UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *Plaintiff*, v. HUMANA INC. and ARCADIAN MANAGEMENT SERVICES, INC., *Defendants.*	Case: 1:12-cv-00464 Assigned To : Walton, Reggie B. Assign. Date : 3/27/2012 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

The United States filed a civil antitrust Complaint on March 27, 2012, seeking to enjoin Humana Inc. ("Humana") from acquiring Arcadian Management Services, Inc. ("Arcadian"), alleging that the acquisition likely would substantially lessen competition in the sale of individual Medicare Advantage plans in forty-five counties and parishes in Arizona, Arkansas, Louisiana, Oklahoma, and Texas ("the relevant geographic markets"), in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18. The loss of competition from the acquisition likely would result in higher premiums and reduced benefits and services in these markets.

At the same time that the United States filed the Complaint, the United States also filed an Asset Preservation Stipulation and Order ("Stipulation") and proposed Final Judgment, which will eliminate the anticompetitive effects that likely would result from the transaction by requiring the Defendants to divest Medicare Advantage business in each relevant geographic market. Under the Stipulation, the Defendants must ensure that the assets to be divested continue to be operated as ongoing, economically viable, and competitive Medicare Advantage offerings until accomplishment of the divestitures that the proposed Final Judgment requires.

The United States and the Defendants have stipulated that the Court may enter the proposed Final Judgment after compliance with the APPA. Entry of the proposed Final Judgment would terminate this action, except that the Court would retain jurisdiction to construe, modify, or enforce the provisions of the Final Judgment and to punish violations thereof.

II. EVENTS GIVING RISE TO THE ALLEGED VIOLATION

A. The Defendants and the Proposed Transaction

Defendant Humana is a leading health insurer in the United States, providing health insurance and other services to more than 17 million people nationwide. In 2010 Humana reported revenues of approximately $33.6 billion.

Humana is one of the largest Medicare Advantage providers in the United States, with almost 1.8 million Medicare Advantage members. Humana provides health insurance to approximately 35,000 Medicare Advantage enrollees in the relevant geographic markets alleged in the Complaint. In the relevant geographic markets, Humana sells Medicare Advantage plans under the Humana Gold Choice, Humana Gold Plus, HumanaChoice, and Humana Reader's Digest Healthy Living Plan names.

Arcadian sells Medicare Advantage HMO plans and focuses on secondary, non-urban, and underserved markets. It has approximately 62,000 Medicare Advantage members in fifteen states. In 2010 it had revenues of $622 million.

Arcadian provides health insurance to over 14,700 Medicare Advantage enrollees in the relevant geographic markets. Humana and Arcadian each have well-established managed-care networks that they use to provide services to enrollees in these markets. In addition, each has an established brand and positive reputation in the relevant geographic markets.

On August 24, 2011, Humana and Arcadian entered into a merger agreement whereby Humana agreed to acquire all of the outstanding shares of Arcadian. Humana and Arcadian valued the transaction at approximately $150 million.

B. Medicare Advantage Insurance

The federal government provides and facilitates the provision of health insurance to millions of Medicare-eligible citizens through two types of programs: traditional Medicare and Medicare Advantage. Under traditional Medicare, a beneficiary receives coverage for inpatient healthcare services in hospitals and other facilities under Medicare Part A and can elect to receive coverage for physician and outpatient healthcare services under Part B. For Part A, the government generally charges no monthly premium if the beneficiary was in the workforce and paid Medicare taxes. For Part B, the government deducts a monthly premium ($99.90 for most beneficiaries) from the beneficiary's Social Security checks. In addition, for doctor visits and hospital stays, the beneficiary must pay deductibles, coinsurance, or both. If a beneficiary wants to limit these potentially high out-of-pocket costs, the beneficiary can purchase a separate Medicare Supplement plan for an additional monthly premium. To receive prescription drug

coverage, seniors enrolled in traditional Medicare can purchase a Medicare prescription drug plan (Medicare Part D) for an additional monthly premium.

Medicare Advantage plans, unlike traditional Medicare, are offered by private insurance companies. Medicare Advantage plans provide all of the medical insurance coverage that seniors receive under traditional Medicare and also usually limit out-of-pocket costs and include drug coverage. These plans also generally provide benefits beyond what traditional Medicare provides, often including coverage for vision, hearing, dental, and wellness programs. However, most Medicare Advantage plans have a more limited healthcare provider network than traditional Medicare, and limited networks help Medicare Advantage insurers lower their costs and offer richer benefits than traditional Medicare.

An insurance company that seeks to offer a Medicare Advantage plan in a county must submit a bid to the Centers for Medicare and Medicaid Services ("CMS") for each Medicare Advantage plan that it intends to offer. The bid must provide the insurer's anticipated costs to cover the required Medicare Part A and Part B benefits for a member. CMS actuaries compare these costs, including an anticipated profit margin, to a Medicare benchmark that reflects, in part, the government's likely cost of covering the beneficiaries. Through 2011, if the insurer's bid for Medicare benefits was lower than the benchmark, the Medicare program retained 25 percent of the savings and the insurer was required to use the other 75 percent ("the rebate") to provide supplemental benefits or lower premiums. Accordingly, a plan with lower projected costs would offer more benefits to seniors and be more attractive. As of 2012, the rebate will vary based on performance as measured through CMS's Medicare star rating system, such that insurers will receive a greater fraction of the rebate the better their performance. Therefore, Medicare

Advantage plans compete for enrollment by lowering costs, lowering premiums, increasing benefits, and improving performance.

Medicare Advantage enrollees can be either group or individual enrollees. Group enrollees are generally retirees who enroll in a Medicare Advantage plan chosen by their former employer or another group. Individual enrollees directly choose their Medicare Advantage plan from among the plans that CMS has approved for the county or parish in which they live.

C. Relevant Markets

1. The Relevant Product Market Is No Broader than the Sale of Individual Medicare Advantage Health Insurance

The Complaint alleges that the relevant product market is no broader than the sale of Medicare Advantage health insurance to individuals. Most successful Medicare Advantage plans, including those in the relevant geographic markets, offer substantially richer benefits at lower costs to enrollees than traditional Medicare does with or without a Medicare Supplement or Medicare prescription drug plan, including lower copayments, lower coinsurance, caps on total yearly out-of-pocket costs, prescription drug coverage, and supplemental benefits that traditional Medicare does not cover, such as dental and vision coverage, and health club memberships. Seniors enrolled in Medicare Advantage plans also often value that they can receive all of these benefits through a single plan and that Medicare Advantage plans manage care in ways that traditional Medicare does not.

Consequently, a small but significant increase in Medicare Advantage plan premiums or reduction in benefits is unlikely to cause a sufficient number of seniors in the relevant geographic markets to switch to traditional Medicare such that the price increase or reduction in benefits would be unprofitable. Accordingly, the relevant product market is no broader than the sale of individual Medicare Advantage plans and is a line of commerce under Section 7 of the Clayton Act, 15 U.S.C. § 18.

2. The Relevant Geographic Markets Are County or Parish Markets

Seniors may enroll only in Medicare Advantage plans that CMS approves for the county or parish in which they live. Consequently, they could not turn to Medicare Advantage plans offered outside the county or parish in which they live in response to a small but significant increase in premiums or a reduction in benefits. Accordingly, each of following forty-five counties and parishes is a relevant geographic market and a section of the country within the meaning of Section 7 of the Clayton Act: Mohave and Yavapai Counties in Arizona; Columbia, Conway, Crawford, Franklin, Hempstead, Howard, Lafayette, Little River, Logan, Miller, Nevada, Pope, Scott, Sebastian, Sevier, and Yell Counties in Arkansas; Allen, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Claiborne, De Soto, Jefferson Davis, Red River, and Webster Parishes in Louisiana; Adair, Delaware, Haskell, Le Flore, McCurtain, Ottawa, and Sequoyah Counties in Oklahoma; and Bowie, Cass, Deaf Smith, Gregg, Harrison, Henderson, Potter, Randall, and Titus Counties in Texas.

3. The Defendants' Shares in Medicare Advantage Are High in the Relevant Geographic Markets

The market for Medicare Advantage plans is already highly concentrated in almost all of the relevant geographic markets and would become significantly more concentrated as a result of the proposed acquisition. If consummated, the merger would give Humana market shares

ranging from 40 to 100 percent in the relevant geographic markets, resulting in highly concentrated markets, as shown below.[1] Collectively, the individual Medicare Advantage plans in these areas account for over $700 million in annual commerce.

Relevant Geographic Markets (as of March 2012)

County	Post-Merger Share	HHI Post-Merger	Increase in HHI
Mohave, AZ	82.3%	6980	3386
Yavapai, AZ	40.8%	5091	407
Columbia, AR	56.0%	4732	1421
Conway, AR	55.0%	3906	376
Crawford, AR	63.8%	4514	1563
Franklin, AR	47.8%	3539	549
Hempstead, AR	55.7%	5064	1218
Howard, AR	58.1%	4576	1681
Lafayette, AR	68.3%	5668	1993
Little River, AR	82.1%	7066	3292
Logan, AR	59.7%	4263	1080
Miller, AR	73.8%	5836	1931
Nevada, AR	58.9%	5158	1139
Pope, AR	44.1%	4055	312
Scott, AR	52.1%	3545	984
Sebastian, AR	57.9%	3882	1133
Sevier, AR	84.1%	7326	3474
Yell, AR	40.3%	3075	610
Allen, LA	78.5%	6622	1310
Beauregard, LA	100.0%	10000	4789
Bienville, LA	49.3%	3721	1189
Bossier, LA	93.3%	8748	848
Caddo, LA	92.7%	8642	1626
Calcasieu, LA	100.0%	10000	3217
Claiborne, LA	42.0%	3523	535
De Soto, LA	100.0%	10000	3648
Jefferson Davis, LA	88.7%	8000	1746
Red River, LA	45.0%	3803	926
Webster, LA	84.1%	7323	1385
Adair, OK	60.1%	5204	1799
Delaware, OK	100.0%	10000	3887
Haskell, OK	58.6%	4666	1688
Le Flore, OK	100.0%	10000	4632
McCurtain, OK	80.6%	6691	2325

[1] The term "HHI" means the Herfindahl-Hirschman Index, a commonly accepted measure of market concentration. The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. The agencies generally consider markets in which the HHI is in excess of 2,500 points to be highly concentrated. *See* U.S. Department of Justice & FTC, *Horizontal Merger Guidelines* § 5.3 (2010). Transactions that increase the HHI by more than 200 points in highly concentrated markets are presumed likely to enhance market power under the *Horizontal Merger Guidelines* issued by the Department of Justice and the Federal Trade Commission. *See id.*

Ottawa, OK	100.0%	10000	1512
Sequoyah, OK	100.0%	10000	4928
Bowie, TX	82.5%	7019	3305
Cass, TX	81.3%	6962	3285
Deaf Smith, TX	66.7%	5556	1636
Gregg, TX	73.7%	5783	2668
Harrison, TX	86.4%	7652	3590
Henderson, TX	68.0%	5197	2224
Potter, TX	72.6%	5776	2197
Randall, TX	75.0%	5928	1421
Titus, TX	75.8%	6331	2198

D. The Acquisition Likely Would Substantially Lessen Competition in the Sale of Individual Medicare Advantage Plans in Each Relevant Geographic Market

The proposed transaction likely would substantially lessen competition in the sale of individual Medicare Advantage plans and end the substantial head-to-head competition between Humana and Arcadian to convince seniors to enroll in each company's Medicare Advantage plans in the relevant geographic markets. That competition has benefited thousands of seniors.

In each market, Humana and Arcadian compete against each other by offering plans with frequently low or no premiums, reducing copayments, eliminating deductibles, lowering annual out-of-pocket maximum costs, managing care, improving drug coverage, offering desirable benefits, and making their provider networks more attractive to potential members. If Defendants complete the proposed transaction, the loss of this competition likely would result in higher premiums and reduced benefits for seniors enrolled in Medicare Advantage plans in the relevant geographic markets.

Competition from existing Medicare Advantage plans and new entrants is unlikely to prevent anticompetitive effects in each relevant geographic market. Entrants face substantial cost, reputation, and distribution disadvantages that will likely make them unable to prevent Humana from profitably raising premiums or reducing benefits in the relevant geographic markets.

III. EXPLANATION OF THE PROPOSED FINAL JUDGMENT

A. The Divestiture Assets

The proposed Final Judgment is designed to eliminate the anticompetitive effects identified in the Complaint by requiring the Defendants to divest Arcadian's individual Medicare Advantage business in 34 of the 45 relevant geographic markets, and Humana's individual Medicare Advantage business in 11 of them (collectively "the Divestiture Assets") to one or more acquirers approved by, and on terms acceptable to, the United States. Specifically, the divestitures will eliminate the anticompetitive effects alleged in the Complaint by requiring the Defendants to divest one or more Medicare Advantage plans in each relevant geographic market to an acquirer that will compete vigorously with the merged Humana-Arcadian. The divestitures are designed to allow the acquirer, or acquirers, of the assets to offer uninterrupted care to members of Arcadian's and Humana's divested Medicare Advantage plans.

The Divestiture Assets include all of Arcadian's and Humana's rights and obligations under the relevant Arcadian or Humana contracts with CMS. The lines of business to be divested cover approximately 12,700 individual Medicare Advantage beneficiaries. In addition to the plans in the forty-five relevant geographic markets, the Divestiture Assets include Arcadian plans in five counties and one parish where Arcadian has either one percent or no enrollment and where the Complaint does not allege likely anticompetitive effects: Johnson County in Arkansas; Cameron Parish in Louisiana; Pushmataha County in Oklahoma; and Armstrong, Carson, and Oldham Counties in Texas. These plans are in areas contiguous to and under the same CMS contract and plan ID as plans in the relevant geographic markets. The Divestiture Assets include these additional plans because doing so makes them more administrable and will facilitate the divestiture of the plans in the relevant geographic markets.

The Divestiture Assets exclude enrollment in Medicare Advantage Special Needs Plans. Enrollment in Special Needs Plans is limited to seniors who are institutionalized, dually eligible for Medicare and Medicaid benefits, or afflicted by severe or disabling chronic conditions. The divestiture of these plans is unnecessary to eliminate the transaction's likely anticompetitive effects because the Defendants' enrollment in Special Needs Plans accounts for only 1.4% of their combined individual Medicare Advantage membership in the markets where divestitures are required.

The Defendants must satisfy the United States that a viable competitor will replace Arcadian's competitive presence in the sale of individual Medicare Advantage plans in each of the forty-five relevant geographic markets identified in the Complaint. The divestitures must be (1) made to an acquirer that has the intent and capability—including the necessary managerial, operational, technical, and financial capability—to compete effectively in the sale of Medicare Advantage products in the market, or markets, in question, and (2) accomplished so as to satisfy the United States that none of the terms of any agreement between Humana and any acquirer gives Humana the ability to interfere with the acquirer's ability to compete effectively. The proposed Final Judgment also provides that the divestiture of the Divestiture Assets may be made to one or more acquirers, provided that in each instance the United States is satisfied that the Divestiture Assets will remain viable and the divestitures will remedy the anticompetitive harm alleged in the Complaint.

B. Selected Provisions of the Proposed Final Judgment

In addition to the requirements discussed above, the following specific provisions of the proposed Final Judgment will enable the acquirer to compete promptly and effectively in the relevant geographic markets for individual Medicare Advantage plans.

1. Provider-Network Contracts

Sections IV.G through IV.K ensure that the acquirer of the assets divested in each relevant geographic market (and the five additional counties and one additional parish discussed above) will have a healthcare provider network sufficient to compete vigorously and minimize any network disruption from the divestiture. To compete effectively in the sale of Medicare Advantage plans, an insurer needs a network of healthcare providers contracted at competitive rates because hospital and physician expenses constitute the large majority of an insurer's costs. By requiring Humana to assist the acquirer in establishing a cost-competitive provider network, Sections IV.G through IV.K will enable the acquirer to compete as effectively as Humana and Arcadia before the proposed transaction.

In particular, Section IV.G requires, at the acquirer's option, that the Defendants assign the acquirer all Arcadian contracts with healthcare providers in all of the relevant geographic markets where those contracts are freely assignable, except Columbia, Hempstead, Howard, Lafayette, Little River, Miller, Nevada, and Sevier Counties in Arkansas, and Bowie, Cass, and Titus Counties in Texas (collectively, "the Texarkana Area," discussed further below). Where those contracts are not freely assignable, the Defendants must use their best efforts to obtain any necessary provider consents to assignment of the Arcadian contracts and assign those contracts to the Acquirer after obtaining the necessary consents. To further ensure that the Acquirer has an adequate network, Section IV.H imposes the same obligation with respect to providers that provide health-care services in a county or parish contiguous to a divestiture county or parish, but that receive the bulk of their Arcadian contract payments from Arcadian members in the divestiture area, also at the acquirer's option.

In addition, to ensure that the acquirer of the assets related to the Texarkana Area has the same providers in its network as Humana currently does and on terms that are equal to Humana's terms, Section IV.K of the Final Judgment requires Humana to lease access to two of its wholly-owned provider networks, ChoiceCare and LifeSynch, to the acquirer of the divestiture assets in the Texarkana Area's relevant geographic markets. Humana's Medicare Advantage plans in the Texarkana Area currently use these networks to access providers. Section IV.K requires Humana to lease to the acquirer access to these networks on non-discriminatory terms until December 31, 2014. This time period and the enrollment that comes with the divestiture should enable the acquirer to develop its own provider network.

2. Quick Divestiture

Section IV of the proposed Final Judgment is designed to ensure that the divestitures occur quickly, and in a manner consistent with applicable regulatory requirements. Section IV.A requires that the Defendants complete the divestitures within sixty days of the filing of the Complaint, with the granting of possible extensions in the sole discretion of the United States and not to exceed ninety days total. If (1) the Defendants have filed all necessary applications or requests for government approval within five days after the date that the United States informs the Defendants that it does not object to a proposed divestiture, and (2) an order or other dispositive action on such applications has not issued or become effective before the end of the period permitted for divestiture, Section IV.B extends the divestiture period until five business days after the approval is received.

3. Branding

The Final Judgment also recognizes the importance of branding to a company's ability to compete effectively in the sale of Medicare Advantage plans. Section IV.M provides that upon

completing the divestiture and through December 31, 2014, the Defendants may not use the Arcadian brand for any type of Medicare Advantage plan, other than a Special Needs Plan, in any of the fifty-one counties and parishes (including the five additional counties and one additional parish discussed above) except those in the Texarkana Area. In addition, Section IV.N allows the acquirer to use the Arcadian brand in any of the fifty-one counties and parishes except those in the Texarkana Area for up to twelve months after divestiture with the United States' approval. Section IV.O allows the acquirer to make reasonable transitional use of the Humana brand in the Texarkana Area.

4. CMS Regulatory Process

Section IV also requires that the Defendants transfer the Divestiture Assets in a manner consistent with CMS rules and regulations, and that the Defendants maintain the viability of those assets in the interim through the CMS bidding process. Specifically, Section IV.S requires Defendants to work with CMS to ensure that the divestiture process satisfies any CMS concerns about network disruption and adheres to rules and regulations regarding novations. Section IV.X provides that if Defendants fail to divest the Divestiture Assets by May 15, 2012, Humana will prepare and submit to CMS, in the ordinary course of business and consistent with past practice, subject to actuarially reasonable adjustment, all necessary filings for the Divestiture Assets including Medicare Advantage Plan bids for 2013, so that the Divestiture Assets remain viable, ongoing Medicare Advantage offerings. CMS's annual Medicare Advantage bid cycle necessitates this provision because plan proposals for the upcoming year must be submitted by no later than June of the current year.

5. Divestiture Trustee and Monitoring Trustee

Section V provides for the appointment, if necessary, of a trustee to sell the Divesture Assets and thereby also encourages a quick, effective divestiture in this matter. Section V.A provides that, if the Defendants have not divested the Divestiture Assets within the time period specified in Section IV, the Court will appoint a trustee selected by the United States to carry out any divestitures the Defendants have not completed. Defendants must pay the trustee's costs and expenses, and the trustee's commission will provide an incentive based on the price, terms, and speed of the divestiture. Once the trustee is appointed, the trustee will file monthly reports with the Court and the United States explaining his or her efforts to accomplish the divestiture. Section V.G provides that if the trustee has not accomplished the divestiture by November 21, 2012, the trustee and the United States will make recommendations to the Court, which will enter such orders as it deems appropriate in order to carry out the purpose of the trust. This may include extending the trust or the term of the trustee's appointment by a period requested by the United States.

As soon as the filing of the Complaint, the United States may also appoint a monitoring trustee, subject to the approval by the Court, which will insure against deterioration of the Divestiture Assets until their divestiture. The monitoring trustee will have the power and authority to monitor Defendants' compliance with the Final Judgment and Stipulation and such powers as the Court may deem appropriate, and Defendants can object to that trustee's actions only for malfeasance. This trustee will serve at Humana's expense and on such terms and conditions as the United States approves, and the Defendants must assist the trustee in fulfilling its obligations. The monitoring trustee will file monthly reports and will serve until the divestiture is complete and any agreements for transitional support services have expired.

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, Humana, and Arcadian 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

The United States considered, as an alternative to the proposed Final Judgment, a full trial on the merits against Defendants. The United States could have continued the litigation and sought a judicial order enjoining Humana's acquisition of Arcadian. The United States is satisfied, however, that divestiture of the assets described in the proposed Final Judgment will preserve competition for the sale of individual Medicare Advantage plans in the relevant geographic markets. Thus, the proposed Final Judgment would achieve all or substantially all of the relief the United States would have obtained through litigation, but avoids the time, expense, and uncertainty of a full trial on the merits.

VII. 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
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> (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.*, 2009-2 Trade Cas. (CCH) ¶ 76,736, 2009 U.S. Dist. LEXIS 84787, No. 08-1965 (JR), 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.").[2]

Under the APPA, a court considers, 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

[2] 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).

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

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

Bechtel, 648 F.2d at 666 (emphasis added) (citations omitted).[3] 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.D.C. 2003) (noting that the court should grant due respect to the United States' "prediction as to the effect of proposed remedies, its perception of the market structure, and its views of the nature of the case").

Courts have greater flexibility in approving proposed consent decrees than in crafting their own decrees following a finding of liability in a litigated matter. "[A] proposed decree

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[3] *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'").

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 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.[4]

VIII. DETERMINATIVE DOCUMENTS

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

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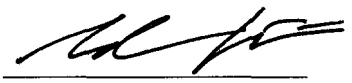
[4] *See United States v. Enova Corp.*, 107 F. Supp. 2d 10, 17 (D.D.C. 2000) (noting that the "Tunney Act expressly allows the court to make its public interest determination on the basis of the competitive impact statement and response to comments alone"); *United States v. Mid-Am. Dairymen, Inc.*,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

Dated this 27th day of March 2012.

Respectfully submitted,



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