December 3, 2018

COMMENTS IN OPPOSITION FROM NOVANT HEALTH, INC.

Regarding Atrium Pineville Medical Center's CON Application for an Operating Room in Mecklenburg County Project I.D. #F-011619-18

The 2018 SMFP found a need for six new ORs in Mecklenburg County. Applicants have requested eight ORs. This is the first time in more than a decade that the SMFP has declared a need for additional ORs in Mecklenburg County that was not a single specialty demonstration project.[1] Novant Health Huntersville Medical Center ("NHHMC") applied for one shared OR. Atrium Pineville Medical Center ("Pineville") applied for one shared OR (Project I.D. #F-011621-18). Atrium Carolinas Medical Center ("CMC") applied for two shared ORs and two dedicated outpatient ORs (Project I.D. #F-011620-18). Carolina Center for Special Surgery, ("CCSS"), an Atrium joint venture with Carolina Neurosurgery Associates, applied for one outpatient OR (Project I.D. #F-011619-18). Metrolina Fresenius, a dialysis facility, ("Metrolina") applied for a new single specialty ambulatory surgery center with one OR (Project I.D. #F-011612-18).

Novant Health is filing comments on the three Atrium applications for additional ORs In this comment we compare the NHHMC application with the CCSS Application and show why the State should approve the NHHMC application and deny the CCSS Application.

In all comments we rely on the Draft 2019 SMFP count of ORs in Mecklenburg County subject to the SMFP need determination.[2] This count excludes dedicated C-section, burn and trauma ORs. In counting ORs under the control of each health system, we count the Charlotte Surgery Center and the Randolph Surgery Center as under the control of Atrium Health because Atrium is a part owner of the facilities and the assets were transferred from Atrium surgical facilities. In applying OR performance standards, we treat these two ambulatory surgery centers as separate from Atrium, based on the definition of Health System in the 2019 SMFP.[3]

In reviewing these applications, we respectfully remind the Agency there is no statute or rule favoring applications from the facility or system that generated the need in the State Medical Facilities Plan.

[1] The 2010 SMFP contained a need for a single specialty ASC; the 2016 SMFP contained a need for dental ORs.
[2] Proposed 2019 State Medical Facilities Plan, Chapter 6, Table 6A: Operating Room Inventory.
[3] Proposed 2019 State Medical Facilities Plan, Chapter 6, p 51.

In the context of CON Review Criteria (1), (3), (4), (5), (6), (13), and (18a), the CCSS Application is not conforming because it:

- Does not demonstrate that it maximizes healthcare value;
- Does not demonstrate need for its proposed project, and therefore does not demonstrate the financial feasibility of its proposed project;
- Does not demonstrate its proposed project will promote equitable access;
- Does not demonstrate it is the most effective alternative;
- Does not demonstrate its proposed project is not a duplication of existing health services; and
- Does not demonstrate its proposed project will enhance competition.

Even were the Agency to find the CCSS Application conforming on these criteria, Novant Health's proposed project is also conforming and better meets the criteria and the overall goals of the SMFP. The competitive imbalance will only worsen if the Agency approves the Atrium applications. Improving competitive balance in Mecklenburg county, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care and expanding patient choice. In a comparative review, the Agency should approve Novant Health's proposed project and deny the CCSS Application.

Brief Description of Projects

Novant Health Project: The proposed project will build out and equip existing space in the surgical suite as a shared use OR. The space is currently used for storage and will be relocated to other existing space. The application also includes the licensure of twelve existing labor/delivery/recovery beds as labor/delivery/recovery/postpartum beds at minimal cost. The OR would be in service on January 1, 2021.

Carolinas Center for Special Surgery Project: Waveco, LLC, which does business as Carolina Center for Specialty Surgery, a freestanding ambulatory surgery center in Charlotte, is a joint venture between The Charlotte-Mecklenburg Hospital Authority (CMHA) and NeuroSpine, LLC. NeuroSpine, LLC is comprised of individual physician owners affiliated with Carolina Neurosurgery and Spine Associates (CNSA). CMHA holds 50 percent ownership interest in Waveco, LLC. The proposed project will build out and equip existing space as an outpatient operating room. The space is currently used for sterile supply and storage. The operating room would be in service on January 1, 2020.

Conformity with CON Statutory Review Criteria

Criterion (1)

Criterion (1): NCGS § 131E-183(a)(1): The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on any health service, health service facility, health service facility beds, dialysis stations, or home health offices that may be approved.

Policy GEN-3 applies to the CCSS application. The CCSS application does not comply with Policy GEN-3 because it does not demonstrate how the proposed project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing health care value for resources expended. It fails to maximize healthcare values because it does not further equitable geographic access or competitive balance.

There is nothing "special" about CCSS. When it opened in 2006, laparoscopic surgery may have been innovative, but no more. It is performed at all hospitals and most ASCs that perform procedures where it is an option. Laparoscopic and other surgical procedures performed at CCSS are performed at many other surgical facilities in Mecklenburg County. There is no reason to give this facility special consideration.

CCSS does not provide equitable access to all patients needing procedures it performs. The table below from the application shows it provides essentially no charity care and little Medicaid care. This poor record of equitable access occurs because (1) almost all the surgical cases at CCSS are scheduled procedures so EMTALA does not apply and (2) the Neurospine physicians are in private practice and are not covered by Atrium charity care policies. They are free to decline referral of outpatients in need of their services and free to schedule any uninsured patients they do take at another facility. Adding an OR at CCSS will do nothing to increase access to care for underserved, uninsured or Medicaid patients.

CCSS Form F.4: Third Full Fiscal Year (From 01/01/2022 to 12/31/2022)

	Percent	Cases	Average Charge	Gross Revenue
Self Pay/Indigent/Charity	0.7%	16	$11,491	$185,413
Managed Care/Commercial	70.7%	1,658	$12,889	$21,364,663
Medicaid	0.8%	18	$6,425	$116,715
Medicare/Medicare Managed Care	23.5%	552	$9,210	$5,080,319
Other/Workers' Comp	4.3%	100	$13,584	$1,364,589
Total	100.0%	2,344	$11,993	$28,111,699

Adding an OR at CCSS does not maximize healthcare value because it adds fewer OR hours than adding a shared use OR in a hospital. CCSS is classified in Group 6, meaning the operating room is only available 1,312 hours per year.[4] All the hospital applicants are in groups that deliver more hours per year and deliver more healthcare value.

In Mecklenburg County there are two competing health systems. It is in the public interest for the Agency to make CON decisions that favor competitive balance between these systems. According to Table 6B of the draft 2019 SMFP, Atrium has 75 ORs and Novant has 64 ORs. Atrium also exercises control over the twelve ORs at Randolph and Charlotte Surgery Centers, for a total of 87. If the Agency gives Atrium five or six ORs and Novant Health none, Atrium will control 92 or 93 ORs, and Novant will control only 64 ORs, a 30% difference. If awarding an OR to CCSS prevents the Agency from approving the NHHMC application, the CCSS award would worsen the competitive balance and thus does not maximize healthcare value.

For all these reasons plus any additional reasons the Agency may discern as it reviews the CCSS application, the CCSS application is nonconforming with Criterion (1) and Policy GEN-3.

Equitable Geographic Access

The table below demonstrates the distribution of surgical facilities and ORs in Mecklenburg County subject to the 2019 SMFP need determination. The geographic classification follows the Agency's geographic classification in its findings on the 2017 acute care beds.[5]

Location of Adjusted Operating Room Planning Inventory in Mecklenburg County

Facility	2019 SMFP Adjusted OR Inventory	Location within Mecklenburg County	City/Town
Huntersville Surgery Center	1	North	Huntersville
Carolina Center for Specialty Surgery	2	Downtown	Charlotte
CMC Pineville	10	South	Pineville
CMC/CMC-Mercy	55	Downtown	Charlotte
CMC-University	7	East	Charlotte
Randolph Surgery Center	6	Downtown	Charlotte
Charlotte Surgery Center	6	Downtown	Charlotte
NH Mint Hill	4	East	Mint Hill
South Park Surgery Center	6	Downtown	Charlotte
NH Ballantyne OP Surgery	2	South	Charlotte (Ballantyne Area)

[4] Draft 2019 SMFP, p. 54
[5] 2017 Mecklenburg County Acute Care Beds Agency Findings, p 133

NH Huntersville OP Surgery	2	North	Huntersville
NH Matthews Surgery Center	2	South	Matthews
NH Presbyterian Medical Center/ NH Charlotte Orthopedic Hospital	36	Downtown	Charlotte
NH Matthews Medical Center	6	South	Matthews
NH Huntersville Medical Center	6	North	Huntersville

Source: 2019 SMFP Table 6B, Column L, Adjusted Planning Inventory. Excludes Mallard Creek Surgery Center, which is an ambulatory surgery demonstration project that is in the inventory but is not included in the need determination calculations.

Equitable access means, in part, that all sections of the county should be treated fairly. There are more ORs downtown and in the south than in the north. The 2019 SMFP applies the county population growth rate to all facilities. However, the population growth rate in the northern part of the county is higher than the county average and higher than the growth rate in downtown and in the southern part of the county as the table below shows[6].

Market/County	2017	2022	% change
North Market	321,218	353,870	10.17%
South Market	247,822	266,799	7.66%
Mecklenburg Co.	1,078,902	1,169,674	8.41%

Market/County	2018	2023	% change
North Market	328,723	360,563	9.69%
South Market	251,203	269,979	7.47%
Mecklenburg Co.	1,100,402	1,190,221	8.16%

Source: Novant Health Group Internal data

Adding another OR at CCSS does not maximize healthcare value by promoting equitable access for all residents of the county when a competing application would add an OR in the north.

Competitive Balance

In Mecklenburg County there are two competing health systems. It is in the public interest for the Agency to make CON decisions that favor competitive balance between these systems. According to Table 6B of the draft 2019 SMFP, Atrium has 75 ORs and Novant has 64 ORs. Atrium also exercises control over the twelve ORs at Randolph and Charlotte Surgery Centers, for a total of 87 ORs. If the Agency awards Atrium five or six ORs under the 2018 SMFP and Novant Health none, Atrium will control 92 or 93 ORs, and Novant will control only 64 ORs. This would allow Atrium

[6] North market includes zip codes: 28078, 28216, 28269, 28214, 28031, 28262. South market includes zip codes: 28227, 28105, 28277, 28270, 28226

to have 30 percent more operating rooms than Novant. If awarding an OR to CCSS prevents the Agency from approving the NHHMC application, the CCSS application worsens the competitive balance and thus does not maximize healthcare value.

There is a significant disparity in the number of ORs under the control of Novant Health as compared to Atrium Health. While ORs have been shifted between physical locations, there has been no change in control of the Adjusted Planning Inventory[7] in the past ten planning years. The table below demonstrates Atrium's market share advantage of ORs in Mecklenburg County.

Percent of Adjusted Operating Room Planning Inventory in Mecklenburg County

Health System and Facility	2010 SMFP	2019 SMFP
Atrium Health		
Huntersville Surgery Center	0	1
Carolina Center for Specialty Surgery	2	2
CMC Pineville/CMC-Mercy	25	10
CMC/CMC-Mercy	42	55
CMC-University	11	7
Randolph Surgery Center	0	6
Charlotte Surgery Center	7	6
Atrium Health Total Controlled	**87**	**87**
Atrium Health % Controlled	**58%**	**58%**
Novant Health		
NH Mint Hill	4	4
South Park Surgery Center	6	6
NH Ballantyne OP Surgery	2	2
NH Huntersville OP Surgery	2	2
NH Matthews Surgery Center	0	2
NH Presbyterian Medical Center/ NH Charlotte Orthopedic Hospital	38	36
NH Matthews Medical Center	8	6
NH Huntersville Medical Center	4	6
Novant Health Total	**64**	**64**
Novant Health % Controlled	**42%**	**42%**
Other		
Mallard Creek Surgery Center*	0	2

Source: 2019 SMFP Table 6B, Column L, Adjusted Planning Inventory. 2010 SMFP, Table 6A Adjusted Planning Inventory = [(IP + OP + Shared) - (C-section + Trauma/Burn) + (CON Adjustments)]"

[7] SMFP Definition: Sum of the operating rooms, CON adjustments, and exclusions (C-sections, Trauma, and Burn) for each facility.

**This is an ambulatory surgery demonstration project that is in the inventory but is not included in the need determination calculations.*

We respectfully submit that Agency decisions which improve the competitive balance between major health systems in the same market are generally in the public interest and maximize healthcare value. Decisions that worsen the competitive balance generally are not in the public interest and do not maximize healthcare value. Novant Health has made and is making substantial investments in facilities and practitioners to compete with Atrium to benefit the public. Approval of the NHHMC application will improve the competitive balance between health systems in Mecklenburg County. Denial of the NHHMC application will worsen the competitive balance in ORs.

For the foregoing reasons, plus any additional reasons the Agency may discern as it reviews the CCSS application, the CCSS application is nonconforming with Criterion (1) and Policy GEN-3 and should be disapproved.

Criterion (3)

Criterion (3): NCGS § 131E-183(a)(3) : The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed and the extent to which all residents of the service area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups likely to have access to the services proposed.

CCSS is nonconforming with Criterion 3 because it does not meet the OR Performance Standard. In Section Q, Form C, Assumptions and Methodology, CCSS lays out its assumptions for growth at CCSS on pages 3 and 4:

> In order to project future operating room cases at CCSS, it was assumed that baseline outpatient volume would grow 1.8 percent annually which is equivalent to ½ of the CY 2015 to 2018 CAGR. The table below provides projected CCSS operating room volume, prior to any shifts of volume, through 2023.
>
> **Projected CCSS Operating Room Utilization Prior to Shifts**

	CY18	*CY19*	*CY20*	*CY21*	*CY22*	*CY23*	*CAGR*
Outpatient Cases	1,975	2,010	2,046	2,082	2,119	2,157	1.8%

CCSS fails to break out actual historical growth by year which actually shows a decrease of 0.5% for 2016 cases and only a small increase of 0.7% for 2018 cases, with the growth coming from only one year, 2017 to 2018, as shown below.

CY15 - CY 16	CY16-CY17	CY17-CY18	4 Year CAGR 2015-2018
-0.5%	10.8%	0.7%	3.5%

CCSS gives no explanation for the one time increase in 2017 and no explanation for the assumption of 1.8% into the future.

CCSS then projects a shift of 225 cases from CMC to CCSS in the third year of the CCSS project (2023), which is approximately 65 percent of the cases it has identified as "potential" to shift. CCSS provides vague supporting text on its Assumptions and Methodology, page 3:

> *In consultation with its medical staff, CCSS administrators identified cases performed at CMC by its existing surgeons that could potentially be relocated to CCSS if the needed capacity were available as planned with the development of the proposed additional operating room. These cases were identified based on the surgical procedures performed, specific surgeons, and appropriateness for an ASC setting*.

CCSS's assumptions are unreasonable and unsupported. CCSS does not identify the surgical procedures or the specific surgeons that will be shifting surgeries, so it is impossible to determine the reasonableness of this shift as calculated by a "black box" methodology. It is also impossible to test the reasonableness of shifting 65 percent of these potentially relocated surgeries because there was no basis for the 65 percent shift.

Assuming CCSS achieves its 1.8% growth rate, which is questionable, without these additional procedures the result is a need for only 0.26 of an additional OR at CCSS in the third project year CY 2022, as shown in the table below. Pursuant to the Operating Room Need Methodology in the 2018 SMFP, the need at CCSS in CY2022 is zero additional ORs.

CCSS [1]	**CY18**	**CY19**	**CY20**	**CY21**	**CY22**	**CY23**
Historical/Projected Cases (1.8% CAGR)	1,975	2,005	2,035	2,065	2,096	2,128
Shift from CMC to CCSS						
Total	1,975	2,005	2,035	2,065	2,096	2,128
Case Time	85	85	85	85	85	85
Hours	2,798	2,840	2,882	2,926	2,970	3,014
Standard Operating Hours	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5	1,312.5
Need	2.1	2.2	2.2	2.2	2.3	2.3
Current ORs	2.0	2.0	2.0	2.0	2.0	2.0
Surplus (-) / Deficit (+)	0.13	0.16	0.20	0.23	0.26	0.30

[1] CMC Application Project I.D. #F-011620-18, Methodology and Assumptions, Page 3

Equitable Geographic Access

The CCSS application is also nonconforming with Criterion (3) because it does not provide equitable geographic access to all residents of the county. New ORs in ASCs should generally be

located in suburban areas of the county where population is growing and where traffic congestion is less. This table identifies the location of the existing and approved ORs in Mecklenburg County.

Location of Adjusted Operating Room Planning Inventory in Mecklenburg County

Facility	2019 SMFP Adjusted OR Inventory	Location within Mecklenburg County	City/Town
Huntersville Surgery Center	1	North	Huntersville
Carolina Center for Specialty Surgery	2	Downtown	Charlotte
CMC Pineville	10	South	Pineville
CMC/CMC-Mercy	55	Downtown	Charlotte
CMC-University	7	East	Charlotte
Randolph Surgery Center	6	Downtown	Charlotte
Charlotte Surgery Center	6	Downtown	Charlotte
NH Mint Hill	4	East	Mint Hill
South Park Surgery Center	6	Downtown	Charlotte
NH Ballantyne OP Surgery	2	South	Charlotte (Ballantyne Area)
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NH Matthews Surgery Center	2	South	Matthews
NH Presbyterian Medical Center/ NH Charlotte Orthopedic Hospital	36	Downtown	Charlotte
NH Matthews Medical Center	6	South	Matthews
NH Huntersville Medical Center	6	North	Huntersville

Source: 2019 SMFP Table 6B, Column L, Adjusted Planning Inventory. Excludes Mallard Creek Surgery Center, which is an ambulatory surgery demonstration project that is in the inventory but is not included in the need determination calculations.

This table identifies the proposed location of the ORs, and total number of ORs at each facility following project completion, for each application in this review cycle.

Location of Adjusted Operating Room Planning Inventory in Mecklenburg County

Facility	2019 SMFP Adjusted OR Inventory	Location within Mecklenburg County	City/Town
NH Huntersville Medical Center	1	North	Huntersville
Carolina Center for Specialty Surgery	1	Downtown	Charlotte
CMC	4	Downtown	Charlotte
CMC Pineville	1	South	Pineville

Metrolina	1	Downtown	Charlotte

Source: 2019 SMFP Table 6B, Column L, Adjusted Planning Inventory. Excludes Mallard Creek Surgery Center, which is an ambulatory surgery demonstration project that is in the inventory but is not included in the need determination calculations.

There are now 111 ORs downtown, 20 ORs in south Mecklenburg County and only 9 ORs in north Mecklenburg County. The NHHMC application would add an OR in the north. The CCSS and the CMC applications would add five ORs downtown. The NHHMC application does more to improve geographic access than the CCSS application.

Equitable access means, in part, that all sections of the county should be treated fairly. There are more ORs downtown and in the south than in the north. The SMFP applies the county population growth rate to all facilities. However, the population growth rate in the northern part of the county is higher than the county average and higher than the growth rate in downtown and in the southern part of the county as the table below shows[8].

Market/County	2017	2022	% change
North Market	321,218	353,870	10.17%
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Market/County	2018	2023	% change
North Market	328,723	360,563	9.69%
South Market	251,203	269,979	7.47%
Mecklenburg Co.	1,100,402	1,190,221	8.16%

Source: Novant Health Group Internal data

Adding another OR at CCSS does not maximize healthcare value by promoting equitable access for all residents of the county when a competing application would add an OR in the north.

For the foregoing reasons, plus any additional reasons the Agency may discern as it reviews the CCSS Application, the CCSS Application is nonconforming with Criterion (3) and should be disapproved.

Criterion (4)

Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

[8] North market includes zip codes: 28078, 28216, 28269, 28214, 28031, 28262. South market includes zip codes: 28227, 28105, 28277, 28270, 28226

As illustrated above in response to Criterion 3, the applicant overstates CCSS's need for incremental ORs in Mecklenburg County by using unreasonable and unsupported assumptions in projecting future utilization of ORs. As such, the alternative of Maintaining the Status Quo represents the least costly and most effective alternative. Using reasonable projections, CCSS does not have a need for additional ORs and has more than adequate surgical capacity to meet current and future demand for surgical services.

Criterion (5)

Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

As discussed under Criterion 3 above, the CCSS application's utilization methodology is based on unreasonable and unsupported assumptions because it overstates the expected growth rate in surgical cases and does not appropriately document the shift in volumes. The financial projections in the application are based on those unreliable utilization projections, and therefore, the application is not based on a reasonable projection of costs and charges and fails to demonstrate financial feasibility under Criterion 5.

Criterion (6)

The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Because CCSS's proposed utilization projections are unreliable and not supported as discussed above, the proposed project fails to demonstrate that it will not result in unnecessary duplication as required under Criterion 6.

Criterion (13)

"The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services;"

The CCSS application projects to serve a much smaller percentage of self-pay, Medicaid and charity patients than the Novant Health project. Consequently, the CCSS application does not adequately demonstrate that the medically underserved will be served by its proposed service. Therefore, the application is non-conforming to Criterion 13(c).

Criterion (18a)

Criterion (18a) NCGS § 131E-183(a)(18a): The applicant shall demonstrate that the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application for a services on which competition would not have a favorable impact.

The CCSS Application provided no substantive analysis of how its approval would affect competition and the competitive balance in Mecklenburg County. The absence of a reasonable analysis of the impact of the application on competition and the effect of more or less competition on the cost effectiveness, quality, and access to the services proposed make the application nonconforming with this criterion.

As discussed above, there are two competing health systems in Mecklenburg County. It is in the public interest for the Agency to make CON decisions that favor competitive balance between these systems. According to Table 6B of the draft 2019 SMFP, Atrium has 75 ORs and Novant has 64 ORs. Atrium also exercises control over the twelve ORs at Randolph and Charlotte Surgery Centers, for a total of 87 ORs. If the Agency awards Atrium five or six ORs under the 2018 SMFP and Novant Health none, Atrium will control 92 or 93 ORs, and Novant will control only 64 ORs. This would allow Atrium to have 30 percent more operating rooms than Novant. If awarding an OR to CCSS prevents the Agency from approving the NHHMC application, the CCSS application worsens the competitive imbalance and thus does not maximize healthcare value.

There is a significant disparity in the number of ORs under the control of Novant Health as compared to Atrium Health. As discussed above, while ORs have been shifted between physical locations, there has been no change in control of Adjusted Planning Inventory[9] in the past ten planning years. The table above demonstrates Atrium's market share advantage in ORs in Mecklenburg county. Awarding ORs to Atrium worsens the competitive imbalance and makes that application nonconforming with Criterion 18(a).

[9] SMFP Definition: Sum of the operating rooms, CON adjustments, and exclusions (C-sections, Trauma, and Burn) for each facility.

For the foregoing reasons, plus any additional reasons the Agency may discern as it reviews the CCSS application, the CCSS application is nonconforming with Criterion (18a) and should be disapproved.

Comparative Analysis

The most effective alternative is for the Agency to approve the NHHMC application and deny the CCSS application as nonconforming. This section of the comment identifies the factors that make the OR component of the NHHMC application superior to the Atrium applications for ORs.

Conformity with Review Criteria

NHHMC adequately demonstrates its application conforms to all applicable statutory and regulatory review criteria. However, CCSS did not adequately demonstrate that its proposal for an OR was conforming to Criteria (1), (3), (4), (5), (6), (13), and (18a). Therefore, the OR component of the NHHMC application is the more effective alternative with regard to conformity with review criteria.

Utilization Percentage

Data from the CCSS application show NHHMC has a greater need for an additional OR than CCSS based on projected percent utilization. Therefore, the NHHMC application should be approved and the CCSS application denied.

The CCSS application presents data showing NHHMC had the highest OR utilization percentage in 2017. CMC/Mercy raised the utilization percentage of its ORs by voluntarily transferring ORs to ASCs in which it owns less than 50%. Data from the CCSS application is reproduced in the table below.

*Facility**	*Total Cases*	*Total Surgical Hours*	*Standard OR Hours Total*	*Percent Utilization*
CMC/CMC-Mercy^	43,543	129,027	111,150	116%
Novant Health Presbyterian Medical Center	29,898	57,606	81,900	70%
SouthPark Surgery Center	10,788	8,810	7,872	112%
CHS Pineville	8,133	17,738	17,550	101%
Charlotte Surgery Center	7,908	9,226	9,184	100%
CHS University	7,383	9,731	16,500	59%
Novant Health Matthews Medical Center	5,597	9,317	9,000	104%
Novant Health Huntersville Medical Center	4,980	9,385	7,500	125%
Novant Health Huntersville Outpatient Surgery	2,385	2,147	2,624	82%
Novant Health Matthews Surgery Center	1,907	2,479	2,624	94%
Carolina Center for Specialty Surgery	1,880	2,663	2,624	101%
Novant Health Ballantyne Outpatient Surgery	923	1,231	2,624	47%
CHS Huntersville	0	0	0	0%
Randolph Surgery Center	0	0	0	0%

*Excludes demonstration projects.
^CMC-Mercy is licensed as part of CMC and its operating rooms are included as part of CMC in the *2018 SMFP*.

Source: CCSS application Project I.D. #F-011621-18, Page 33

Data in the CCSS application also show Huntersville will have a higher utilization percentage than CCSS after the approved OR at NHHMC begins service. Data from the CCSS Application is reproduced in the table below.

*Facility**	*Total Cases*	*Total Surgical Hours*	*Adjusted OR Hours Total*	*Adjusted Percent Utilization*
CMC/CMC-Mercy^	43,543	129,027	107,250	120%
Charlotte Surgery Center	7,908	9,226	7,872	117%
SouthPark Surgery Center	10,788	8,810	7,872	112%
Novant Health Matthews Medical Center	5,597	9,317	9,000	104%
Novant Health Huntersville Medical Center	4,980	9,385	9,000	104%
CHS Pineville	8,133	17,738	17,550	101%
Carolina Center for Specialty Surgery	1,880	2,663	2,624	101%
Novant Health Matthews Surgery Center	1,907	2,479	2,624	94%
CHS University	7,383	9,731	10,500	93%
Novant Health Presbyterian Medical Center	29,898	57,606	70,200	82%
Novant Health Huntersville Outpatient Surgery	2,385	2,147	2,624	82%
Novant Health Ballantyne Outpatient Surgery	923	1,231	2,624	47%
CHS Huntersville	0	0	1,313	0%
Randolph Surgery Center	0	0	7,872	0%

*Excludes demonstration projects.
^CMC-Mercy is licensed as part of CMC and its operating rooms are included as part of CMC in the *2018 SMFP*.

Source: CCSS Application Project I.D. #F-011621-18, Page 34

Competitive Balance in Mecklenburg County

We respectfully submit that Agency decisions which improve the competitive balance between major health systems in the same market are generally in the public interest and those that worsen the competitive balance generally are not. As discussed above, Novant Health has made and is making substantial investments in facilities and practitioners to compete with Atrium to benefit the public. Approval of the NHHMC application will improve the competitive balance between health systems in Mecklenburg County. Approval in whole or part of the Atrium applications will worsen the competitive balance.

In 2019, the total OR inventory in Mecklenburg County controlled by Atrium will be 87. The total Novant Health OR inventory in Mecklenburg County is 64[10]. There is a significant disparity in the number of ORs under the control of Novant Health as compared to Atrium Health.

While ORs have been shifted between physical locations, there has been no change in control of Adjusted Planning Inventory[11] in the past ten planning years. Since 2010, Novant has consistently

[10] Proposed 2019 State Medical Facilities Plan, Chapter 6, Table 6A: Operating Room Inventory
[11] SMFP Definition: Sum of the operating rooms, CON adjustments, and exclusions (C-sections, Trauma, and Burn) for each facility.

had 42 percent of the market share. This competitive imbalance will only worsen if the Agency approves the Atrium applications. The Agency should therefore approve the NHHMC application for one OR and deny the CCSS application as nonconforming. Improving competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high quality care and expanding patient choice.

Mecklenburg County is North Carolina's largest county by population. Mecklenburg County needs two strong systems to give patients a choice of where to receive their care, and payors are not forced to bow to the demands of Atrium Health. As has been widely reported in the national press, the United States Department of Justice Antitrust Division and the State of North Carolina sued Atrium Health in federal court in Charlotte in June 2016, alleging that Atrium Health's anti-steering clauses in its managed care contracts violated Section 1 of the Sherman Antitrust Act. This law prohibits contracts, combinations and conspiracies that unreasonably restrain trade. See 15 U.S.C. § 1. Atrium Health is alleged to have abused its dominance in the greater Charlotte area to force payors to keep patients within the Atrium Health system, rather than allowing payors to direct patients to lower cost, higher quality options, such as Novant Health.

After over two years of litigation, a proposed settlement was recently announced. The settlement agreement is attached as Exhibit A to this comment. Two class actions brought by consumers against Atrium Health are still pending. These class actions are based on the allegations of the USDOJ/State of North Carolina antitrust complaint. The complaints are attached as Exhibit B. Atrium has abused its market power in Mecklenburg County and the Greater Charlotte Area. The Agency should not increase that market power by way of its CON decisions. Awarding more beds to Atrium Health would undermine the proposed antitrust settlement by further increasing Atrium Health's market power. Novant Health respectfully urges the Agency not to undermine the work that the Attorney General of the State of North Carolina (DOJ) has undertaken to address Atrium Health's market power. The NHHMC application is the most effective alternative.

Access for Underserved Populations

CCSS does not provide equitable access to all patients needing procedures it performs. It provides essentially no charity care and little Medicaid care. This poor record of equitable access occurs because (1) almost all the surgical cases at CCSS are scheduled procedures so EMTALA does not apply and (2) the Neurospine physicians are in private practice and are not covered by Atrium charity care policies. They are free to decline referral of outpatients in need of their services and free to schedule any uninsured patients they do take at another facility.

The table below compares the payor mix for CCSS and NHHMC. An additional OR at NHHMC provides far greater access for uninsured and Medicaid patients than one at CCSS. Access to a surgical facility is meaningless without access to surgeons. NHHMC has surgeons on its medical staff employed by Novant Health Medical Group who adhere to the same charity care and financial assistance policies as NHHMC. Adding an OR at CCSS will do nothing to increase access to care

for underserved, uninsured or Medicaid patients. Adding an OR at NHMMC is a more effective alternative than adding one at CCSS.

Percent of Medicaid Patients - Operating Year 2		
Applicant	**% Medicaid Patients Total Facility**	**% Medicare Patients Total Facility**
NHHMC	7.70%	39.19%
CCSS	0.90%	28.20%

Source: Section L.3(a) (all applications)

Geographic Accessibility (Location within Mecklenburg County)

There are now 111 ORs downtown, 20 ORs in south Mecklenburg County and only 9 ORs in north Mecklenburg County. The NHHMC application would add an OR in the north. The CCSS and the CMC applications would add five ORs downtown. The NHHMC application does more to improve geographic access than the CCSS Application.

Facility	2019 SMFP Adjusted OR Inventory	Location within Mecklenburg County	City/Town
NH Huntersville Medical Center	1	North	Huntersville
Carolina Center for Specialty Surgery	1	Downtown	Charlotte
CMC	4	Downtown	Charlotte
CMC Pineville	1	South	Pineville
Metrolina	1	Downtown	Charlotte

"Source: 2019 SMFP Table 6B, Column L, Adjusted Planning Inventory. Excludes Mallard Creek Surgery Center, which is an ambulatory surgery demonstration project that is in the inventory but is not included in the need determination calculations.

Equitable access means, in part, that all sections of the county should be treated fairly. There are more ORs downtown and in the south than in the north. The SMFP applies the county population growth rate to all facilities. However, the population growth rate in the northern part of the county is higher than the county average and higher than the growth rate in downtown and in the southern part of the county as the table below shows[12].

[12] North market includes zip codes: 28078, 28216, 28269, 28214, 28031, 28262. South market includes zip codes: 28227, 28105, 28277, 28270, 28226

Market/County	2017	2022	% change
North Market	321,218	353,870	10.17%
South Market	247,822	266,799	7.66%
Mecklenburg Co.	1,078,902	1,169,674	8.41%

Market/County	2018	2023	% change
North Market	328,723	360,563	9.69%
South Market	251,203	269,979	7.47%
Mecklenburg Co.	1,100,402	1,190,221	8.16%

Source: Novant Health Group Internal data

Adding another OR at CCSS does not maximize healthcare value by promoting equitable access for all residents of the county when a competing application would add an OR in the north. The NHHMC application does more to promote equitable geographic access than the CCSS application.

Service to Mecklenburg County Residents

The 2018 SMFP defines the service area for operating rooms as the planning area in which the operating room is located. *"An operating room's service area is the operating room planning area in which the operating room is located. The operating room planning areas are the single and multicounty groupings shown in Figure 6.1."* Figure 6.1 the 2018 SMFP shows Mecklenburg County as a single county OR planning area. The service area for this review consists of Mecklenburg County. Facilities may also serve residents of counties not included in their service area. Generally, the application projecting to serve the highest percentage of Mecklenburg County residents is the more effective alternative with regard to this comparative factor. The table below shows the NHHMC application is more effective than the CCSS application on this factor.

Percent of Mecklenburg County Residents Operating Year 2

Rank	Applicant	% Mecklenburg County Residents
1	NHHMC	63.1%
2	CCSS	37%

Source: Section C.3(a) (all applications)

Conclusion

The CCSS Application for an additional OR should be denied because it is non-conforming with CON Review Criteria (1), (3), (4), (5), (6), (13), and (18a). In a comparative review with the OR

component of the NHHMC application, the NHHMC application should be approved before the CCSS application for all the reasons discussed above.

EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

UNITED STATES OF AMERICA and STATE OF NORTH CAROLINA, *Plaintiffs,* v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM, *Defendant*.	Case No. 3:16-cv-00311

JOINT STIPULATION AND ORDER
REGARDING THE PROPOSED FINAL JUDGMENT

Plaintiffs, United States of America and State of North Carolina, and Defendant, The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System (collectively, the "Parties"), by and through their attorneys, hereby stipulate, subject to approval and entry by the Court, as follows:

1. A proposed Final Judgment in the form attached hereto as Exhibit 1 may be filed and entered by the Court, upon the motion of any Party or upon the Court's own action, at any time after compliance with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16, ("APPA") and without further notice to any Party or other proceedings, provided that the United States has not withdrawn its consent, which it may do at any time before the entry

of the proposed Final Judgment by serving notice thereof on the Defendant and by filing the notice with the Court.

2. The Defendant agrees to arrange, at its expense, publication as quickly as possible of the newspaper notices required by the APPA, which shall be drafted by the United States in its sole discretion. The publication shall be arranged no later than three (3) business days after Defendant's receipt from the United States of the text of the notice and the identity of the newspapers within which the publication shall be made. The Defendant shall promptly send to the United States (1) confirmation that publication of the newspaper notices has been arranged, and (2) the certification of the publication prepared by the newspaper within which the notices were published.

3. The Defendant agrees to abide by and comply with the provisions of the proposed Final Judgment, pending the Court's entry of the proposed Final Judgment, or until expiration of time for all appeals of any Court ruling declining entry of the proposed Final Judgment, and agrees, from the date of the signing of this Stipulation, to comply with all terms and provisions of the proposed Final Judgment. The United States shall have the full rights and enforcement powers in the proposed Final Judgment as though the same were in full force and effect as a final order of this Court entering the proposed Final Judgment.

4. This Stipulation will apply with equal force and effect to any amended proposed Final Judgment agreed upon in writing by the Parties and submitted to the Court.

5. If (a) the United States has withdrawn its consent, as provided in Paragraph 1 above, or (b) the proposed Final Judgment is not entered pursuant to this Stipulation, the time has expired for all appeals of any Court ruling declining entry of the proposed Final Judgment, and the Court has not otherwise ordered continued compliance with the terms and provisions of the proposed

Final Judgment, then the Parties are released from all further obligations under this Stipulation, and the making of this Stipulation shall be without prejudice to any Party in this or any other proceeding.

6. The Defendant represents that the actions it is required to perform pursuant to the proposed Final Judgment can and will be performed, and that the Defendant will later raise no claim of mistake, hardship or difficulty of compliance as grounds for asking the Court to modify any of the provisions contained therein.

Dated: November 15, 2018

SO ORDERED:

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

SO STIPULATED:

FOR PLAINTIFF
UNITED STATES OF AMERICA:

/s/ John R. Read
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EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

UNITED STATES OF AMERICA and STATE OF NORTH CAROLINA, *Plaintiffs,* v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM, *Defendant*.	Case No. 3:16-cv-00311-RJC-DCK

[PROPOSED] FINAL JUDGMENT

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

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

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

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

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

I. JURISDICTION

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

II. DEFINITIONS

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

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

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

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

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

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

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

commissioner, officer, manager, agent, or employee is acting within the course of his or her duties for Atrium Health. MedCostLLC and MedCost Benefits Services LLC will remain excluded from the definition of "Defendant" as long as Atrium does not acquire any greater ownership interest in these entities than it has at the time that this Final Judgment is lodged with the Court.

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

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

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

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

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

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

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

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

O. "Tiered Network" means a network of Healthcare Providers for which (i) an Insurer divides the in-network Providers into different sub-groups based on objective price,

access, and/or quality criteria; and (ii) members receive different levels of benefits when they utilize Healthcare Services from Providers in different sub-groups.

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

III. APPLICABILITY

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

IV. PROHIBITED CONDUCT

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

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

1. express prohibitions on Steered Plans or Transparency;

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

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

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

V. PERMITTED CONDUCT

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

B. For any Co-Branded Plan or Narrow Network in which Defendant is the most-prominently featured Provider, Defendant may restrict steerage within that Co-Branded Plan or Narrow Network. For example, Defendant may restrict an Insurer from including at inception or

later adding other Providers to any (i) Narrow Network in which Defendant is the most-prominently featured Provider, or (ii) any Co-Branded Plan.

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

VI. REQUIRED CONDUCT

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

A. This Final Judgment has been entered (enclosing a copy of this Final Judgment) and that it prohibits Defendant from entering into or enforcing any contract term that would

prohibit, prevent, or penalize Steered Plans or Transparency, or taking any other action that violates this Final Judgment; and

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

VII. COMPLIANCE

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

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

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

3. within sixty (60) calendar days of entry of this Final Judgment, develop and implement procedures necessary to ensure Defendant's compliance with this Final Judgment. Such procedures shall ensure that questions from any of Defendant's commissioners, officers, or employees about this Final Judgment can be answered by counsel (which may be outside counsel) as the need arises. Paragraph 21.1 of the Amended Protective Order Regarding

Confidentiality shall not be interpreted to prohibit outside counsel from answering such questions.

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

1. access during Defendant's office hours to inspect and copy, or at the option of the United States, to require Defendant to provide electronic copies of all books, ledgers, accounts, records, data, and documents in the possession, custody, or control of Defendant, relating to any matters contained in this Final Judgment; and

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

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

Final Judgment, and (2) the compliance procedures adopted under Paragraph VII(A)(3) of this Final Judgment.

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

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

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

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

calendar days' notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding).

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

VIII. RETENTION OF JURISDICTION

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

IX. ENFORCEMENT OF FINAL JUDGMENT

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

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

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

X. EXPIRATION OF FINAL JUDGMENT

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

XI. PUBLIC INTEREST DETERMINATION

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

Date: _____

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

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

Exhibit A

Aetna

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

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

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

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

Blue Cross and Blue Shield of North Carolina

The Benefit Plan Exhibit to the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and Defendant (originally effective January 1, 2014), as replaced by the Fifth Amendment, states in part:

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

Cigna

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

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

Medcost

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

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

UnitedHealthcare

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

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

Exhibit B

Cigna

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

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

UnitedHealthcare

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

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

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

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

EXHIBIT B

FILED

STATE OF NORTH CAROLINA
COUNTY OF MECKLENBURG

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
16 CVS 16404

Christopher DiCesare, individually and on behalf of all others similarly situated,

Plaintiff,

-v-

The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System,

Defendant.

COMPLAINT

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Plaintiff Christopher DiCesare, individually and on behalf of a class of similarly situated individuals, hereby states and alleges the following against Defendant Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System ("Carolinas HealthCare").

I. INTRODUCTION

1. Carolinas HealthCare is the dominant hospital system in the Charlotte area, with yearly revenues exceeding $9 billion. Carolinas HealthCare is the nation's second largest supposedly "public" hospital system. Though Carolinas HealthCare purports to be a nonprofit working in the public interest, Carolinas HealthCare in fact operates in its own interest, leveraging its market power to maximize revenues at the expense of its patients. Carolinas HealthCare generates average annual profits of over $300 million, manages $2 billion in investments, and owns over $1 billion in property. Carolinas HealthCare has expanded aggressively, growing by 50 percent since 2011. After acquiring new practices, Carolinas HealthCare immediately increases the billing rates for the same services those practices offered before. These price increases are often devastating for families struggling to pay for life-saving healthcare. For instance, Carolinas HealthCare overcharges for cancer drugs and refuses to pass along savings from government discount programs to its patients. Last year, the Levine Cancer Institute (owned by Carolinas HealthCare), collected nearly $4,500 per dose of irinotecan, a drug used in the treatment of colon or rectal cancer. The average sales price of that drug was less than $60. Meanwhile, Carolinas HealthCare increased the pay for its CEO (Michael Tarwater) by 26 percent over the previous year, to $6.6 million. Last year, the top 10 executives at Carolinas HealthCare received over $1 million in compensation each.

2. Healthcare costs in the United States are the highest in the world, and increase every year. Spending on healthcare in the United States exceeds $3 trillion per year. Healthcare

costs in the Charlotte area—home to approximately 2.6 million people—are often significantly higher than the national average.

3. This class action challenges a powerful and unlawful tool Carolinas HealthCare uses to charge supracompetitive prices, and to insulate itself from competition that would force prices down. That tool is the use of "anti-steering" provisions, placed in contracts between Carolinas HealthCare and major commercial health insurers. These anti-steering provisions forbid health insurers from offering patients information and financial incentives to use lower cost healthcare services from Carolinas HealthCare's rivals. By design, these "anti-steering" provisions reduced competition and harmed Mr. DiCesare and the class he seeks to represent, increasing health care costs and insurance premiums unlawfully.

4. Carolinas HealthCare's misconduct violates North Carolina law. Mr. DiCesare seeks injunctive relief and damages for violations of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1, 75-1.1, 75-2, and 75-2.1.

II. JURISDICTION AND VENUE

5. Jurisdiction and venue are appropriate in Mecklenburg County, North Carolina, pursuant to Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1, 75-1.1, 75-2, and 75-2.1.

6. This Court has subject matter jurisdiction over the claims asserted under North Carolina General Statute § 7A-240.

7. Defendant Carolinas HealthCare is subject to the jurisdiction of this Court under North Carolina General Statute §§ 1-75.3 and 1-75.4 as it is a domestic corporation domiciled within this state, is engaged in substantial activity in North Carolina, and the claimed injuries arise out of its actions that occurred and are occurring within North Carolina.

III. THE PARTIES

8. Plaintiff Christopher DiCesare is a citizen and resident of the State of North Carolina. Mr. DiCesare resides and works in Mecklenburg County. Beginning before 2013 and continuing to the present, Mr. DiCesare has been covered by a PPO health insurance plan offered by Cigna Healthcare of North Carolina, Inc. Mr. DiCesare paid, and continues to pay, premiums to Cigna, and has received medical care from Carolinas HealthCare.

9. Defendant Carolinas HealthCare System is a North Carolina corporation providing healthcare services with its principal place of business in Charlotte. It conducts business primarily through its Carolinas Medical Center, a large general acute-care hospital located in downtown Charlotte. It also operates nine other general acute-care hospitals in the Charlotte area.

IV. CLASS ACTION ALLEGATIONS

10. Mr. DiCesare brings this action on behalf of himself and all others similarly situated (the "Proposed Class"), pursuant to Rule 23 of the North Carolina Rules of Civil Procedure. The Proposed Class is defined as follows:

> All residents and citizens of North Carolina who, from January 1, 2013 to the present, paid premiums to Aetna Health of the Carolinas, Inc., Blue Cross Blue Shield of North Carolina, Cigna Healthcare of North Carolina, Inc., or United Healthcare of North Carolina, Inc., in exchange for coverage under a non-HMO group health insurance plan covering 51 or more persons that included any Carolinas HealthCare System provider in its network. The class includes both natural persons and legal entities who otherwise meet its criteria. Excluded from the Proposed Class are: Carolinas HealthCare, its employees, and any and all judges, justices, and chambers' staff assigned to hear or adjudicate any aspect of this litigation.

11. Based upon the nature of the trade and commerce involved, there are (at least) hundreds of thousands of Proposed Class members. Joinder of all members of the Class therefore is not practicable.

12. The questions of law and fact common to the Proposed Class include but are not limited to:

a. whether Carolinas HealthCare's misconduct violates North Carolina law;

b. whether Carolinas HealthCare has fraudulently concealed its misconduct;

c. whether Carolinas HealthCare, through the misconduct alleged herein, restrained trade, commerce, or competition in the relevant market for general acute care inpatient hospital services in the Charlotte area;

d. whether Mr. DiCesare and the Proposed Class he seeks to represent have suffered antitrust injury and/or have been threatened with antitrust injury;

e. the difference between the premiums Mr. DiCesare and the Proposed Class in fact paid for coverage under a non-HMO group health insurance plan, and the premiums Mr. DiCesare and the Proposed Class would have paid for coverage in the absence of the unlawful acts, contracts, and combinations alleged herein; and

f. the type and measure of damages suffered by Mr. DiCesare and the Proposed Class.

13. These and other questions of law and fact are common to the Proposed Class, and predominate over any questions affecting only individual members of the Proposed Class.

14. Mr. DiCesare's claims are typical of the claims of the Proposed Class.

15. Mr. DiCesare will fairly and adequately represent the interests of the Proposed Class and he has no conflict with the interests of the Proposed Class.

16. Carolinas HealthCare has acted on grounds generally applicable to the Proposed Class, thereby making final injunctive relief appropriate with respect to the Proposed Class as a whole.

17. This class action is superior to the alternatives, if any, for the fair and efficient adjudication of this controversy. There will be no material difficulty in the management of this action as a class action. Prosecution as a class action will eliminate the possibility of repetitive, duplicative, and potentially inconsistent litigation that would waste the resources of the parties and the courts.

V. FACTUAL ALLEGATIONS

A. The Relevant Market For General Acute Care Inpatient Hospital Services In The Charlotte Area

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

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

20. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other, insurers typically contract for the various individual acute inpatient hospital services together, and Carolinas HealthCare's steering restrictions have an adverse impact on the sale of all acute inpatient hospital services. Therefore, acute inpatient hospital services are properly grouped together.

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

22. A relevant geographic market is the Charlotte Combined Statistical Area, as defined by the U.S. Office of Management and Budget, which consists of Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina, and Chester, Lancaster, and York counties in South Carolina. The Charlotte area has a population of about 2.6 million people.

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

24. Acute inpatient hospital services outside the Charlotte area do not reasonably substitute for such services in the Charlotte are; consequently, competition from providers located outside the Charlotte area would not prevent a hypothetical monopolist provider of acute inpatient hospital services located in Charlotte from profitably imposing small but significant price increases over a sustained period of time.

25. There are significant barriers to entry or expansion in the relevant market. Building facilities capable of competing with Carolinas HealthCare would require large capital costs, acquisition of hospital-size building sites, years to complete adequate physical facilities, the hiring of relevant employees with a broad range of skills, training, and certifications, and overcoming regulatory and licensing hurdles.

26. Accordingly, a relevant market in this action is general acute care inpatient hospital services in the Charlotte area.

B. Carolinas HealthCare Has Long Enjoyed Market Power And Has Charged "Premium To Market" Reimbursement Rates

27. Carolinas HealthCare is the dominant hospital system in the Charlotte area, with approximately a 50 percent share of the relevant market, and annual revenues of approximately $9 billion. From 2011 to 2015, Carolinas HealthCare increased its number of care locations by over 50%, from around 600 to over 900, largely by acquisitions. Thereafter, Carolinas HealthCare leveraged its market power to immediately increase the billing rates for the same services provided by those facilities. Its closest competitor by size is Novant, which owns five general acute care hospitals in the Charlotte area and has less than half of Carolinas HealthCare's revenue. After Novant, the next-largest hospital in the Charlotte area is CaroMont Regional Medical Center, which has less than one tenth of Carolinas HealthCare's revenue.

28. Carolinas HealthCare exerts market power in its dealings with health insurers. Carolinas HealthCare's market power results from its large size, the comprehensive range of healthcare services that it offers, its high market share, and insurers' need to include access to Carolinas HealthCare's hospitals—as well as its other facilities and providers—in at least some of their provider networks in insurance plans that cover people in the Charlotte area. From an insurer's perspective, the ubiquity and scale of Carolinas HealthCare means that smaller

providers such as Novant and CaroMont are not reasonable substitutes for access to Carolinas HealthCare's facilities. Carolinas HealthCare's market power is further evidenced by its ability to profitably charge prices to insurers that are higher than competitive levels across a range of services, and to impose on insurers restrictions that reduce competition.

29. Carolinas HealthCare's market power has enabled it to negotiate high prices (in the form of high "reimbursement rates") for treating insured patients. Carolinas HealthCare has long had a reputation for being a high-priced healthcare provider. In a 2013 presentation, Carolinas HealthCare's internal strategy group bragged that Carolinas HealthCare "has enjoyed years of annual reimbursement rate increases that are premium to the market, with those increases being applied to rates that are also premium to the market." For instance, a major health insurer reports that Carolinas HealthCare demands reimbursement rates that are up to 150 percent more than other hospitals in the Charlotte area for providing the same services.

C. Insurers Sought To Increase Competition And Lower Reimbursement Rates By Providing Financial Incentives To Patients To Use Lower Cost Healthcare Services

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

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

32. Steering—and the competition from lower-priced healthcare providers that steering animates—threatened Carolinas HealthCare's high prices and revenues. In 2013, Carolinas HealthCare's internal strategy group surveyed a dozen of Carolinas HealthCare's senior leaders, asking them to list the "biggest risks to [Carolinas HealthCare] revenue streams." Nine of the twelve leaders polled identified the steering of patients away from Carolinas HealthCare as one of the biggest risks to Carolinas HealthCare's revenues.

D. Carolinas HealthCare Eliminated The Competitive Threat By Imposing Anti-Steering Provisions, Increasing Reimbursement Rates, Healthcare Costs, And Insurance Premiums

33. To protect itself against steering that would induce price competition and potentially require Carolinas HealthCare to lower its high prices, Carolinas HealthCare imposed steering restrictions in its contracts with insurers, beginning in approximately 2013. These restrictions impeded, and continue to impede, insurers from providing information and financial incentives to patients to encourage them to use lower-cost but comparable or higher-quality alternative healthcare providers.

34. Tiered networks are a popular type of steering that insurers use in healthcare markets. Typically, insurers using tiered networks place healthcare providers that offer better value healthcare services (lower cost, higher quality) in top tiers. Patients who use top-tier providers pay lower out-of-pocket costs. For example, for a given hypothetical procedure, a patient might be responsible for paying $25,000 in coinsurance at a lower-tier hospital, but only $4,500 in coinsurance to have the same procedure performed at a top-tier hospital, which provides the same procedure at a lower total cost to the insurer and the patient.

35. Narrow-network insurance plans are another popular steering tool. Typically, narrow networks consist of a subset of all the healthcare providers that participate in an insurer's conventional network. A consumer who chooses a narrow-network insurance plan typically pays

lower premiums, and lower out-of-pocket expenses than a conventional broad-network insurance plan, as long as the consumer is willing to choose from the smaller network of providers for his or her healthcare needs.

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

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

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

39. Carolinas HealthCare also imposes restrictions in its contracts with insurers that impede insurers from providing truthful information to consumers about the value (cost and quality) of Carolinas HealthCare's healthcare services compared to Carolinas HealthCare's

competitors. Carolinas HealthCare's restrictions on insurers' price and quality transparency are an indirect restriction on steering, because they prevent patients from accessing information that would allow them to make healthcare choices based on available price and quality information.

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

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

42. Carolinas HealthCare maintains and enforces steering restrictions in its contracts with all four of these insurers. In some instances, the contract language prohibits steering outright. For example, Carolinas HealthCare secured a contractual obligation from one insurer that it "shall not directly or indirectly steer business away from" Carolinas HealthCare. In other instances, the contract language gives Carolinas HealthCare the right to terminate its agreement with the insurer if the insurer engages in steering, providing Carolinas HealthCare the ability to deny the insurer and its enrollees access to its dominant hospital system unless the steering ends. Although the contractual language that Carolinas HealthCare has imposed varies with each insurer, it consistently creates disincentives that deter insurers from providing to their enrollees

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

RAYMOND BENITEZ, individually and on behalf of all others similarly situated, *Plaintiff,* v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY, d/b/a CAROLINAS HEALTHCARE SYSTEM, ATRIUM HEALTH, *Defendant.*	Case No. **COMPLAINT** **CLASS ACTION** **JURY TRIAL DEMANDED**

Plaintiff Raymond Benitez, individually, and on behalf of all others similarly situated, for his complaint against Defendant Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System, Atrium Health ("CHS"), states as follows:

NATURE OF THE ACTION

1. This is an action for restraint of trade seeking classwide damages and injunctive relief under Section One of the Sherman Act and Sections 4 and 16 of the Clayton Act.

2. This matter arises from CHS's abuse of its market dominance through the imposition of unlawful contract restrictions that prohibit commercial health insurers from offering inpatients financial benefits to use less-expensive health care services offered by CHS's competitors. This unlawful restraint of trade is the subject of a separate injunctive action by the United States of America and the State of North Carolina. This related action seeks a remedy for consumers who, as a result of CHS's unlawful conduct, have been forced to pay CHS above-

competitive prices for inpatient services through co-insurance payments and other direct payments.

THE PARTIES

3. Plaintiff Raymond Benitez resides in Charlotte, North Carolina in Mecklenburg County. Between July 4, 2016 and July 10, 2016 he utilized CHS general acute care inpatient hospital services for seven overnight stays. He was insured by Blue Cross Blue Shield of North Carolina and under his policy made a co-insurance payment directly to CHS of $3,440.36.

4. CHS is a North Carolina not-for-profit corporation providing healthcare services with its principal place of business in Charlotte. Its flagship facility is Carolinas Medical Center, a large general acute-care hospital located in downtown Charlotte. It also operates nine other general acute-care hospitals in the Charlotte area. It has done business until recently as Carolinas HealthCare System and now does business as Atrium Health.

JURISDICTION, VENUE, AND INTERSTATE COMMERCE

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

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

7. Venue is proper under 28 U.S.C. § 1391 and Section 1 of the Clayton Act, 15 U.S.C. § 22. CHS transacts business and resides in this District, and the events giving rise to the claims occurred in this District.

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

FACTUAL ALLEGATIONS

I. Background

9. CHS is the second largest public health system in the United States. It has what CHS calls 12 million patient "encounters" each year, or "one every three seconds" in the Charlotte area. Many of these involve hospital admissions. More than 50% of all Charlotte inpatient revenues are paid to CHS. Its largest competitor has less than half of CHS's revenues.

10. As this Court has pointed out, the complex world of healthcare is perplexing for consumers and "… [these complexities] present difficulties, frequently to consumers who become limited by who can provide their healthcare and how much it will cost." The free market is the greatest force for efficient, cost-based pricing, and innovation in human history. Just as democracy can thrive only in a free political system unhindered by outside forces, market efficiency and capitalism can survive only if market power is kept in check. Thus, it is imperative to ensure full and fair competition in healthcare markets. Only this keeps the healthcare pricing facing insurance and inpatient consumers at competitive levels and preserves competitive choice. This is the goal of both public and private enforcement of the antitrust laws.

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

premium to the market, with those increases being applied to rates that are also premium to the market."

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

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

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

15. The United States of America and the State of North Carolina seek to enjoin CHS from using unlawful contract steering restrictions that prohibit commercial health insurers in the Charlotte area from offering inpatients financial benefits to use less-expensive healthcare services offered by CHS's competitors. These steering restrictions reduce competition resulting in pricing injury to Charlotte area consumers. This related action seeks remedy for the overcharge damages of inpatients paying CHS directly for inpatient services through co-insurance payments or otherwise.

16. Section 5 of the Clayton Act, 15 U.S.C. § 16(a), accords preclusive or prima facie effect in a private damage action to civil and criminal judgments obtained by the United States Department of Justice. This encourages private damage actions relying, in part, on government prosecutions. Thus, public enforcement by the United States Department of Justice, which typically pursues only the most flagrant violations of the antitrust laws, is supplemented by private enforcement enlarging penalties for such violations and deterring future misconduct.

17. Plaintiff relies, in part, on the United States' and the State of North Carolina's thorough assessments of the CHS restraint of trade and their conclusions as to what constitutes the public interest. Plaintiff does not seek consolidation with the government action. However, Plaintiff is prepared to proceed with coordination of discovery should the Court deem that appropriate.

II. Relevant Market

18. The sale of general acute care inpatient hospital services to insurers ("acute inpatient hospital services") is a relevant product market. The market includes sales of such services to insurers' individual, group, fully-insured, and self-funded health plans, as well as to inpatients directly compensating CHS through coinsurance or otherwise.

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

20. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other (e.g., obstetrics is

not a substitute for cardiac services), insurers typically contract for the various individual acute inpatient hospital services as a bundle, and CHS's steering restrictions have an adverse impact on the sale of all acute inpatient hospital services. Therefore, acute inpatient hospital services can be aggregated for analytical convenience.

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

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

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

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

III. Market Power

25. CHS – with more than 50% of all Charlotte inpatient revenues – exerts market power in its dealings with commercial health insurers ("insurers"). CHS's market power results from its large size, the comprehensive range of healthcare services that it offers, its high market share, and insurers' need to include access to CHS's hospitals – as well as its other facilities and providers – in at least some of their provider networks in insurance plans that cover people in the Charlotte area. CHS's market power is further evidenced by its ability to profitably charge prices to insurers and inpatients that are higher than competitive levels across a range of services, and to impose on insurers restrictions that reduce competition.

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

27. Insurers want to steer inpatient enrollees towards lower-cost providers and to offer innovative insurance plans that steer. For years, insurers have tried to negotiate the removal

of steering restrictions from their contracts with CHS, but cannot because of CHS's market power. In the absence of the steering restrictions, insurers would likely steer consumers to lower-cost providers more than their current contracts with CHS presently permit.

IV. Anti-Steering Conduct Restraining Trade

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

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

30. Narrow-network insurance plans are another popular steering tool. Typically, narrow networks consist of a subset of all the healthcare providers that participate in an insurer's conventional network. A consumer who chooses a narrow-network insurance plan typically pays lower premiums and lower out-of-pocket expenses than a conventional broad-network insurance

plan as long as the consumer is willing to choose from the smaller network of providers for his or her healthcare needs.

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

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

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

34. CHS also imposes restrictions in its contracts with insurers that impede insurers from providing truthful information to consumers about the value (cost and quality) of CHS's healthcare services compared to CHS's competitors. CHS's restrictions on insurers' price and quality transparency are an indirect restriction on steering because they prevent inpatients from

accessing information that would allow them to make healthcare choices based on available price and quality information.

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

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

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

V. Antitrust Injury

38. As a result of this reduced competition due to CHS's steering restrictions, inpatients and employers in the Charlotte area pay higher prices for health insurance coverage, have fewer insurance plans from which to choose, and are denied access to consumer comparison shopping and other cost-saving innovative and more efficient health plans that would be possible if insurers could steer freely.

39. Insurance companies are not the sole source of non-government reimbursement inpatient revenues to CHS. CHS also receives payments directly from Charlotte area inpatient consumers in the form of "co-insurance" payments and other direct payments for expenses not covered by insurance. A co-insurance payment is the percentage of the bill for inpatient medical services paid directly by the insured inpatient consumer, with the rest paid by the insurance company.

40. As a direct result of CHS's anti-competitive conduct, inpatient consumers are forced to pay above-competitive prices for co-insurance and other direct payments to CHS.

CLASS ALLEGATIONS

A. Fed. R. Civ. P. 23(a) Prerequisites

41. Plaintiff ("Class Representative") is a representative of persons residing in the Charlotte Combined Statistical Area making direct payments for general acute care inpatient procedures to the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System and Atrium Health ("CHS") on or after February 28, 2014. Such persons include inpatients making direct co-insurance payments to CHS as a result of their health plan deductibles or otherwise; or, if no health insurance covers a procedure, direct payments to CHS for all or part of the procedure's costs. Excluded from the class are (a) direct inpatient payments to CHS which are set at a fixed amounts by insurance plan or otherwise regardless of the cost of the CHS

procedure; and (b) the Presiding Judge, employees of this Court, and any appellate judges exercising jurisdiction over these claims as well as employees of that appellate court.

42. Prosecution of the claims of the Class as a class action is appropriate because the prerequisites of Rule 23(a) of the Federal Rules of Civil Procedure are met:

(a) The number of persons in the Class is in the thousands, and the members of the Class are therefore so numerous that joinder of all members of the Class is impracticable. Joinder also is impracticable because of the geographic diversity of the members of the Class, the need to expedite judicial relief, and the Class Representative's lack of knowledge of the identity and addresses of all members of the Class.

(b) There are numerous questions of law and fact arising from the pattern of conspirators' restraint of trade which are common to the members of the Class. These include, but are not limited to, common issues as to (1) whether the Defendant has engaged in restraint of trade; and (2) whether this conduct, taken as a whole, has materially caused antitrust price injury to be inflicted on members of the Class. In addition, there are common issues as to the nature and extent of the injunctive and monetary relief available to the members of the Class.

43. The claims of the Class Representative are typical of the claims of the members of the Class and fairly encompass the claims of the members of the Class. The Class Representative and the members of the Class are similarly or identically harmed by the same systematic and pervasive concerted action.

44. The Class Representative and the Representative's counsel will fairly and adequately protect the interests of the members of the Class. There are no material conflicts between the claims of each Class Representative and the members of the Class that would make

class certification inappropriate. Counsel for the Class will vigorously assert the claims of the Class Representative and the other members of the Class.

B. Federal Rule of Civil Procedure 23(b)(3) Prerequisites

45. In addition, the prosecution of the claims of the Class as a class action pursuant to Rule 23(b)(3) is appropriate because:

(a) Questions of law or fact common to the members of the Class predominate over any questions affecting only its individual members; and

(b) A class action is superior to other methods for the fair and efficient resolution of the controversy.

C. Federal Rule of Civil Procedure 23(b)(2) Prerequisites

46. The prosecution of the claims of the Class as a class action pursuant to Rule 23(b)(2) is appropriate because the conspirators have acted, or refused to act, on grounds generally applicable to the Class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the Class as a whole.

CHS'S VIOLATION OF SECTION 1 OF THE SHERMAN ACT

47. Plaintiffs incorporate paragraphs 1 through 46 of this Complaint.

48. CHS has market power in the sale of general acute care inpatient hospital services in the Charlotte area.

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

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

(a) Depriving insurers and their enrolled inpatients of the benefits of a competitive market and competitive pricing for their purchase of acute inpatient hospital services;

(b) Protecting CHS's market power and enabling CHS to maintain at supracompetitive levels the prices for acute inpatient hospital services;

(c) Substantially lessening competition among providers in their sale of acute inpatient hospital services;

(d) Restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services; and

(e) Reducing consumers' incentives to seek acute inpatient hospital services from more cost-effective providers.

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

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

53. Inpatient consumers and their insurers have paid above-competitive pricing directly to CHS materially caused by the restraint of trade.

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

PRAYER FOR RELIEF

WHEREFORE, Plaintiff individually and as a member of the proposed Class alleged prays that:

A. This Court declare that CHS's conduct constitutes a violation of the Sherman Act, 15 U.S.C. § 1, allowing treble damage relief to the proposed Class under Section 4 of the Clayton Act, 15 U.S.C. § 15;

B. This Court permanently enjoin Defendant from continuing the conspiracy and unlawful actions described herein under Section 16 of the Clayton Act, 15 U.S.C. § 26;

C. Plaintiff recover reasonable attorneys' fees and costs as allowed by law;

D. Plaintiff recover pre-judgment and post-judgment interest at the highest rate allowed by law; and

E. Plaintiff be granted such other and further relief as the Court deems just and equitable.

JURY DEMAND

Plaintiff demands a trial by jury.

February 28, 2018

Respectfully submitted,

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truthful information about their healthcare options and the benefits of price and quality competition among healthcare providers that the insurers could offer if they had full freedom to steer.

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

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

45. As a result of this reduced competition due to Carolinas HealthCare's steering restrictions, individuals and employers such as Mr. DiCesare in the Charlotte area pay higher prices for health insurance coverage, have fewer insurance plans from which to choose, and are denied access to consumer comparison shopping and other cost-saving innovative and more

efficient health plans that would be possible if insurers could steer freely. Deprived of the option to benefit from choosing more cost-efficient providers, Charlotte area patients also incur higher out-of-pocket costs for their healthcare.

E. The United States Department of Justice and the Attorney General of North Carolina Filed Suit To Stop Carolinas HealthCare From Imposing "Anti-Steering" Requirements On Commercial Health Insurers

46. On June 9, 2016, the United States Department of Justice ("DOJ") and the Attorney General of North Carolina ("AG") filed suit against Carolinas HealthCare in United States District Court for the Western District of North Carolina. The DOJ and AG complaint alleges substantially the same misconduct as that alleged by Mr. DiCesare here.

47. The DOJ and AG complaint indicates that the DOJ and AG took testimony of relevant witnesses. For instance, the DOJ and AG complaint states that, when asked under oath whether Carolinas HealthCare should limit the ability of insurers to offer tiered networks or narrow networks that exclude Carolinas HealthCare, Carol Lovin, Carolinas HealthCare's Chief Strategy Officer, said that Carolinas HealthCare should not. And when asked her view about the possibility of eliminating Carolinas HealthCare's steering restrictions, she testified, "Would I personally be okay with getting rid of them? Yes, I would." The DOJ and AG allege that this testimony confirms that Carolinas HealthCare's misconduct has no justification.

VI. FIRST CLAIM FOR RELIEF: CONTRACT, COMBINATION, OR CONSPIRACY IN RESTRAINT OF TRADE

48. Mr. DiCesare on behalf of himself and all others similarly situated, realleges and incorporates herein by reference each of the allegations contained in the preceding paragraphs of this Complaint, and further alleges against Carolinas HealthCare as follows.

49. Carolinas HealthCare has and likely will continue to negotiate and enforce contracts containing steering restrictions with insurers in the Charlotte area. The contracts

containing the steering restrictions are contracts, combinations, and conspiracies within the meaning of North Carolina General Statutes §§ 75-1 and 75-2.

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

a. protecting Carolinas HealthCare's market power and enabling Carolinas HealthCare to charge supracompetitive prices for acute inpatient hospital services;

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

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

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

e. depriving consumers of information about better and less costly health care alternatives; and

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

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

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

53. The challenged steering restrictions unreasonably restrain trade in violation of North Carolina General Statutes §§ 75-1 and 75-2.

VII. SECOND CLAIM FOR RELIEF: MONOPOLIZATION

54. Mr. DiCesare on behalf of himself and all others similarly situated, realleges and incorporates herein by reference each of the allegations contained in the preceding paragraphs of this Complaint, and further alleges against Carolinas HealthCare as follows.

55. Carolinas HealthCare has monopolized, and continues to monopolize, the relevant market alleged herein in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1.1, 75-2, and 75-2.1.

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

a. protecting Carolinas HealthCare's market power and enabling Carolinas HealthCare to charge supracompetitive prices for acute inpatient hospital services;

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

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

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

e. depriving consumers of information about better and less costly health care alternatives; and

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

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

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

59. The challenged steering restrictions unreasonably restrain trade in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1.1, 75-2, and 75-2.1.

PRAYER FOR RELIEF

WHEREFORE, Mr. DiCesare prays that this Court enter judgment on his behalf and that of the Proposed Class by adjudging and decreeing that:

A. This Court certify the Proposed Class and that Mr. DiCesare and the Proposed Class have trial by jury;

B. Carolinas HealthCare has engaged in a trust, contract, combination, or conspiracy in violation of North Carolina General States §§ 75-1 and 75-2, and that Mr. DiCesare and the members of the Proposed Class have been damaged and injured in their business and property as a result of this violation;

C. Carolinas HealthCare has monopolized, and continues to monopolize, the relevant market alleged herein in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes §§ 75-1.1, 75-2, and 75-2.1, and that Mr. DiCesare and the members of the Proposed Class have been damaged and injured in their business and property as a result of this violation;

D. Mr. DiCesare and the members of the Proposed Class he represents recover threefold the damages determined to have been sustained by them as a result of Carolinas HealthCare's misconduct, complained of herein, and that judgment be entered against Carolinas HealthCare for the amount so determined;

E. Judgment be entered against Carolinas HealthCare and in favor of Mr. DiCesare and each member of the Proposed Class he represents, for restitution and disgorgement of ill-gotten gains as allowed by law and equity as determined to have been sustained by them, together with the costs of suit, including reasonable attorneys' fees;

F. For prejudgment and post-judgment interest;

G. For injunctive relief, declaring Carolinas HealthCare's misconduct unlawful and enjoining Carolinas HealthCare, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts an insurer from engaging, or attempting to engage, in steering towards any healthcare provider, and enjoining

Carolinas HealthCare from retaliating, or threatening to retaliate, against any insurer for engaging or attempting to engage in steering; and

H. For equitable relief, including a judicial determination of the rights and responsibilities of the parties; and

K. For such other and further relief as the Court may deem just and proper.

Dated: September 9, 2016

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