the exclusionary contracts challenged in this lawsuit.

A. Prohibited Conduct

Section IV of the proposed Final Judgment seeks to restore competition between health-care providers in the Wichita Falls MSA by prohibiting United Regional from using exclusivity terms in its contracts. In particular, Section IV.A prohibits United Regional from (1) conditioning the prices or discounts that it offers to commercial health insurers on whether those insurers contract with other health-care providers, such as Kell West; and (2) preventing insurers from entering into agreements with United Regional's rivals. Section IV.B prohibits United Regional from taking any retaliatory actions against an insurer that enters (or seeks to enter) into an agreement with a rival health-care provider.

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

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

B. Permissible Conduct

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

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

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

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

C. Required Conduct

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

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

D. Compliance

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

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

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

IV. Remedies Available to Potential Private Litigants

Section 4 of the Clayton Act, 15 U.S.C. 15, provides that any person who has been injured as a result of conduct prohibited by the antitrust laws may bring suit in federal court to recover three times the damages the person has suffered, as well as costs and reasonable attorneys' fees. Entry of the proposed Final Judgment will neither impair nor assist the bringing of any private antitrust damage action. Under the provisions of Section 5(a) of the Clayton Act, 15 U.S.C. 16(a), the proposed Final Judgment has no prima facie effect in any subsequent private lawsuit that may be brought against Defendants.

V. Procedures Available for Modification of the Proposed Final Judgment

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

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

Written comments should be submitted to: Joshua H. Soven, Chief, Litigation I Section, Antitrust Division, United States Department of Justice, 450 Fifth Street, NW., Suite 4100, Washington, DC 20530.

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

VI. Alternatives to the Proposed Final Judgment

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

VII. Standard of Review Under the APPA for the Proposed Final Judgment

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

(A) The competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration of relief sought, anticipated effects of alternative remedies actually considered, whether its terms are ambiguous, and any other competitive considerations bearing upon the adequacy of such judgment that the court deems necessary to a determination of whether the consent judgment is in the public interest; and

(B) The impact of entry of such judgment upon competition in the relevant market or markets, upon the public generally and individuals alleging specific injury from the violations set forth in the complaint including consideration of the public benefit, if any, to be derived from a determination of the issues at trial.

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

As the United States Court of Appeals for the District of Columbia Circuit has held, a court considers under the APPA, among other things, the relationship between the remedy secured and the specific allegations set forth in the United States' complaint, whether the decree is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the decree may positively harm third parties. *See Microsoft,* 56 F.3d at 1458–62. With respect to the adequacy of the relief secured by the decree, a court may not "engage in an unrestricted evaluation of what relief would best serve the public." *United States* v. *BNS Inc.,* 858 F.2d 456, 462 (9th Cir. 1988) (citing *United States* v. *Bechtel Corp.,* 648 F.2d 660, 666 (9th

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

Cir. 1981)); *see also Microsoft,* 56 F.3d at 1460–62; *InBev,* 2009 U.S. Dist. LEXIS 84787, at *3; *United States* v. *Alcoa, Inc.,* 152 F. Supp. 2d 37, 40 (D.DC 2001). Courts have held that:

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

Bechtel, 648 F.2d at 666 (emphasis added) (citations omitted).[7] In determining whether a proposed settlement is in the public interest, a district court "must accord deference to the government's predictions about the efficacy of its remedies, and may not require that the remedies perfectly match the alleged violations." *SBC Commc'ns,* 489 F. Supp. 2d at 17; *see also Microsoft,* 56 F.3d at 1461 (noting the need for courts to be "deferential to the government's predictions as to the effect of the proposed remedies"); *United States* v. *Archer-Daniels-Midland Co.,* 272 F. Supp. 2d 1, 6 (D.DC 2003) (noting that the court should grant due respect to the United States' "prediction as to the effect of proposed remedies, its perception of the market structure, and its views of the nature of the case").

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

Moreover, the court's role under the APPA is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its complaint, and does not authorize the court to "construct [its] own hypothetical case and then evaluate the decree against that case." *Microsoft,* 56 F.3d at 1459; *see also InBev,* 2009 U.S. Dist. LEXIS 84787, at *20 ("the 'public interest' is not to be measured by comparing the violations alleged in the complaint against those the court believes could have, or even should have, been alleged"). Because the "court's authority to review the decree depends entirely on the government's exercising its prosecutorial discretion by bringing a case in the first place," it follows that "the court is only authorized to review the decree itself," and not to "effectively redraft the complaint" to inquire into other matters that the United States did not pursue. *Microsoft,* 56 F.3d at 1459–60. As the United States District Court for the District of Columbia recently confirmed in *SBC Communications,* courts "cannot look beyond the complaint in making the public interest determination unless the complaint is drafted so narrowly as to make a mockery of judicial power." *SBC Commc'ns,* 489 F. Supp. 2d at 15.

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

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,

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Dated: February 25, 2011.

Certificate of Service

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

Scott I. Fitzgerald (WA Bar #39716),

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In the United States District Court for the Northern District of Texas, Wichita Falls Division

United States of America and State of Texas, Plaintiffs, v. United Regional Health Care System, Defendant.

Case No.: 7:11-cv-00030.

Judge: Reed C. O'Connor.

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

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

Filed: Feb. 25, 2011.
Description: Antitrust.

[Proposed] Final Judgment

Whereas, Plaintiffs, the United States of America and the State of Texas, filed their Complaint on February 25, 2011, alleging that Defendant, United Regional Health Care System, has unlawfully maintained its monopoly by entering into exclusionary agreements with commercial health insurers, harming competition and consumers in violation of Section 2 of the Sherman Act, 15 U.S.C. 2; and

Whereas, Plaintiffs and Defendant, 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, Plaintiffs require Defendant to agree to undertake certain actions and refrain from certain conduct for the purpose of remedying the anticompetitive effects alleged in the Complaint;

Now therefore, before any testimony is taken, without trial or adjudication of any issue of fact or law, without this Final Judgment constituting any evidence against or admission by Defendant regarding any issue of fact or law, and upon consent of the parties to this action, it is *ordered, adjudged, and decreed:*

I. Jurisdiction

This Court has jurisdiction over the subject matter of this action and over Defendant. The Complaint states a claim upon which relief may be granted against Defendant under Section 2 of the Sherman Act, 15 U.S.C. 2.

II. Definitions

As used in this Final Judgment:

A. "Commercial Health Insurer" (or "Insurer") means a Person providing commercial health insurance or access to health-care provider networks, including but not limited to managed-care organizations, rental networks (*i.e.*, Persons that lease, rent, or otherwise provide direct or indirect access to a proprietary network of healthcare providers), and self-funded plans, regardless of whether that Person bears any risk or makes any payment relating to the provision of health care. The term "Commercial Health Insurer" (or "Insurer") includes Insurers that provide Medicare Advantage plans, but does not include Medicare, Medicaid, or TRICARE, or entities that otherwise contract on their behalf.

B. "Conditional Volume Discount" means a price, discount, or rebate that is offered to a Commercial Health Insurer *on condition* that the volume of that Insurer's Purchases from Defendant meets or exceeds a specified threshold.

C. "Cost-to-Charge Ratio" means the ratio of Defendant's total operating expenses to its total patient charges, for all service lines in aggregate, as reported to the Centers for Medicare & Medicaid Services pursuant to 42 U.S.C. 1395g and 42 CFR 413.20(b).

D. "Hospital Services" include (1) acute-care diagnostic and therapeutic inpatient services and (2) acute-care diagnostic and therapeutic outpatient services, including but not limited to ambulatory surgery and radiology services.

E. "Hospital-Services Provider" means any provider of Hospital Services, including but not limited to facilities that provide Hospital Services solely on an outpatient basis.

F. "Incremental Volume Discount" means a Conditional Volume Discount that is offered to a Commercial Health Insurer for which the price, discount, or rebate applies only to Purchases *above* the specified threshold. For purposes of this Final Judgment, the term "Incremental Volume Discount" does not include any price, discount, or rebate that is offered on condition that the Insurer's Purchases of Hospital Services from Defendant meet or exceed a specified percentage threshold of that Insurer's Purchases of Hospital Services in a defined geographic area.

G. "Person" means any natural person, corporation, company, partnership, joint venture, firm, association, proprietorship, agency, board, authority, commission, office, or other business or legal entity, whether private or governmental.

H. "Purchase," when used in reference to a Commercial Health Insurer's purchase of Hospital Services, includes but is not limited to arrangements between Commercial Health Insurers and Hospital-Services Providers pursuant to which the parties agree to the prices, discounts, and other terms on which Hospital Services are to be provided to patients, insurers, and self-funded employers, regardless of whether the Commercial Health Insurer that is party to the arrangement directly receives or pays for the Hospital Service.

I. "Service Line" means (1) for inpatient services, each of the mutually-exclusive major diagnosis categories (MDCs) as defined by the Centers for Medicare & Medicaid Services, and (2) for outpatient services, the "admit service area" as used in the Defendant's course of business to identify outpatient service lines.

J. The terms "and" and "or" have both conjunctive and disjunctive meanings.

III. Applicability and Interpretation

A. This Final Judgment applies to the Defendant; its directors, officers, managers, agents, employees, successors, and assigns; its controlled subsidiaries, divisions, groups, affiliates, and partnerships; and all other Persons in active concert or participation with the Defendant who receive actual notice of this Final Judgment by personal service or otherwise. 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.

B. The purpose of this Final Judgment is to prevent and remedy the use by Defendant of allegedly unlawful exclusionary agreements that limit competition for the sale of Hospital Services. This Final Judgment shall be interpreted to promote that purpose and not to limit it.

IV. Prohibited Conduct

A. Defendant shall not enter into, adopt, maintain, or enforce any term in any agreement that directly or indirectly:

(1) Conditions any price or discount offered to or paid by any Commercial Health Insurer on that Insurer's not entering into an agreement for the Purchase of Hospital Services from, or including in a provider network, another Hospital-Services Provider; or

(2) Prohibits any Commercial Health Insurer from entering into an agreement for the Purchase of Hospital Services from, or including in a provider network, another Hospital-Services Provider.

B. Defendant shall not take, or threaten to take, any actions to discriminate, retaliate, or punish any Commercial Health Insurer because that Insurer agrees, obtains, or seeks to agree or obtain Hospital Services from another Hospital-Services Provider, including but not limited to:

(1) Terminating any agreement with the Commercial Health Insurer;

(2) Offering less favorable terms and conditions to the Commercial Health Insurer; or

(3) Refusing to enter into an agreement with the Commercial Health Insurer.

C. Defendant shall not offer or agree to sell Hospital Services to any Commercial Health Insurer at a Conditional Volume Discount, except as allowed by Section V.A(3).

D. Defendant shall not offer or agree to any term in an agreement with a Commercial Health Insurer that prohibits the Insurer from offering products that encourage members to use other in-network Hospital-Services Providers; nor shall Defendant take, or threaten to take, any actions to discriminate, retaliate, or punish any Commercial Health Insurer for offering such products, including but not limited to the retaliatory actions listed in Section IV.B(1)–(3).

V. Permitted Conduct

A. Nothing in this Final Judgment shall prohibit Defendant from offering or agreeing to sell Hospital Services to:

(1) Any Commercial Health Insurer at any price or discount, provided that such prices or discounts do not violate the prohibitions in Section IV;

(2) Different Commercial Health Insurers at different prices or discounts, provided that such prices or discounts do not violate the prohibitions in Section IV;

(3) Any Commercial Health Insurer at an Incremental Volume Discount, provided that the discounted prices are above cost. For purposes of this decree, this above-cost requirement is satisfied if the discounted prices for each Service Line that apply to purchases above the specified threshold, expressed as a percentage of billed charges (the "discounted prices"), are greater than the Defendant's Cost-to-Charge Ratio based on the most recent report submitted to the Centers for Medicare & Medicaid Services before the date on which the Insurer and Defendant executed the contract. Provided, however, that after three years from the date the contract is effective, and for every three-year period thereafter, the discounted prices must be greater than the Defendant's Cost-to-Charge Ratio based on the most recent report submitted to the Centers for Medicare & Medicaid Services before the beginning of the three-year period.

B. Nothing in this Final Judgment shall prohibit Defendant from considering a Commercial Health Insurer's previous or anticipated overall size or volume when negotiating a price or discount.

C. Nothing in this Final Judgment shall prohibit Defendant from participating in a Commercial Health Insurer's preferred provider network or other forms of limited-provider panels provided that such activity does not violate the prohibitions in Section IV.

D. Except as prohibited by Section IV.B, and subject to the requirement in Section VI.B, Defendant and any Commercial Health Insurer may renegotiate or terminate their agreements according to the notice and termination provisions in such agreements.

VI. Required Conduct

A. Within 15 days after entry of this Final Judgment, Defendant shall notify in writing each Commercial Health Insurer with which Defendant has an agreement that this Final Judgment has been entered, enclosing a copy of this Final Judgment.

B. Defendant shall provide Hospital Services to each Commercial Health Insurer at the discount previously conditioned on exclusivity, even if any such Insurer enters into agreements with other Hospital-Services Providers, unless and until such discount is renegotiated according to Section V.D; provided, however, that Defendant is not required to provide such discount for greater than 270 days after Defendant notifies Insurer of its intent to renegotiate the contract.

VII. Compliance and Access

A. Defendant shall appoint an Antitrust Compliance Officer within seven days of entry of this Final Judgment, and a successor within thirty days of a predecessor's vacating the appointment, with responsibility for implementing an antitrust compliance program to ensure Defendant's compliance with this Final Judgment.

B. Each Antitrust Compliance Officer appointed pursuant to Section VII.A shall:

(1) Within 15 days after this Final Judgment takes effect, provide a copy of this Final Judgment to each of Defendant's directors and officers, and to each employee whose job responsibilities relate in any substantive way to negotiating or reviewing agreements with Commercial Health Insurers for the Purchase of Hospital Services;

(2) Distribute in a timely manner a copy of this Final Judgment to any Person who succeeds to, or subsequently holds, a position of director or officer or an employee whose job responsibilities relate in any substantive way to negotiating or reviewing agreements with Commercial Health Insurers for the Purchase of Hospital Services; and

(3) Within 60 days after this Final Judgment takes effect, develop and implement the procedures necessary to ensure Defendant's compliance with this Final Judgment. Such procedures shall ensure that questions from any of Defendant's directors, officers, or employees about this Final Judgment can be answered by counsel as the need arises.

C. For purposes of determining or securing compliance with this Final Judgment, or of 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 U.S. Department of Justice or the Office of the Texas Attorney General (including their consultants and other retained persons) shall, upon written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Office of the Texas Attorney General 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 or the State of Texas, to require Defendant to provide hard copy or 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 counsel present, regarding such matters. The interviews shall be subject to the reasonable convenience of the interviewee without restraint or interference by Defendant.

D. Within 270 days after the entry of this Final Judgment, Defendant shall submit to the United States and the State of Texas a written report setting forth its actions in compliance with this Final Judgment, specifically describing (1) the status and results of all negotiations with Commercial Health Insurers, and (2) the compliance procedures adopted pursuant Section VII.B(3) of this Final Judgment. For any new or revised agreement with any Commercial Health Insurer that is executed within one year of the entry of this Final Judgment, Defendant shall submit to the United States and the State of Texas a copy of such agreement within fourteen days from the date the agreement is executed.

E. Upon the written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Office of the Texas Attorney General, Defendant shall submit written reports or respond to written interrogatories, under oath if requested, relating to any of the matters contained in this Final Judgment. Written reports authorized under this paragraph may, at the sole discretion of the United States, require Defendant to conduct, at its cost, an independent

audit or analysis relating to any of the matters contained in this Final Judgment.

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

G. If at the time information or documents are furnished by Defendant to the United States or the State of Texas, 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," then the United States and the State of Texas shall give Defendant fourteen days' notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding), except as otherwise required by law or court order.

VIII. Retention of Jurisdiction

This Court retains jurisdiction to enable any party to this Final Judgment to apply to this 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. Expiration of Final Judgment

Unless this Court grants an extension, this Final Judgment shall expire seven years from the date of its entry.

X. 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' response to comments. Based upon the record before the Court, which includes the Competitive Impact Statement and any comments and response to comments filed with the Court, entry of this Final Judgment is in the public interest.

Date: _____

Court approval subject to procedures set forth in the Antitrust Procedures and Penalties Act, 15 U.S.C. 16.

_____

United States District Judge

[FR Doc. 2011–5529 Filed 3–9–11; 8:45 am]

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DEPARTMENT OF JUSTICE

Office of Justice Programs

[OJP (BJA) Docket No. 1547]

Meeting of the Department of Justice Global Justice Information Sharing Initiative Federal Advisory Committee

AGENCY: Office of Justice Programs (OJP), Justice.

ACTION: Notice of meeting.

SUMMARY: This is an announcement of a meeting of the Department of Justice (DOJ) Global Justice Information Sharing Initiative (Global) Federal Advisory Committee (GAC) to discuss the Global Initiative, as described at *http://www.it.ojp.gov/global.*

DATES: The meeting will take place on Wednesday, April 20, 2011, from 8:30 a.m. to 4 p.m. ET.

ADDRESSES: The meeting will take place at the Embassy Suites Washington, DC—Convention Center Hotel, 900 Tenth Street, NW., Washington, DC 20001, *Phone:* (202) 739–2001.

FOR FURTHER INFORMATION CONTACT: J. Patrick McCreary, Global Designated Federal Employee (DFE), Bureau of Justice Assistance, Office of Justice Programs, 810 Seventh Street, Washington, DC 20531; *Phone:* (202) 616–0532 [**Note:** This is not a toll-free number]; *E-mail: James.P.McCreary@usdoj.gov.*

SUPPLEMENTARY INFORMATION: This meeting is open to the public. Due to security measures, however, members of the public who wish to attend this meeting must register with Mr. J. Patrick McCreary at the above address at least (7) days in advance of the meeting. Registrations will be accepted on a space available basis. Access to the meeting will not be allowed without registration. All attendees will be required to sign in at the meeting registration desk. Please bring photo identification and allow extra time prior to the meeting.

Anyone requiring special accommodations should notify Mr. McCreary at least seven (7) days in advance of the meeting.

Purpose

The GAC will act as the focal point for justice information systems integration activities to help facilitate development and coordination of national policy, practices, and technical solutions in support of the Administration's justice priorities.

The GAC will guide and monitor the development of the Global information sharing concept. It will advise the Assistant Attorney General, OJP; the Attorney General; the President (through the Attorney General); and local, state, tribal, and federal policymakers. The GAC will also advocate for strategies for accomplishing a Global information sharing capability.

Interested persons whose registrations have been accepted may be permitted to participate in the discussions at the discretion of the meeting chairman and with approval of the DFE.

J. Patrick McCreary,

Global DFE, Bureau of Justice Assistance, Office of Justice Programs.

[FR Doc. 2011–5452 Filed 3–9–11; 8:45 am]

BILLING CODE 4410–18–P

DEPARTMENT OF LABOR

Employment and Training Administration

Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

TA–W–71,287	MASCO BUILDER CABINET GROUP INCLUDING ON–SITE LEASED WORKERS FROM RESERVES NETWORK AND RELIABLE STAFFING, JACKSON, OHIO.
TA–W–71,287A	MASCO BUILDER CABINET GROUP INCLUDING ON–SITE LEASED WORKERS FROM RESERVES NETWORK AND RELIABLE STAFFING WAVERLY, OHIO.
TA–W–71,287B	MASCO BUILDER CABINET GROUP INCLUDING ON–SITE LEASED WORKERS FROM RESERVES NETWORK AND RELIABLE STAFFING SEAL TOWNSHIP, OHIO.