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Anne Marie Helm

University of California Hastings College of the Law, helm@uchastings.edu

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OPTIMIZING PRIVATE ANTITRUST ENFORCEMENT IN HEALTH CARE

ANNE MARIE HELM*

ABSTRACT

Americans are paying too much for health care services and insurance, in large part due to insufficiently competitive markets. Waves of consolidation have fortified providers and insurers with market power, resulting in higher prices and lower quality for consumers. As antidotes, advocates have proposed various legislative, regulatory, and enforcement solutions. Yet, unlike public antitrust enforcement, private antitrust enforcement is either not mentioned or criticized as sour grapes from competitors or a money grab by consumers. Instead of ignoring or bashing private litigation, those looking to address the health care pricing crisis in the United States should be looking to optimize it. Effective private enforcement can restore competition, deter antitrust violations, and compensate victims in the markets for health care services and insurance. For plaintiffs, the key to optimizing private antitrust enforcement is overcoming the unavoidable challenges in litigating these cases—from satisfying pleading standards and establishing standing, to defining relevant markets. This article explains the key obstacles involved in these cases and tracks recent and current plaintiffs whose experiences provide insight.

* Chief of Staff to the Chancellor & Dean, University of California, Hastings College of the Law; Co-founder, The Source on Healthcare Price and Competition (sourceonhealthcare.org). Many thanks to Jaime King, Tim Greaney, Josh Davis, and Corey Capps for their valuable input on this project.

I. INTRODUCTION

Americans are paying too much for health care services and insurance, in large part due to insufficient competition among providers and payors.¹ Waves of consolidation in these markets have fortified providers and insurers with market power, resulting in higher prices and lower quality for consumers.² As antidotes, health economists and other policy advocates have proposed various legislative, regulatory, and enforcement solutions.³ Yet private antitrust enforcement is rarely recommended to remedy health care market dysfunction. Whereas *public* antitrust enforcement is generally touted as indispensable,⁴ *private* antitrust enforcement is often disregarded as baseless, self-serving litigation that only strains judicial resources and may even raise costs.⁵ But the notion that private litigation is important should not be controversial.⁶ Private

1. MARTIN GAYNOR ET AL., MAKING HEALTH CARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE 1 (Apr. 2017), <https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf>.

2. See Robert Berenson, *Acknowledging the Elephant: Moving Market Power and Prices to the Center of Health Policy*, HEALTH AFF. BLOG (June 3, 2014), <http://healthaffairs.org/blog/2014/06/03/acknowledging-the-elephant-moving-market-power-and-prices-to-the-center-of-health-policy/>; WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 1, 8 (Feb. 2006), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1; MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 1–3 (June 2012), <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>; MARTIN GAYNOR ET AL., MAKING HEALTH CARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE 1 (Apr. 2017), <https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf>; Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161, 1163 (2012) (finding that health insurance consolidation between 1998 and 2006 led to a seven percent increase in large group health insurance premiums); José R. Guardado et al., *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, HEALTH MGMT., POL'Y & INNOVATION 8 (2013) (finding the UnitedHealth Group and Sierra Health Services merger increased the post-merger premiums in the Nevada markets by 13.7 percent, suggesting that the merging parties exploited the market power gained from the merger); PAUL B. GINSBURG, CTR. FOR STUDYING HEALTH SYS. CHANGE, WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER (Nov. 2010).

3. See, e.g., GAYNOR ET AL., *supra* note 1, at 17, 23, 28–29 (recommending: (1) changes to laws on information sharing, certificate of need laws, and certificates of public advantage; (2) new legislation banning anti-competitive contract clauses; and (3) increased federal and state antitrust enforcement).

4. See, e.g., Edith Ramirez, *Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2245 (2014).

5. See, e.g., Gregory J. Werden et al., *Deterrence and Detection of Cartels: Using All the Tools and Sanctions*, 56 ANTITRUST BULL. 207, 227–34 (2011) (disputing Lande & Davis's findings).

6. See Robert H. Lande & Joshua P. Davis, *Comparative Deterrence from Private Enforcement and Criminal Enforcement of the U.S. Antitrust Laws*, 2011 BYU L. REV. 315, 315

antitrust enforcement can restore competition, deter antitrust violations, and compensate victims in the markets for health care services and insurance, and, accordingly, the United States should be looking for ways to optimize it.

When passed, the antitrust statutes envisioned private cases as a fundamental part of an overall enforcement scheme.⁷ Indeed, the treble damages remedy was meant to spur private litigation.⁸ The Supreme Court has acknowledged as much: “By offering potential litigants the prospect of a recovery in three times the amount of their damages, Congress encouraged these persons to serve as ‘private attorneys general.’”⁹ The Court later elaborated, “The treble-damages provision wielded by the private litigant is a chief tool in the antitrust enforcement scheme, posing a crucial deterrent to potential violators.”¹⁰ Over the last century, private cases have greatly outnumbered public enforcement actions.¹¹ Recently, however, “private actions have caught up in the well-

(2011) [hereinafter Lande & Davis, *Comparative Deterrence*] (arguing that private antitrust litigation is more effective than Department of Justice (DOJ) criminal enforcement at deterring cartels); Robert H. Lande & Joshua P. Davis, *The Extraordinary Deterrence of Private Antitrust Enforcement: A Reply to Werden, Hammond, and Barnett* 58 ANTITRUST BULL. 173, 185–86 (2013) [hereinafter Lande & Davis, *Extraordinary Deterrence*].

7. The private right of action under the antitrust laws is (are) contained in Sections 4 and 16 of the Clayton Act, which apply respectively to actual and threatened injuries. 15 U.S.C. §§ 15, 26 (2012). Section 4 provides: “[A]ny person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States.” 15 U.S.C. § 15(a) (2012). Under both provisions, the “antitrust laws” include the Sherman and Clayton Acts. 15 U.S.C. § 12(a) (2012). However, the “antitrust laws” do not include Section 3 of the Robinson-Patman Act. 15 U.S.C. § 12(a) (2012). This is distinct from the legal framework in most other countries, as the United States provides some of the broadest access to private parties in antitrust. See Kenneth Ewing, *Private Anti-Trust Remedies Under US Law*, 1 PLC CROSS-BORDER COMPETITION HANDBOOK 87, 87 (2006–2007), <https://www.stepto.com/assets/attachments/2804.pdf>. Many countries limit enforcement to governmental entities, and, where private remedies are available, those remedies are typically more limited in scope. See Ewing, *supra*, at 87, 91; see also Nicholas Heaton & Benjamin Holt, *Know-How: Private Litigation*, GCR, <http://globalcompetitionreview.com/know-how/topics/1000309/private-litigation-2017> (last visited Nov. 12, 2017) (providing a database of comparative international competition laws) (last visited Dec. 12, 2017).

8. By statute, plaintiffs are entitled to the treble damages remedy, which provides for recovery of “threefold the damages by [the plaintiff] sustained, and the cost of suit, including a reasonable attorney’s fee.” 15 U.S.C. § 15(a) (2012).

9. *Hawaii v. Std. Oil Co.*, 405 U.S. 251, 262 (1972); accord *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 635 (1985) (“A claim under the antitrust laws is not merely a private matter.”) (quoting *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.* 723 F.2d 155, 168 (1st Cir. 1983); *American Safety Equipment Corp. v. J.P. Maguire & Co., Inc.* 391 F.2d 821, 826 (2d Cir. 1968)).

10. *Mitsubishi Motors Corp.*, 473 U.S. at 635.

11. Paul E. Godek, *Does the Tail Wag the Dog?: Sixty Years of Government and Private Antitrust in the Federal Courts*, THE ANTITRUST SOURCE 1, 1–3 (Dec. 2009), https://www.americanbar.org/content/dam/aba/publishing/antitrust_source/Dec09_Godek12_17f.authcheckdam.pdf; see also Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102

orchestrated, ideologically driven ‘tort reform’ movement” and have been characterized as “legalized blackmail” as opposed to a vital component of our statutory antitrust scheme.¹² Private antitrust enforcement does not deserve this characterization and indeed is a much needed means to address health care pricing.

Antitrust law is premised on the notion that competition leads to lower costs, higher-quality products and services, and encourages investment and innovation. In health care, as former Federal Trade Commission (FTC) Chair Edith Ramirez stated, “The success of health care reform in the United States depends on the proper functioning of our market-based health care system.”¹³ Although highly regulated and somewhat complicated by the buyer and seller relationships among patients, providers, and payors, health care in the United States is nonetheless market-based. As such, the sector depends on competition to drive prices down and quality up, even after the at-risk Patient Protection and Affordable Care Act.¹⁴ There is a real need for more antitrust enforcement in health care. As to hospital mergers, a named top public enforcement priority,¹⁵ the FTC has only challenged *one percent* of mergers over the past decade.¹⁶ And, even with both the FTC and the Department of Justice (DOJ) enforcing the federal antitrust laws, the lower-priority cases challenging anti-competitive conduct are even more scant, and criminal cases are rarer still.¹⁷

COLUM. L. REV. 545, 585 (2002) (describing empirical study of antitrust cases in health care between 1985 and 1999: “Of the 542 opinions in our sample, only 31 (representing 22 disputes) involved cases brought by the DOJ (10 disputes), the FTC (11 disputes), or state attorneys general (1 dispute)”).

12. Robert H. Lande & Joshua P. Davis, Am. Antitrust Inst., *Restoring the Legitimacy of Private Enforcement*, in A REPORT TO THE 45TH PRESIDENT (forthcoming 2017) (manuscript at 1), https://scholarworks.law.ubalt.edu/cgi/viewcontent.cgi?article=2017&context=all_fac.

13. Ramirez, *supra* note 4, at 2245.

14. *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition: Hearing on Serial No. 114-46 Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 1, 3 (Sept. 10, 2015) (statement of Thomas L. Greaney, Professor) (noting that the ACA “relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public”).

15. See Julie Brill, Comm’r, Fed. Trade Comm’n, Keynote Address at Hal White Antitrust Conf. 1, 3–4 (June 9, 2014), https://www.ftc.gov/system/files/documents/public_statements/314861/140609halwhite.pdf (exclusively discussing hospital merger enforcement in a speech on health care and competition, including a historical discussion and specific discussion of recent Federal Trade Commission (FTC) hospital merger victories).

16. Deborah L. Feinstein, Dir., Bureau of Competition, Fed. Trade Comm’n, American Antitrust Institute Health Care Roundtable: Competition & Health Care—Enforcement & Policy Priorities 18 (Feb. 22, 2017), https://www.ftc.gov/system/files/documents/public_statements/1120623/feinstein_aai_speech_2-22-17.pdf.

17. See *id.*; DEP’T OF JUSTICE, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (Aug. 1996), <https://www.justice.gov/sites/default/files/atr/legacy/2007/08/14/0000.pdf>.

In this void, private antitrust enforcement is essential to address market power in health care, and one that assumes a role that public enforcement cannot—or does not—presently fill.¹⁸

The insufficiency of public enforcement to address antitrust concerns in health care will likely only be exacerbated by the new presidential administration, under which at least one commentator has noted that “it is fair to expect some tempering of the level of activity that characterized the Obama administration.”¹⁹ Generally, Republican administrations are less likely to intervene in transactions and challenge the conduct of businesses, and despite some campaign rhetoric to the contrary, President Trump’s appointments seem to indicate an approach more in line with the party than with a new populism.²⁰ Of course, political influence is not limited to the federal realm; in states, the political priorities of elected attorneys general influence antitrust policy as well. Nevertheless, even the most aggressive public enforcement scheme would be incapable of addressing antitrust issues in health care without its private cousin.

What can private antitrust enforcement accomplish? Effective enforcement achieves deterrence, compensates victims,²¹ and maintains or restores competition in health care markets. Private enforcement allows health care entities to police their own markets and consumers to seek relief from anti-competitive acts. But it is often said that antitrust laws are meant to protect competition and consumers, not competitors.²² The concern is that entities, acting in their own self-interest, will use the antitrust laws to try to modify contracts, redress various business torts, stifle competition, and extort settlements from rivals.²³ Despite criticisms that private suits are self-interested and therefore anti-competitive, a lawsuit can be both self-interested and pro-

18. See *Palmyra Park Hosp. Inc. v. Phoebe Putney Memorial Hosp.*, 604 F.3d 1291, 1305 (11th Cir. 2010) (noting that due to limited resources, the government is not necessarily a better plaintiff than a competitor).

19. Maria Raptis, *Skadden Discusses Antitrust Enforcement in the Trump Administration*, THE CLS BLUE SKY BLOG (Apr. 19, 2017), <http://clsbluesky.law.columbia.edu/2017/04/19/skadden-discusses-antitrust-enforcement-in-the-trump-administration/> (last visited Oct. 27, 2017).

20. See *id.*

21. See Lande & Davis, *Comparative Deterrence*, *supra* note 6, at 315–18 (arguing that private antitrust litigation is more effective than DOJ criminal enforcement at deterring cartels); Lande & Davis, *Extraordinary Deterrence*, *supra* note 6, at 174.

22. Marivin Ammori, *Monopolies: Antitrust Law Protects Consumers, Not Competitors*, WIRED (Oct. 16, 2012, 3:00 PM), <https://www.wired.com/2012/10/antitrust-is-supposed-to-protect-consumers-not-competitors/>.

23. R. Preston McAfee et al., *Private Antitrust Litigation: Procompetitive or Anticompetitive?*, ANTITRUST DOCUMENTS GROUP 2–5 (Dec. 1, 2005), <https://www.justice.gov/atr/private-antitrust-litigation-procompetitive-or-anticompetitive>.

competitive.²⁴ Indeed, the antitrust laws were written to take advantage of private plaintiffs' incentives and information to bring suits that benefit both themselves and consumers.

Moreover, to limit the likelihood of abuse, courts have narrowed the per se doctrine, increased standing requirements,²⁵ and augmented the pleading standards; all of which deter frivolous, self-serving suits. In any event, studies have shown that antitrust actions by competitors in more concentrated markets, like health care markets, are more likely to be pro-competitive than they would be in more dispersed industries.²⁶ Some would argue that these measures even overdeter and overscreen.²⁷

How can private antitrust enforcement in health care be optimized? For plaintiffs, the key is overcoming the challenges in pursuing antitrust cases in health care. Those challenges fall into two groups: (1) those resulting from policies designed to decrease the incidence of self-serving and/or frivolous suits, and (2) those forming the essence of antitrust matters in health care. Understanding both sets is essential to optimizing private antitrust enforcement in health care. The first set requires plaintiffs to plead facts in light of new, more demanding standards to demonstrate antitrust injury and to attempt to certify classes of plaintiffs. The second set includes defining relevant markets and selecting claims for a lawsuit. Understanding the sources of these obstacles and how other recent plaintiffs have (or have failed to) overcome them is essential to optimizing private enforcement's role in addressing the competition problems in health care.

This article contains three parts. Part II describes how plaintiffs typically use private enforcement in health care services and insurance markets. Part III addresses the common challenges involved in private antitrust actions in health care and suggests strategies based on recent cases.

II. HOW PLAINTIFFS USE PRIVATE ANTITRUST ENFORCEMENT IN HEALTH CARE SERVICES AND INSURANCE MARKETS

Some practitioners and scholars have termed antitrust a "judicial enforcement (or 'law enforcement') model" because "the Sherman and Clayton Acts . . . creat[e] a species of common law, the meaning of which can evolve with changing conditions, which gives the federal courts a critical role in

24. See, e.g., *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-cv-1509-Orl-37DAB, 2015 WL 275806, at *7–8, *10 (M.D. Fla. Jan. 22, 2015) (holding that plaintiff whose interests overlapped with the public interest in competition among health care providers had standing).

25. See William Kolasky, *Antitrust Litigation: What's Changed in Twenty-Five Years?*, 27 ANTITRUST 9, 9–10, 12–13 (2012) (noting that the Supreme Court's changes to the antitrust standing requirement with the *Brunswick Corp. v. Pueblo Bowl-o-Mat* decision in 1977 put an end to the increase in number of antitrust suits (after a quadrupling in the decade prior)).

26. McAfee et al., *supra* note 23, at 12.

27. See Lande & Davis, *supra* note 12, at 1–2.

fashioning our competition laws.”²⁸ Accordingly, the development of antitrust law is a dynamic process that takes into account changing conditions for which the role of the federal courts cannot be understated.²⁹ Health care markets are certainly an area in which market conditions have changed over time, and courts and litigants have responded. Under these conditions, plaintiffs have evolved into litigants who prototype claims and analyses, not always certain how their experiments will turn out. The large majority of cases in this realm are brought under the Sherman Act, challenging either unilateral or concerted conduct,³⁰ or under Clayton Act Section 3, which proscribes exclusive dealing.³¹ Notwithstanding, some private litigants have brought merger challenges under Clayton Act Section 7, although informational asymmetries and injunctive remedies based on potential—as opposed to actual—damages discourage most plaintiffs from bringing these cases.³² Occasionally, a Clayton Act claim of an impermissible merger is just one claim of many in a private suit alleging a

28. Mark S. Popofsky & Douglas H. Halward-Driemeier, *Antitrust and the Roberts Court*, 28 ANTITRUST, Summer 2014, at 26, 26. Plaintiffs typically sue under the Sherman Antitrust Act, 15 U.S.C. §§ 1–7 (2012), and the Clayton Act, *id.* §§ 12–27; 29 U.S.C. §§ 52–53 (2012). In addition, most states (all but Pennsylvania) have antitrust statutes that are largely coextensive with federal law. *See* Dan Packel, *Pa. Sen. Proposes Antitrust Law as State Lags Behind Others*, LAW360 (Mar. 15, 2013, 5:15 PM), <https://www.law360.com/articles/424213/pa-sen-proposes-antitrust-law-as-state-lags-behind-others> (last visited Feb. 2, 2018). Further, many state antitrust statutes include a provision providing that federal antitrust precedents should be used as a guide in interpreting the state’s antitrust laws. *See, e.g.*, VA. CODE ANN. § 59.1-9.17 (1974) (Construction of Chapter) (“This chapter shall be applied and construed to effectuate its general purposes in harmony with judicial interpretation of comparable federal statutory provisions.”).

29. Popofsky & Halward-Driemeier, *supra* note 28, at 26.

30. 15 U.S.C. §§ 1–2 (2012).

31. *Id.* § 14.

32. The government typically has more information about upcoming mergers in light of the federal merger pre-notification program created in 1976 by the Hart-Scott-Rodino Antitrust Improvements Act, 15 U.S.C. § 18(a) (2012). Parties planning mergers of a certain size must notify the FTC and the DOJ (the antitrust agencies) in advance of proposed deals. Lisl Dunlop & Shoshana Speiser, *Merger Control in the United States: Overview*, THOMSON REUTERS PRACTICAL LAW (June 1, 2017), [https://content.next.westlaw.com/Document/Ieb49d8761cb511e38578f7ccc38dcbee/View/FullText.html?contextData=\(sc.Default\)&transitionType=Default&firstPage=true&bhcp=1](https://content.next.westlaw.com/Document/Ieb49d8761cb511e38578f7ccc38dcbee/View/FullText.html?contextData=(sc.Default)&transitionType=Default&firstPage=true&bhcp=1). After filing the required pre-merger notification forms, the entities may not complete the deal until the waiting period expires, the antitrust agencies terminate the waiting period early, or until they participate in a more extensive review following a “Second Request” for more information. *Id.* However, occasionally private plaintiffs file merger challenges and the FTC or DOJ follows. *See* Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys., Ltd., 778 F.3d 775, 782 (9th Cir. 2015), *aff’d* 2014 WL 407446 (D. Idaho 2014); Bruce D. Sokler et al., *Hospital Wins First Round Against Largest Rival in Antitrust Suit Alleging Illegal Exclusive Dealing Agreements with Insurers*, HEALTH CARE ANTITRUST ALERT (Mar. 30, 2015), <https://www.mintz.com/newsletter/2015/Advisories/4811-0315-NAT-AFR-HC/> (“It will likely be a historical footnote that the FTC’s seminal *St. Luke’s* case began as private litigation brought by a rival hospital before the FTC or the Idaho Attorney General ever showed up.”).

scheme of monopolization and exclusive dealing arrangements in provider-insurer contracts.³³

In light of the breadth and flexibility of the antitrust statutes, the same facts that give rise to an antitrust lawsuit often give rise to other claims. For example, a hospital suing another hospital and insurer based on provisions contained in the defendants' contracts might bring the suit as a conspiracy in restraint of trade under Sherman Act Section 1, which may involve allegations of exclusive dealing arrangements, tying, a group boycott or concerted refusal to deal, and/or as a monopolization or conspiracy to monopolize case that describes the same conduct. The recent fact patterns of several cases in this area are described below:

A. *Providers as Plaintiffs*

- A surgical hospital sues a larger hospital(s) and/or insurer, and/or managed care organization alleging the defendants acted to keep it out of the market for surgical services by conspiring or illegally contracting with other providers and/or insurers.³⁴
- Physician groups sue a health care corporation comprised of hospital and insurance plan alleging the health care giant used its market power, gained in part from anti-competitive mergers, to obtain exclusive referral arrangements aimed at eliminating competitors.³⁵
- A specialty practice sues a hospital and an insurer for forming a Health Maintenance Organization (HMO) and excluding the specialty practice from the HMO's network.³⁶
- Providers and insurance subscribers sue a large insurance company alleging horizontal market allocation.³⁷
- A large hospital sues a competitor hospital alleging that the competitor, the only local provider of essential services, used its status as a "must-

33. See Third Amended Complaint at 64, 66, 70, 73, 77, 80, 84, 88, 92, *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-CV-01509-RBD-DAB (M.D. Fla. May 22, 2014).

34. See, e.g., *Med. Ctr. at Elizabeth Place, LLC v. Atrium Health Sys.*, 817 F.3d 934, 936 (6th Cir. 2016); *Arapahoe Surgery Ctr., LLC v. Cigna Healthcare, Inc.*, 80 F. Supp. 3d 1257, 1260–61 (D. Colo. 2015); *Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc.*, 527 F. Supp. 2d 1257, 1263–64 (D. Kan. 2007); *Surgical Care Ctr. of Hammond, L.C. v. Hosp. Serv. Dist. No. 1 of Tangipahoa Par.*, 309 F.3d 836, 838 (5th Cir. 2002); *Marion HealthCare LLC v. S. Ill. Healthcare*, 2013 WL 4510168, at *1–2 (S.D. Ill. Aug. 26, 2013).

35. *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-CV-1509-ORL-37DAB, 2015 WL 275806, at *1 (M.D. Fla. Jan. 22, 2015); *N.M. Oncology and Hematology Consultants v. Presbyterian Healthcare Servs.*, 54 F. Supp. 3d 1189, 1197 (D.N.M. 2014).

36. *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 594 (8th Cir. 2009).

37. *In re Blue Cross Blue Shield Antitrust Litig.*, No. 2:13-CV-20000-RDP, 2017 WL 2797267, at *2, *6 (N.D. Ala. 2017).

have” participating provider to obtain exclusive dealing arrangements with commercial health insurers.³⁸

- A hospital sues a competitor hospital alleging the competitor “leveraged a state-granted monopoly in certain medical services” to exclude the hospital from local insurance companies’ provider networks by tying favorable insurance reimbursement rates for monopolized services to a refusal to include the plaintiff hospital in the insurance companies’ networks.³⁹
- A large hospital with its own health plan sues a large insurance company alleging the insurance company attempted to block both the hospital’s acquisition of a general acute care community hospital and its entry into the insurance market.⁴⁰

B. *Payors as Plaintiffs*

- An insurance company sues a competitor insurance company for using most favored nations clauses in insurer-provider contracts alleging that the exclusionary clauses drove up health care costs and inhibited competition.⁴¹
- Self-funded payors sue a large hospital alleging it overpaid for health insurance because of contracts with insurance entities that contained anti-competitive provisions.⁴²

C. *Consumers as Plaintiffs*

- Purchasers of commercial health insurance sue a large hospital alleging the hospital overpaid for health insurance because of provider-insurer contracts that contained anti-competitive provisions that require the

38. *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 859 F.3d 408, 409–10 (7th Cir. 2017); Complaint at 1–2, *Marion HealthCare, LLC v. S. Ill. Healthcare*, No. 3:12-cv-00871-JPG-PMF (S.D. Ill. Aug. 3, 2012).

39. *Palmyra Park Hosp., Inc. v. Phoebe Putney Mem’l Hosp.*, 604 F.3d 1291, 1294 (11th Cir. 2010).

40. *Steward Health Care Sys., LLC v. Blue Cross Blue Shield of R.I.*, 997 F. Supp. 2d 142, 148–49 (D.R.I. 2014).

41. *Aetna, Inc. v. Blue Cross Blue Shield of Mich.*, No. 11–15346, 2012 WL 2184568, at *1 (E.D. Mich. June 14, 2012). This lawsuit was a “follow-on” case to the government case of *United States v. Blue Cross Blue Shield of Michigan*, which the government voluntarily dismissed after the Michigan state legislature passed a law banning most favored nations clauses in provider-insurer contracts. See Press Release, U.S. Department of Justice, Justice Department Files Motion to Dismiss Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts (Mar. 25, 2013), <https://www.justice.gov/opa/pr/justice-department-files-motion-dismiss-antitrust-law-suit-against-blue-cross-blue-shield> (last visited Nov. 11, 2017).

42. *UFCW & Emp’rs Benefit Tr. v. Sutter Health*, 194 Cal. Rptr. 3d 190, 193 (Cal. Ct. App. 2015).

insurer to buy all or none of the hospital's services and/or prevent insurer from steering patients to lower-priced providers.⁴³

- Individual and small-employer customers sue a large insurance company alleging horizontal market allocation.⁴⁴

These lawsuits, which seek to combat the effects of market power in health care services and insurance markets, have sprung up in response to the growing consolidation in those markets, and, accordingly, are a relatively recent phenomenon. As a consequence, there is no set structure for a complaint; rather, each plaintiff tends to select claims based on case-specific facts and litigation strategy. Nonetheless, all plaintiffs must deal with the following key challenges in litigating their cases.

III. KEY CHALLENGES

A. *Policy-Driven Challenges*

The first key set of challenges plaintiffs face in private antitrust suits are those which result from “tort reform,” a term that generally refers to changes to the civil justice system to reduce the number of cases filed by plaintiffs, the number of cases that survive past the earliest stages of litigation, and/or the amount of damages plaintiffs receive.⁴⁵ Though not based on tort statutes, courts in private antitrust cases have imposed the same types of limiting mechanisms that ostensibly seek to deter or dispense frivolous lawsuits. In antitrust cases, tort reform changes began in the late 1970s when, after early enthusiasm by Congress and the courts over private litigants’ role as “private attorneys general,”⁴⁶ the Supreme Court issued a series of decisions that reined in private antitrust suits by narrowing the per se doctrine and tightening standing requirements.⁴⁷ After years of abridgment, today the per se rule only extends to “‘naked’ price fixing and market division agreements, a small subset of boycotts, or concerted refusals to deal, and—by a very thin thread—some tying

43. *Sidibe v. Sutter Health*, 51 F. Supp. 3d 870, 872–75 (N.D. Cal. 2014), *rev’d*, 667 F. App’x 641 (9th Cir. 2016); Complaint at 2, *DiCesare v. Charlotte-Mecklenburg Hosp. Auth.*, 2017 WL 1359599 (N.C. Super. Ct. Apr. 11, 2017) (No. 2016 CVS 16404).

44. *In re Blue Cross Blue Shield Antitrust Litig.*, 2017 WL 2797267 (N.D. Ala. 2017); *In re Blue Cross Blue Shield Antitrust Litig.*, 26 F. Supp. 3d 1172, 1179–81 (N.D. Ala. 2014).

45. See, e.g., *Tort Reform*, BLACK’S LAW DICTIONARY (10th ed. 2014).

46. *Hawaii v. Standard Oil Co. of Cal.*, 405 U.S. 251, 262 (1972); *accord* *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 635 (1985) (“A claim under the antitrust laws is not merely a private matter.”) (quoting *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.* 723 F.2d 155, 168 (1st Cir. 1983); *Am. Safety Equip. Corp. v. J.P. Maguire & Co., Inc.* 391 F.2d 821, 826 (2d Cir. 1968)).

47. See, e.g., *Brunswick Corp. v. Pueblo Bowl-o-Mat, Inc.*, 429 U.S. 477, 489 (1977). Around that time, the Supreme Court also began to limit the per se doctrine, which gives a stronger presumption of unreasonableness to certain restraints on trade. See William Kolasky, *Antitrust Litigation: What’s Changed in Twenty-Five Years*, 27 ANTITRUST 9, 11 (2012).

arrangements.”⁴⁸ More recently, in the early 2000s, in response to perceived abuses by the plaintiffs’ bar in the form of large class actions, the Supreme Court revised antitrust pleading requirements and then all federal pleading requirements to prevent meritless cases from proceeding to discovery.⁴⁹ As a result, all plaintiffs in health care antitrust cases face certain procedural obstacles as they navigate a system designed to winnow out cases at the earliest stages.

1. Per se versus Rule of Reason

The per se rule is the judicially created concept that some antitrust violations are so inherently illegal that plaintiffs need to plead and prove only that the conduct occurred;⁵⁰ the anti-competitive effects are implied. After a high point in the mid-twentieth century, when numerous antitrust offenses received per se treatment, the doctrine has been increasingly limited, either by express overruling or increased dubiousness.⁵¹ Instead, the rule of reason, “which requires the plaintiff to plead and prove that defendants with market power have engaged in anticompetitive conduct,”⁵² has become the dominant rubric of judicial analysis. Under the rule of reason, the court conducts a balancing inquiry that determines whether the alleged restraint is reasonable, and, if so, it passes antitrust scrutiny.⁵³ Matters are further complicated for litigants by the fact that it is not always clear whether a case will receive per se or rule of reason treatment until close to its resolution. A plaintiff who arrives at summary judgment having declined to prove a case under the rule of reason takes a significant risk⁵⁴ because the court could ultimately decide not to apply per se treatment at summary judgment:

[I]f there is any reasonable chance that the court will ultimately require the rule of reason, the plaintiff has no choice but to proceed through discovery under that rule even if the chance is small. This means that the value of the per se rule is lost in a significant number of cases, because the plaintiff must do all of the things that rule of reason analysis requires, including developing expert testimony on questions about relevant market, market power, and anticompetitive effects, even though the case may ultimately be decided under the per se rule. At least prior to trial, the greatest cost in litigating a rule of reason

48. Herbert J. Hovenkamp, *The Rule of Reason*, PENN L.: LEGAL SCHOLARSHIP REPOSITORY 1, 2 (July 2017), http://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=2780&context=faculty_scholarship (last visited Nov. 11, 2017).

49. *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 556, 559 (2007); *Ashcroft v. Iqbal*, 556 U.S. 662, 678–79, 684 (2009).

50. *See N. Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958).

51. Hovenkamp, *supra* note 48, at 41.

52. *Id.* at 2.

53. *See* PHILLIP E. AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* 380–81 (3d ed. 2010).

54. *See* Hovenkamp, *supra* note 48, at 9.

case is the cost of developing a record, so most of the cost savings that the per se rule promises will have been lost.⁵⁵

In recognition of this predicament, most plaintiffs err on the side of putting together a case that anticipates rule of reason analysis.

In health care, some plaintiffs who have recently pursued exclusively per se cases have failed to convince the court of this course, warning future plaintiffs of the risks of such a strategy. For example, in one of the cases related to most favored nations clauses in provider-insurer contracts in Michigan, the plaintiff lost a motion to dismiss after committing to a per se pleading strategy.⁵⁶ A number of other district courts have likewise made clear that vertical arrangements, including contracts and agreements between hospitals and insurers that are often the subject of lawsuits in this arena, receive rule of reason treatment.⁵⁷ More recently, in *Medical Center at Elizabeth Place v. Premier Health Partners*, a hospital plaintiff, MCEP, that sued the partners of competitor hospital group's joint venture, claiming the joint venture was a conspiracy to orchestrate a group boycott (a "non-venture") to exclude the plaintiff from managed care contracts, physicians, and funding, lost at summary judgment because of its per se case.⁵⁸ The district court declined to offer per se treatment to the allegations noting that the Supreme Court had a presumption of rule of reason analysis particularly with regard to vertical restraints in antitrust cases and quoted the Supreme Court's admonition that "easy labels do not always supply ready answers."⁵⁹ As part of its lengthy analysis, the district court seemed somewhat swayed by the fact that one of the main restraints at issue in the case the "panel limitations" clause in contracts between the joint venture member

55. *Id.* at 10.

56. *City of Pontiac v. Blue Cross Blue Shield of Mich.*, No. 11-10276, 2012 WL 1079895, at *8 (E.D. Mich. Mar. 30, 2012).

57. *Marion Healthcare, LLC v. S. Ill. Healthcare*, No. 12-CV-00871-DRH-PMF, 2013 WL 4510168, at *9 (S.D. Ill. Aug. 26, 2013) (agreeing with the defendant that rule of reason is appropriate for a case challenging allegedly exclusionary contracts between defendant hospital and insurer); *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, No. 1:13-cv-01054-SLD-JEH, 2015 WL 1399229, at *4, *8 (C.D. Ill. Mar. 25, 2015) (deciding ultimately on foreclosure grounds under a rule of reason analysis at summary judgment); *see also* *Prime Healthcare Servs., Inc. v. Serv. Emps. Int'l Union*, No. 11-cv-2652-GPC-RBB, 2013 WL 3873074, at *11 (S.D. Cal. July 25, 2013), *aff'd*, 642 F. App'x 665 (9th Cir. 2016); *Rheumatology Diagnostics Lab., Inc. v. Aetna, Inc.*, No. 12-cv-05847-JST, 2013 WL 3242245, at *9 (N.D. Cal. June 25, 2013).

58. *Med. Ctr. at Elizabeth Place, LLC v. Premier Health Partners*, No. 3:12-cv-26, 2017 WL 3433131, at *1 (S.D. Ohio Aug. 9, 2017).

59. *Id.* at *2 (citing *Broadcast Music, Inc. v. Columbia Broadcast Sys., Inc.*, 441 U.S. 1, 8 (1979)). This case's loss was particularly tragic for the plaintiff because, after winning on appeal to the Sixth Circuit Court of Appeals, which overturned the district court's ruling on summary judgment that the defendants were a single entity and therefore incapable of a conspiracy, they returned to district court, only to lose because their case was brought under the per se rule instead of the rule of reason. *See id.* at *1, *6.

hospital defendants and their contracted insurers was a vertical, as opposed to horizontal, restraint.⁶⁰ That clause provided that if the insurer were to add other hospitals to its provider network, the hospital would have the option to terminate the contract or renegotiate its rates for health care services.⁶¹ Plaintiff MCEP argued that the restraint deserved per se treatment because the restraint's operation excluded the plaintiff, a *horizontal* competitor, from the market, which the court concluded was too far of a logical leap.⁶²

The obvious takeaway is that even for a conspiracy case among horizontal competitors, like the group boycott and especially one that involves provider-insurer contracts, as so many of these cases do, the plan should be to plead and prove the case under a rule of reason rubric. Thus, even when pleading these cases as conspiracies (as is often the case),⁶³ plaintiffs should be prepared to establish all facets of a rule of reason case.⁶⁴ Because, as the court pointed out in *Elizabeth Place*, the restraints at issue are often *vertical*, even when an alleged horizontal conspiracy is involved (e.g., competitor hospital alleges that rival hospitals conspired to exclude it from the market by obtaining exclusivity from all local insurers), the likelihood of obtaining per se treatment is low.⁶⁵ Given the importance of surviving beyond the pleading stage of private litigation, this strategy is even more salient.

2. *Twilight*

Despite developing after the antitrust standing doctrine, new pleading standards affect all elements of a plaintiff's case, including standing; this article will discuss them first. In 2007, and again in 2009, the Supreme Court overhauled the federal civil pleading standards for the first time in sixty years, raising the bar considerably for surviving a motion to dismiss for failure to state a claim.⁶⁶ Prior to 2007, the federal pleading standard under Rule 8(a) of the Federal Rules of Civil Procedure (FRCP Rule 8) required a "short and plain statement of the claim showing that the pleader is entitled to relief."⁶⁷ The Supreme Court's longstanding interpretation of FRCP Rule 8 was that it required

60. *Id.* at *14.

61. *Id.*

62. *Med. Ctr. at Elizabeth Place*, 2017 WL 3433131, at *14.

63. *See, e.g., id.* at *4; *Arapahoe Surgery Ctr., LLC v. Cigna Healthcare, Inc.*, 80 F. Supp. 3d 1257, 1261 (D. Colo. 2015); *Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc.*, 527 F. Supp. 2d 1257, 1263 (D. Kan. 2007).

64. Plaintiffs must establish the following: (1) the defendants conspired; (2) the conspiracy produced anti-competitive effects in the relevant product and geographic markets; (3) the conduct was illegal; and (4) the scheme was the proximate cause of the plaintiff's antitrust injury. *Med. Ctr. at Elizabeth Place*, 2017 WL 3433131, at *3.

65. *Id.* at *15.

66. *See Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555–56 (2007); *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 684 (2009).

67. FED. R. CIV. P. 8(a)(2) (2016).

“notice pleading”—i.e., “a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove *no set of facts* in support of his claim which would entitle him to relief.”⁶⁸ The deferential “no set of facts” standard—in place from 1957 to 2007—gave the benefit of the doubt to the plaintiff, who, as a matter of policy, was presumed to bring a legally viable claim unless such claim was essentially inconceivable under the facts alleged in the complaint.

This changed in 2007 in *Bell Atlantic Corp. v. Twombly* when the Supreme Court ruled that to plead a Sherman Act Section 1 conspiracy claim, a plaintiff must give the court “*plausible* grounds to infer an agreement” by filing “a complaint with enough factual matter (taken as true) to suggest that an agreement was made.”⁶⁹ At first, the new plausibility standard was limited to antitrust conspiracy claims under the Sherman Act. Then, two years later in *Ashcroft v. Iqbal*, the Court extended the plausibility standard to *all* federal claims brought under Rule 8 in federal court and provided further guidance for applying the new standard.⁷⁰ The cases are often discussed and cited together and have even been given the moniker *Twigbal* as a shorthand.

The policy behind the *Twombly* decision was to rein in the perceived misuse of the courts by private litigants, especially through class action attorneys, filing baseless lawsuits aimed at lucrative damages awards or, more commonly, settlements.⁷¹ *Twombly* was part of a larger effort by the Supreme Court to discourage the proliferation of large class action suits based on thinly pled allegations. The Court cited repeatedly to its decision of two years prior in *Dura Pharmaceuticals, Inc. v. Broudo* in which it required a higher showing of causation at the pleading stage in securities fraud cases, and *Twombly* made sense in that context.⁷² The Court’s extension of *Twombly*’s new rule to all federal claims two years later in *Iqbal* was both much more expansive and more fraught with controversy. For starters, unlike *Twombly*, *Iqbal* was not a class action nor an antitrust case nor even a case involving allegations of corporate malfeasance; instead, it was a *Bivens* action, which is an individual’s suit against

68. *Conley v. Gibson*, 355 U.S. 41, 45–47 (1957) (emphasis added), *abrogated by* *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007).

69. *Twombly*, 550 U.S. at 556 (emphasis added).

70. *Iqbal*, 556 U.S. at 684.

71. *Twombly*, 550 U.S. at 557–59 (“[T]he threat of discovery expense will push cost-conscious defendants to settle even anemic cases before reaching those proceedings. Probably, then, it is only by taking care to require allegations that reach the level suggesting conspiracy that we can hope to avoid the potentially enormous expense of discovery in cases with no ‘reasonably founded hope that the [discovery] process will reveal relevant evidence’ to support a § 1 claim.”) (alteration in *Dura Pharm., Inc. v. Broudo*, 544 U.S. 336, 347 (2005)) (quoting *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 741 (1975)).

72. *Dura Pharm., Inc. v. Broudo*, 544 U.S. 336, 346–47 (2005); *Twombly*, 550 U.S. at 557, 557–59, 562 (citing *Dura Pharm.*, 544 U.S. at 346, 347).

a federal officer alleged to have violated the plaintiff's constitutional rights.⁷³ In other words, whereas *Twombly* fit the mold of the type of case criticized as an instance of opportunistic plaintiffs' lawyers suing deep-pocketed corporate defendants hoping for a settlement, *Iqbal* most certainly did not. The plaintiff-respondent *Iqbal* had been detained in connection with investigations into the September 11, 2001, attacks and had filed suit against multiple federal officials.⁷⁴ In addition, the Supreme Court held that *Twombly* applied to *all* federal pleadings, and "facts" that were nothing more than legal conclusions would no longer suffice in federal pleading; instead, "only a complaint that states a *plausible* claim for relief survives a motion to dismiss."⁷⁵ The Court then explained the new process lower courts should use: "Determining whether a complaint states a plausible claim for relief will . . . be a context-specific task that requires the reviewing court to draw on its judicial experience and common sense."⁷⁶ In other words, the new plausibility standard was both flexible and subjective. Critics argued that the purpose of the FRCP, enacted almost seventy years earlier, was to increase ordinary citizens' access to the federal courts by simplifying the historically more technical code pleading, which *Iqbal* directly contravened.⁷⁷

Opinions about the actual effects of the new plausibility standards on federal cases are varied. A major study conducted by the Federal Judicial Center in 2011 concluded that on the whole "*Twombly* and *Iqbal* have had a modest effect on the resolution of Rule 12(b)(6) motions."⁷⁸ Other studies likewise have found no statistically significant effect on dismissal rates.⁷⁹ However, studies focused on dismissal rates may ignore "selection effects," meaning the deterrent effects on plaintiffs who may decide not to file a case at all in light of the new

73. *Iqbal*, 556 U.S. at 668, 676.

74. *Id.* at 668 (naming as defendants: John Ashcroft, the former Attorney General of the United States, and Robert Mueller, then Director of the Federal Bureau of Investigation).

75. *Id.* at 679 (emphasis added).

76. *Id.* (citing the decision on appeal from the Court of Appeals for the Second Circuit, *Iqbal v. Hasty*, 490 F.3d 143, 157–58 (2007)).

77. See, e.g., Arthur R. Miller, *From Conley to Twombly to Iqbal: A Double Play on the Federal Rules of Civil Procedure*, 60 DUKE L.J. 1, 9–10 (2010) ("Federal civil procedure has been politicized and subjected to ideological pressures. Thus, the Supreme Court's recent decisions in *Bell Atlantic Corp. v. Twombly* and *Ashcroft v. Iqbal* should be seen as the latest steps in a long-term trend that has favored increasingly early case disposition in the name of efficiency, economy, and avoidance of abusive and meritless lawsuits. It also marks a continued retreat from the principles of citizen access, private enforcement of public policies, and equality of litigant treatment in favor of corporate interests and concentrated wealth. To a significant degree, the liberal-procedure ethos of 1938 has given way to a restrictive one.") (footnotes omitted).

78. Kevin R. Reich, *Five Years After Twombly: Where Are We Now?*, 10 ABA ANTITRUST SEC. JOINT CONDUCT COMMITTEE E-BULL. no. 1, 2012, at 2.

79. William H. J. Hubbard, *The Effects of Twombly and Iqbal*, 14 J. EMPIRICAL LEGAL STUD. 474, 475 (2017).

plausibility requirement.⁸⁰ And aggregate effects aside, plaintiffs are required to plead their cases in light of the new standard, which comes up in courts' standing analyses as well as substantive considerations like market definition, discussed in Part III.

3. Antitrust Standing

Antitrust standing, a creature of the common law, imposes a more onerous showing than its older cousin, constitutional standing.⁸¹ Of course, plaintiffs in antitrust suits also must have Article III standing to bring their cases,⁸² but the inquiry is usually collapsed into one "antitrust standing" analysis, whose requirements are often distilled into two prongs: A plaintiff must show (1) he has suffered *antitrust* injury and (2) that he is an efficient enforcer, i.e., the appropriate plaintiff to bring suit.⁸³ First, the antitrust injury requirement ensures both that the defendant harmed *competition or markets* (and not just the plaintiff, in a more tort-like sense) and that the plaintiff was injured in fact either as a direct market participant or as being "inextricably intertwined" with the harm resulting from the anti-competitive scheme.⁸⁴ Next, the efficient enforcer requirement ensures that the plaintiff be not too remote, i.e., has suffered directly from the defendant's conduct,⁸⁵ and is therefore the best plaintiff to bring suit; otherwise the best plaintiff might try to sue later on (potentially after damages have been awarded to the inferior plaintiff).

80. *Id.* at 476.

81. See generally *Brunswick Corp. v. Pueblo Bowl-o-Mat, Inc.*, 429 U.S. 477, 489 (1977); see also John J. Miles, *HEALTH CARE AND ANTITRUST LAW*, § 9:7 n.4 (2017) (collecting cases).

82. See Jonathan M. Jacobson & Tracy Greer, *Twenty-One Years of Antitrust Injury: Down the Alley with Brunswick v. Pueblo Bowl-o-Mat*, 66 ANTITRUST L.J. 273, 288 n.104 (1998) (citing *Sanner v. Chicago Bd. of Trade*, 62 F.3d 918, 922–27 (7th Cir. 1995); *Malamud v. Sinclair Oil Corp.*, 521 F.2d 1142, 1152 (6th Cir. 1975)).

83. *Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 535 n.31 (1983); Miles, *supra* note 81, at § 9:7 n.4.

84. *Blue Shield of Va. v. McCready*, 457 U.S. 465, 483–84 (1982) (noting that although the plaintiff was not a competitor or customer of the defendant, the plaintiff's injury was "inextricably intertwined" with the injury the defendants intended to inflict on the market and others, i.e., it "flow[ed] from that which makes defendants' acts unlawful" within the meaning of *Brunswick*, and [fell] squarely within the area of congressional concern").

85. See Jacobson & Greer, *supra* note 82, at 288. The danger of allowing recovery by a remote plaintiff is that a more directly injured plaintiff would later sue, and the defendant would be put at risk of another set of damages. Examples of ill-suited antitrust plaintiffs who typically cannot meet the standing requirement "include officers, employees, shareholders, prospective shareholders, creditors, guarantors, distributors, brokers, sales representatives, and suppliers of businesses injured by the violation." Miles, *supra* note 81, at § 9:7.

a. Antitrust Injury

Following an uptick in antitrust cases filed by competitors in the mid-twentieth century, courts became concerned that businesses were using the antitrust statutes as federal business tort statutes unrelated to competition or consumers. In response, in 1977, the Supreme Court clarified in *Brunswick Corp. v. Pueblo Bowl-o-Mat, Inc.* that to use the Clayton Act's private right of action, a plaintiff must show "antitrust injury, which is to say injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful. The injury should reflect the anticompetitive effect either of the violation or of anticompetitive acts made possible by the violation."⁸⁶ In *Brunswick*, the Court echoed the seminal *Brown Shoe Co. v. United States*, explaining: "The antitrust laws, however, were enacted for 'the protection of competition, not competitors.'"⁸⁷ The Supreme Court further clarified in 1990 that antitrust injury required some showing of public harm.⁸⁸ The issues of relative injury to the plaintiff and competition have come up in two recent antitrust cases brought by hospitals. In *Methodist Health Services Corp. vs. OSF Healthcare System*, the Seventh Circuit affirmed the district court's grant of summary judgment for the defendant, expressing doubt over the plaintiff's contention that it had brought its case to restore competition on behalf of multiple injured parties, none of whom were party to the lawsuit, and concluded that the plaintiff was "simply an unsuccessful competitor."⁸⁹ On the other hand, in another recently settled district court case, *Omni Healthcare, Inc. v. Health First, Inc.*, the district court in Florida made clear it would redress injuries that were more personal to the plaintiff so long as those injuries coincided with an injury to competition and also resulted from the same conduct of the defendant.⁹⁰ Plaintiffs also must show that they suffered direct harm; such harm is presumed for competitors and direct customers but not for those who are not participants in the relevant antitrust market.⁹¹ Some courts include this analysis when considering a plaintiff's remoteness in the antitrust injury prong, determining whether the plaintiff was "inextricably intertwined" with the harm resulting from the defendant's conduct, whereas other courts do an almost identical analysis under the "efficient enforcer" prong, discussed below.

86. *Brunswick Corp. v. Pueblo Bowl-o-Mat, Inc.*, 429 U.S. 477, 489 (1977). *Brunswick* was a Clayton Act case, but subsequent Supreme Court cases made clear that the *Brunswick* rule applied equally to cases under the Sherman Act. See *Blue Shield of Va.*, 457 U.S. at 482 (applying the antitrust injury rule to a claim brought under Sherman I); *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 334–335 (1990) (holding that antitrust injury is an essential element of every private antitrust case, irrespective of the substantive theory of liability); see also Jacobson & Greer, *supra* note 82, at 282.

87. *Brunswick Corp.*, 429 U.S. at 488 (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 320 (1962)). This definition of "antitrust injury" was extended to Section 16 cases for injunctive

b. Efficient Enforcer

For the purpose of antitrust standing analysis, the law favors direct consumers or customers as plaintiffs.⁹² Notwithstanding that preference, in determining whether the plaintiff is an efficient enforcer of the antitrust laws, courts in the health care cases at issue vary in their rigidity of applying a presumption in favor of a customer or competitor in light of the particular characteristics and constituents of those health care markets. As described in Part II, recent cases in this arena have seen plaintiffs as the following: hospitals, ambulatory surgery centers, physician groups, insurance companies, insurance subscribers, and patients. One recent district court clarified that “[t]here is no ‘bright-line rule’ for determining whether a plaintiff is an efficient enforcer,” and instead of strictly assessing the role played by the plaintiff in the market at issue, “the ‘efficient enforcer’ requirement ensures that the ‘*particular plaintiff*’ will efficiently vindicate the goals of the antitrust laws.”⁹³ Moreover, in cases where a plaintiff is not a customer or competitor precisely because of being excluded from the market by the defendant’s anti-competitive conduct, courts are cognizant that to deny standing on that basis would be inconsistent with the policy behind the antitrust laws.⁹⁴ Finally, courts have demonstrated awareness of “efficient enforcer” issues that are inherent in the structure of health care markets, where patients may be customers of insurance companies but not of providers, who receive payment directly from insurers instead of patients and, in such a scenario, have recognized the antitrust standing of insurance plan

relief in 1986. *Cargill, Inc. v. Monfort of Colo., Inc.*, 479 U.S. 104, 122 (1986); *see also* CHRISTINE L. WHITE ET AL., *ANTITRUST AND HEALTHCARE: A COMPREHENSIVE GUIDE* 61 (2013).

88. *Atl. Richfield Co.*, 495 U.S. at 334; *see also* Jacobson & Greer, *supra* note 82, at 284.

89. *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 859 F.3d 408, 411 (7th Cir. 2017).

90. *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-CV-1509-ORL-37DAB, 2015 WL 275806, at *8 (M.D. Fla. Jan. 22, 2015) (citing *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1450 (11th Cir. 1991)).

91. *Blue Shield of Va.*, 457 U.S. at 472, 480, 483–84 (noting that although the plaintiff was not a competitor or customer of the defendant, the plaintiff’s injury was “inextricably intertwined” with the injury the defendants intended to inflict on the market and others, i.e., it “flow[ed] from that which makes defendants’ acts unlawful” within the meaning of *Brunswick*, and [fell] squarely within the area of congressional concern”).

92. *See, e.g.*, *Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 544–545 (1983); Miles, *supra* note 81, at § 9:7 n.4.

93. *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-CV-1509-ORL-37DAB, 2015 WL 275806, at *7 (M.D. Fla. Jan. 22, 2015) (quoting *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1452 (11th Cir. 1991)).

94. *See, e.g.*, *Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I.*, 997 F. Supp. 2d 142, 160 (D.R.I. 2014) (“To permit the defendant in an unlawful exclusion case to hide behind the presumptive disfavoring of non-market participants would subject plaintiffs in such cases to an insurmountable Catch–22. Were courts to observe a blanket prohibition on claims brought by those excluded from the market by alleged anticompetitive conduct, those firms responsible for the exclusion might never be held accountable.”).

subscribers to sue a provider who contracts with their insurance company.⁹⁵ Defendants have largely been unsuccessful in using the Indirect Purchaser Rule, or *Illinois Brick Co. v. Illinois* Doctrine, which states that only direct purchasers may sue for antitrust violations in these cases.⁹⁶

In the recent case *Palmyra Park Hospital, Inc. v. Phoebe Putney Memorial Hospital*, the Eleventh Circuit Court of Appeals overruled the district court's dismissal on the grounds that the plaintiff hospital was not an "efficient enforcer," and therefore the plaintiff lacked standing.⁹⁷ In that case between two competing Georgia hospitals, Palmyra alleged that Phoebe Putney had used its monopoly power (state-granted by way of a certificate of need) to demand that Blue Cross and other insurers exclude Palmyra from their provider networks.⁹⁸ Specifically, Palmyra claimed that Phoebe Putney tied favorable reimbursement rates to a refusal to include Palmyra in those networks so that insurers who included Palmyra in their networks would have to pay Phoebe Putney more for the same health care services.⁹⁹ The Eleventh Circuit's analysis focused on the particular features of health care markets, which led to the holding that Palmyra is not only an efficient enforcer but also an ideal plaintiff to bring this suit.¹⁰⁰ Whereas the district court had concluded that "[t]he most direct affect [sic] of Defendants' alleged anticompetitive conduct would be felt by the allegedly coerced insurers who pay higher reimbursement rates and the patients who ultimately pay higher premiums and co-pays for medical services,"¹⁰¹ the appellate court, after analyzing the incentives at play, concluded that those insurers had suffered little harm and therefore were unlikely plaintiffs.¹⁰² In fact, once the tie was in place (i.e., Blue Cross and others agreed to exclude Palmyra from its networks in exchange for better reimbursement rates),¹⁰³ it is unclear that the insurers would be paying higher rates at all, and to the extent they were, the cost could easily be passed on to their subscribers. Thus, the insurers had

95. See, e.g., *Sidibe v. Sutter Health*, 4 F. Supp. 3d 1160, 1173 n.7, 1181 (N.D. Cal. 2013) (dismissing second amended complaint on other grounds).

96. See, e.g., *id.* at 1173 n.7 (noting that patients who sued hospital based on its allegedly competitive contracts with the insurers whose health plans plaintiffs subscribed to had standing); cf. *Med. Sav. Ins. Co. v. HCA, Inc.*, No. 2:04CV156FTM-29DNF, 2005 WL 1528666, at *2, *8 (M.D. Fla. June 24, 2005) (involving an insurance company that had no contracts with hospitals and just paid amounts of charges it deemed "reasonable" that sued hospitals for conspiracy to boycott; citing *Ill. Brick Co. v. Illinois*, 431 U.S. 720, 735 (1977), the court said patients were the more efficient enforcer), *aff'd*, 186 Fed. App'x 919 (11th Cir. 2006).

97. *Palmyra Park Hosp., Inc. v. Phoebe Putney Mem'l Hosp.*, 604 F.3d 1291, 1294 (11th Cir. 2010).

98. *Id.*

99. *Id.* at 1296.

100. *Id.* at 1306.

101. *Id.* at 1303–04 (quoting lower court opinion).

102. *Palmyra Park Hosp., Inc.*, 604 F.3d at 1305.

103. *Id.* at 1302–03.

questionable damages and little incentive to sue, and their subscribers likewise may or may not have had damages in the form of increased premiums—and organizing and determining this harm would be difficult and likely prohibitive to filing suit.¹⁰⁴ The most significant effect of the arrangement between Phoebe Putney and the insurers was an incentive change for patients: Patients had the incentive to go to in-network hospital Phoebe Putney and not out-of-network Palmyra because of how insurance companies reimburse for hospital charges.¹⁰⁵ No patient would be willing to pay out of pocket for similar treatment at an out-of-network hospital, so the contracting arrangement took away demand from Palmyra—so much so that the hospital experienced a drop in revenue from twenty-four million dollars to six million dollars.¹⁰⁶ Indeed, the Third Circuit held that “[a]s Phoebe Putney’s chief competitor, Palmyra is undoubtedly well suited to vindicate these harms.”¹⁰⁷

c. Special Considerations in Health Care

In some recent health care antitrust cases, defendants accused of harming competition through arrangements that artificially depress prices have argued that lower prices benefit, as opposed to harm, consumers.¹⁰⁸ This argument fails generally because antitrust injury includes harms that result from conspiracies to lower prices in contravention of fair and open competition.¹⁰⁹ But in health care cases, courts have also specifically pointed out that diminishment of quality and limitation of access are key in the health care analysis, as patient decisions are not made based on price to the same extent that they are in other markets for goods and services.¹¹⁰ For example, in the Third Circuit’s reversal in *West Penn Allegheny Health System, Inc. v. UPMC*, provider West Penn sued competitor provider UPMC and insurer Highmark for various antitrust violations, including those related to UPMC and Highmark’s agreement that Highmark, who also had a business relationship with plaintiff West Penn, was “not to do anything to benefit West Penn financially.”¹¹¹ Pursuant to that agreement, the complaint alleged that West Penn had asked Highmark to renegotiate and raise its rates. It

104. *See id.* at 1305.

105. *See id.* at 1304.

106. *Id.* at 1302–03.

107. *Palmyra Park Hosp., Inc.*, 604 F.3d at 1305 (the court also noting that contrary to the district court’s suggestion, the government was not necessarily the best plaintiff in light of limited resources).

108. *See, e.g., W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 104 (3d Cir. 2010); *N.Y. Medscan LLC v. N.Y. Univ. Sch. of Med.*, 430 F. Supp. 2d 140, 147 (S.D.N.Y. 2006).

109. *E.g., Knevelbaard Dairies v. Kraft Foods, Inc.*, 232 F.3d 979, 988 (9th Cir. 2000) (“[T]he central purpose of the antitrust laws . . . is to preserve competition. It is competition—not the collusive fixing of prices at levels either low or high—that these statutes recognize as vital to the public interest.”).

110. *See, e.g., W. Penn Allegheny Health Sys., Inc.*, 627 F.3d at 104.

111. *Id.* at 103.

further alleged that although Highmark acknowledged that the rates were too low (i.e., below market), Highmark nonetheless refused to raise the rates in light of its agreement with UPMC.¹¹² West Penn asserted that it had suffered antitrust injury as a result of those depressed rates, and Highmark countered that the depressed rates allowed the insurer to offer lower premiums to subscribers and to find antitrust injury in this situation would frustrate the purpose of the antitrust laws, which is to promote consumer welfare.¹¹³ The court rejected Highmark's argument, finding instead that Highmark had not, in fact, passed those savings on to subscribers, and doing so likely would have "diminish[ed] the quality and availability of hospital services."¹¹⁴ Similarly, in a district court case in which the plaintiff alleged that the defendant had engaged in anti-competitive conduct in the market for Positron Emission Tomography and Computed Tomography medical scanning equipment, the court was not swayed by the defendant's argument that consumers, and therefore competition, had not suffered because prices had not gone up.¹¹⁵ Finding that the plaintiffs had adequately pled antitrust injury, the court stated: "Indeed, in the context of the provision of health care services for cancer patients, the quality of care is likely to be at least as important to patients as the price."¹¹⁶ Lastly, a district court in New Mexico recently found antitrust injury by recognizing that an insurer payment of below-market reimbursement rates to a provider indicated that insurer's market power in the relevant market, explaining that a monopsonist (seller) with market power is every bit as capable of causing antitrust injury as is a monopolist (buyer).¹¹⁷ Accordingly, in health care, diminution in quality should be considered in any discussion of antitrust standing.

d. *Twiqbal*

The standing inquiry in antitrust cases has been further complicated by the muddling of standards by lower courts in response to *Twombly* and *Iqbal*.¹¹⁸ Understanding both the development of the antitrust standing rules as well as how courts are applying them in health care cases particularly since *Twiqbal* is essential to filing an effective complaint. Outside of health care, some courts,

112. *Id.* at 100.

113. *Id.* at 104.

114. *W. Penn Allegheny Health Sys., Inc.*, 627 F.3d at 104.

115. *N.Y. Medscan LLC v. N.Y. Univ. Sch. of Med.*, 430 F. Supp. 2d, 140, 147–48 (S.D.N.Y. 2006).

116. *Id.*

117. *N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, 54 F. Supp. 3d 1189, 1205–06 (D.N.M. 2014).

118. See Jacobson & Greer, *supra* note 82, at 288; see also *Somers v. Apple, Inc.*, 729 F.3d 953, 965 (9th Cir. 2013); *Prime Healthcare Servs., Inc. v. Servs. Emps. Int'l Union*, No. 11–cv–2652–GPC–RBB, 2013 WL 3873074, at *12 (S.D. Cal. July 25, 2013), *aff'd*, 642 F. App'x 665 (9th Cir. 2016).

including the Court of Appeals for the Ninth Circuit, have expressly mingled antitrust injury and the plausibility standard for pleading claims by citing *Twombly* and *Iqbal* to support the proposition that “to state a plausible antitrust injury, [the plaintiff] must allege facts that rise beyond mere conceivability or possibility.”¹¹⁹ Likewise, in health care, some lower courts are mingling *Twombly* with antitrust injury.¹²⁰ Be that as it may, the *Twiqbal* growing pains have not necessarily resulted in a stricter standing requirements for plaintiffs. For example, in 2010, the Court of Appeals for the Third Circuit reversed the district court’s dismissal of a health care provider’s suit against another provider and insurer on the grounds that the district court’s application of *Twombly* overshot the requirements of that case, including as to antitrust standing.¹²¹ That early district court decision, written in response to a renewed motion to dismiss based on the Supreme Court’s rulings in *Twombly* and *Iqbal*, was guided by the defendant’s insistence that the plausibility “requirement includes pleading facts sufficient to satisfy the antitrust injury requirement.”¹²² The court applied a strict version of plausibility to all facets of the complaint. The Third Circuit acknowledged the new standard but clarified that it applied equally to all federal claims and did not impose heightened pleading requirements for antitrust cases.¹²³

4. Class Certification

Although private antitrust litigation immediately conjures thoughts of large class action cases, most cases involving health care services and insurance premiums are individual actions by competitors, unlike the larger consumer cases against pharmaceutical companies. The scarcity of class actions in this arena is likely due to the individualized nature of damages in health care,¹²⁴

119. *Somers*, 729 F.3d at 695 (citing *Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)).

120. See, e.g., *Prime Healthcare Servs., Inc.*, 2013 WL 3873074, at *12. In *Prime Healthcare Services, Inc. v. Service Employees International Union*, the district court cited *Twombly* for the proposition that the plaintiff must plead sufficient facts to allege antitrust injury simply by misquoting *Twombly* to read that the plaintiff’s “allegations must ‘raise a reasonable expectation that discovery will reveal evidence of’ an injury to competition,” *id.*, whereas *Twombly* says “raise a reasonable expectation that discovery will reveal evidence of *illegal agreement*,” *Twombly*, 550 U.S. at 556 (emphasis added).

121. *W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 98 (3d Cir. 2010) (“We conclude that it is inappropriate to apply *Twombly*’s plausibility standard with extra bite in antitrust and other complex cases.”).

122. *W. Penn Allegheny Health Sys., Inc. v. UPMC*, No. 09CV0480, 2009 WL 3601600, at *19 (W.D. Pa. Oct. 29, 2009), *rev’d*, 627 F.3d 85 (3d Cir. 2010).

123. *W. Penn Allegheny Health Sys., Inc.*, 627 F.3d at 98 (“We conclude that it is inappropriate to apply *Twombly*’s plausibility standard with extra bite in antitrust and other complex cases.”).

124. See *Palmyra Park Hosp., Inc. v. Phoebe Putney Mem’l Hosp.*, 604 F.3d 1291, 1305 (11th Cir. 2010) (explaining why a patient class might not be the most efficient enforcer).

which may deter plaintiffs from trying to satisfy the FRCP 23(b)(3) requirement that issues common to the class will predominate over issues specific to individual class members in the case.¹²⁵ Nonetheless, a few notable class actions have been filed with some classes certified in this sphere.

Most famous among the class actions in this area may indeed be the most unlikely: *Messner v. Northshore University HealthSystem*, a merger challenge to the consummated merger of two hospitals in the Chicago area.¹²⁶ Challenges to mergers by the government, of course, are common, and indeed this private challenge followed a merger challenge from the FTC. But private plaintiffs rarely challenge mergers because of timing issues (mergers are typically challenged when they are still in the planning stages, a time when plaintiffs often have little information about the deal) and because the typical remedy in a merger challenge is an injunction. Although the class was certified after being remanded to the district court in 2013, it still feels like somewhat of a one-off—plaintiffs have not followed suit en masse to challenge mergers in federal court either as follow-on cases to FTC merger challenges. Still, the *Messner* case contains valuable language for would-be challengers. Given that after a careful examination of the markets for health care services at issue, including that the calculation of damages would be affected by factors including “(1) health service provider contract negotiation, (2) multi-year contract terms, (3) hospital location, reputation, and quality, and (4) prevalent improvements in the technology behind certain services,” the court nonetheless concluded that predominance issues did not preclude class certification.¹²⁷ The court explained, “Individual questions need not be absent. The text of FRCP 23(b)(3) itself contemplates that such individual questions will be present. The rule requires only that those questions not predominate over the common questions affecting the class as a whole.”¹²⁸

Even though *Messner* has not given rise to a wave of follow-on Clayton Act-based merger challenges over the past five years, its language was recently relied upon by a *state* court in certifying a class in a challenge to hospital contracting provisions brought by self-funded payors in California.¹²⁹ The court cited the Seventh Circuit’s suggestion in *Messner* that “even in the ‘market for hospital services [which] seems to be particularly complex,’ certification may be

125. FED. R. CIV. P. 23(b)(3).

126. *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 808 (7th Cir. 2012).

127. Justin Boley, *Seventh Circuit Vacates Northshore Hospital Antitrust Class Certification Denial*, WEXLER WALLACE LLP (Jan. 17, 2012), <https://www.wexlerwallace.com/seventh-circuit-vacates-messner-antitrust-class-certification-denial/> (last visited Nov. 1, 2017).

128. *Messner*, 669 F.3d at 815.

129. Order Granting in Part Motion to Strike, Granting Class Certification, and Setting Case Management Conference at 9, *UFCW & Emp’rs Benefit Tr. v. Sutter Health*, Cal. App. Dep’t Super. Ct (Aug. 14, 2017) (No. CGC 14-538451) (quoting *Messner*, 669 F.3d at 816).

proper.”¹³⁰ That case, *UFCW & Employers Benefit Trust v. Sutter Health*, contains similar allegations to *Sidibe v. Sutter Health*, which is back in district court after the Ninth Circuit reversed the lower court’s dismissal for failure to state a claim but has not yet reached class certification.¹³¹ *Sidibe* will be the first case in federal court to seek certification for a class of patients (insurance subscribers) suing for damages from overcharges related to a hospital’s anti-competitive clauses in insurer contracts and related tying arrangements (as part of a monopolization scheme)—facts similar to those present in several suits brought by competitors against hospitals over the past several years.¹³² Interestingly, another putative class of plaintiffs has filed a case similar to *UFCW* in state court in North Carolina.¹³³ That case, which is still pre-class certification, is distinct in that the plaintiffs chose to file in state court, even though the suit was a follow-on to a DOJ matter.¹³⁴

Also currently pending, and in pre-class certification, are two large tracks (provider plaintiffs and subscriber plaintiffs, respectively) of antitrust class actions against Blue Cross Blue Shield (BCBS) entities in multi-district litigation in the Northern District of Alabama.¹³⁵ The plaintiffs alleged that BCBS plans and their association used their market power, derived from being the dominant insurer in multiple markets, to engage in and profit from the anti-competitive scheme.¹³⁶ In the alleged scheme, the individual BCBS plans and their national association conspired to carve up insurance markets among the insurers across the country in a nationwide market allocation scheme under which BCBS plans were allocated a particular market and then would agree not to compete with other neighboring BCBS plans in at least seventeen states.¹³⁷ The two-tracked litigation presents “a unique case where one class (providers)

130. *Id.*

131. Current Docket, *Sidibe v. Sutter Health*, 51 F. Supp. 3d 870 (N.D. Cal. 2014).

132. See, e.g., *Palmyra Park Hosp., Inc. v. Phoebe Putney Mem’l Hosp.*, 604 F.3d 1291, 1294, 1298 (11th Cir. 2010); *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 859 F.3d 408, 409 (7th Cir. 2017); *Marion HealthCare LLC v. S. Ill. Healthcare*, 12–CV–00871–DRH–PMF, 2013 WL 4510168, at *1 (S.D. Ill. Aug. 26, 2013); *Arapahoe Surgery Ctr., LLC v. Cigna Healthcare, Inc.*, 80 F. Supp. 3d 1257, 1262 (D. Colo. 2015).

133. *DiCesare v. Charlotte-Mecklenburg Hosp. Auth.*, No. 16 CVS 16404, 2017 WL 1359599, at *1 (N.C. Super. Ct. Apr. 11, 2017), *cert. denied*, 804 S.E.2d 541 (N.C. 2017) (mem.).

134. *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720 (W.D.N.C. 2017).

135. *In re Blue Cross Blue Shield Antitrust Litig.*, 2:13-CV-20000-RDP, 2017 WL 2797267 (N.D. Ala. June 28, 2017).

136. Corrected Consolidated Second Amended Provider Complaint, *In re Blue Cross Blue Shield Antitrust Litig.*, 26 F. Supp. 3d 1172 (N.D. Ala. 2014) (No. 2:12-cv-02532-RDP).

137. *Id.* at 131; see also Irina Rodriguez, Moderator, Office of the New York Attorney General, *Blue Cross Blue Shield Antitrust Litigation: Update on the Issues*, (May 4, 2016), A.B.A. Antitrust Sec. L. Rep., at Slide 11, https://www.americanbar.org/content/dam/aba/publications/antitrust_law/20160504_at160504_materials.authcheckdam.pdf.

asserts an antitrust injury (low reimbursement rates) which tends to benefit the other class (subscribers who may have paid lower premiums as a result),” such that “[e]ach class will be putting forth evidence that the other class wasn’t injured.”¹³⁸ It is unclear how this potential conflict and other factors will play in the class certification motions, which will be filed soon.

B. Substantive Antitrust Challenges

1. Market Definition

As venerated antitrust scholar Professor Hovenkamp observed, “Markets do not define themselves.”¹³⁹ Litigants define markets, and doing so accurately is an exercise not only in economics but also in advocacy. As former FTC Chairman Robert Pitofsky stated in 1990, “[A]ntitrust practitioners have long known that the most important single issue in most enforcement actions—because so much depends on it—is market definition.”¹⁴⁰ Indeed, market definition is not only important to public antitrust, but it is also an essential element and one of the main stumbling blocks in private cases. To plead most antitrust claims, the plaintiff must define the relevant market in the complaint along with the reasoning behind the proposed definition.¹⁴¹ Defining relevant markets is a highly fact-specific inquiry,¹⁴² which makes doing so in a private complaint, before the benefit of discovery, particularly challenging. And defendants may, and often do, move to dismiss a case for failure to state a claim based on the proposed market definition included in the complaint.¹⁴³ Indeed, market definition is central to most antitrust analyses because “[w]ithout a definition of [the relevant] market there is no way to measure [a defendant’s] ability to lessen or destroy competition.”¹⁴⁴

Defining a relevant market is the first step towards convincing the fact finder that a defendant possesses the legally essential *market power* over a product or

138. Rodriguez, *supra* note 137, at Slide 13.

139. HERBERT HOVENKAMP, *FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE* 111 (5th ed. 2016).

140. Robert Pitofsky, *New Definitions of Relevant Market and the Assault on Antitrust*, 90 COLUM. L. REV. 1805, 1807 (1990).

141. HOVENKAMP, *supra* note 139, at 111 n.19.

142. EDWIN S. ROCKEFELLER, *THE ANTITRUST RELIGION* 41 (2007).

143. See, e.g., *Sidibe v. Sutter Health*, 51 F. Supp. 3d 870, 872 (N.D. Cal. 2014), *rev’d*, 667 F. App’x 641 (9th Cir. 2016); *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-cv-1509-Orl-37DAB, 2015 WL 275806, at *1 (M.D. Fla. Jan. 22, 2015); *Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I.*, 997 F. Supp. 2d 142, 149 (D.R.I. 2014); *Marion HealthCare, LLC v. S. Ill. Healthcare & Health Servs. Corp.*, No. 12-cv-871-SMY-PMF, 2015 WL 3466585, at *1 (S.D. Ill. May 29, 2015).

144. *Total Renal Care, Inc. v. W. Nephrology & Metabolic Bone Disease, P.C.*, No. 08-cv-00513-CMA-KMT, 2009 WL 2596493, at *6 (quoting *Walker Process Equip., Inc. v. Food Mach. & Chem. Corp.*, 382 U.S. 172, 177 (1965)).

a geographic area. This exercise is required to prove claims under the rule of reason, which is the presumptive judicial rubric for most antitrust claims.¹⁴⁵ Once a market is defined, the plaintiff demonstrates the defendant's market share therein—a high share signaling likely market power. Market power is defined as “the power to raise prices above competitive levels without losing so many sales that the price increase is unprofitable.”¹⁴⁶ Firms that acquire market power often engage in anti-competitive conduct beyond just raising prices, including, e.g., demanding exclusivity provisions in contracts, using market power in one market to demand better pricing and terms in another market, and/or tying the sale of other, unwanted products to the sale of a product over which they have market power.¹⁴⁷ Plaintiffs may sue based on each of these types of conduct, and market power is a prerequisite for each.¹⁴⁸

Determining the “relevant market” in an antitrust case is a two-part calculation that “is a collection of products and geographic locations, delineated as part of an inquiry aimed at making inferences about market power and anticompetitive effect.”¹⁴⁹ The terms “relevant market” and “antitrust market” are used “to distinguish these markets from what business executives and consultants might define for other purposes.”¹⁵⁰ The determination of relevant market is two-part in that it requires one to define both (1) a product market and (2) a geographic market,¹⁵¹ which are distinct, yet intertwined. The product market is bounded by “the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it.”¹⁵² Once determined, the product market serves to define the geographic market, which “extends to the area of effective competition where buyers can turn for alternative sources of supply” of the product at issue.¹⁵³ Or as one court explained, “The relevant product market identifies the products or services that compete with each other, and the relevant geographic market identifies the area

145. Hovenkamp, *supra* note 48, at 2.

146. HOVENKAMP, *supra* note 139, at 106.

147. See Richard D. Cudahy & Alan Devlin, *Anticompetitive Effect*, 95 MINN. L. REV. 59, 72 (2010).

148. See HOVENKAMP, *supra* note 139, at 106–07. Moreover, market power is an essential element of many antitrust claims, and, to complicate matters, the *degree* of market power required to prove those claims varies. *Id.* at 107. For example, monopolization requires a high degree of market power, attempted monopolization requires less market power, and a pre-merger challenge requires showing a “dangerous probability of acquiring market power” in the future. *Id.*

149. Jonathan B. Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L.J. 129, 130 (2007).

150. *Id.*

151. See *id.*

152. *Sidibe v. Sutter Health*, 51 F. Supp. 3d 870, 883 (N.D. Cal. 2014) (quoting *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 325 (1962)), *rev'd*, 667 F. App'x 641 (9th Cir. 2016).

153. *Id.* (quoting *Tanaka v. Univ. of S. Cal.*, 252 F.3d 1059, 1063 (9th Cir. 2001)).

where the competition in the relevant product market takes place.”¹⁵⁴ Or as an economist might explain, the inquiry looks at consumer substitution patterns to determine the metes and bounds of both product and geographic markets.

The FTC and DOJ’s jointly issued *Horizontal Merger Guidelines* are the source for one of the main tests used in relevant market definition. The test, first included in the 1982 version of the Guidelines, aids in product as well as geographic market definition, where it continues to play a role in the new workshopped models discussed herein. Thus, it is explained here prior to the other aspects of the development of market definition models. The test aims to determine consumer substitution patterns, which are the basis for market definition. Essentially the test asks whether a monopolist in a given market could raise its prices above the competitive level without losing customers.¹⁵⁵ In economic terms, the test determines “the smallest grouping of sales for which the elasticity of demand and supply are sufficiently low that a ‘hypothetical monopolist’ with 100% of that grouping could profitably reduce output and increase price substantially above marginal cost.”¹⁵⁶ Put more simply, it checks whether consumers will substitute for another product in response to a price hike of a certain size. The test uses the “small but significant non transitory increase in price” test (“SSNIP”) as its key metric, which is imposed, hypothetically, to arrive at the smallest relevant market.¹⁵⁷ The size of the price increase used for the test is small; it is not so small as to not matter at all to consumers but not so large that it causes buyers to leave or for other sellers to enter the market.¹⁵⁸ Once the smallest grouping is determined, the entity’s market share in that market is considered to determine whether it has market power.¹⁵⁹ In sum, the process aims to “find the smallest group of products or firms for which there are no close substitutes, thus allowing such a hypothetical monopolist to exert market power.”¹⁶⁰

a. Market Definition in Health Care

Defining relevant markets is crucial to antitrust analysis regardless of industry; however, the process presents unique challenges in health care due to the role of health insurers, the non-price reasons for consumer behavior, and the differentiation in health care services. Whereas most industries present obvious consumers, in light of the various and overlapping players in health care markets,

154. *Id.* at 883.

155. HOVENKAMP, *supra* note 139, at 112.

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.* at 111–12.

160. Martin Gaynor et al., *A Structural Approach to Market Definition with an Application to the Hospital Industry* 6 (Nat’l Bureau of Econ. Research, Working Paper No. 16656, 2011), <http://www.nber.org/papers/w16656>.

who the buyers and sellers are is much less clear.¹⁶¹ The role of the payor, as well as the distinctions between private and public payors, has become crucial to a proper market definition. In addition, a patient's decision to purchase a particular health care service is influenced by non-price factors, including the recommendations of her physician, the network of her health plan or managed care organization, and the plans offered by her employer.¹⁶² On top of that, a patient is typically more willing to travel for a non-emergency or elective service, like a knee replacement, than for an acute one, like an appendectomy, or may have no choice but to travel for a specialty service that is only available in a few locations, like an organ transplant.

b. Lessons from Public Enforcement

Market definition, unlike the other challenges discussed in this article, is an area where the lessons from public enforcement, especially hospital merger cases, are instructive. As one legal expert presciently put it two decades ago: "The antitrust treatment of horizontal mergers by the Justice Department and the Federal Trade Commission is one of the most well developed and closely scrutinized areas of antitrust law."¹⁶³ However, at the time of this statement about merger analysis, the FTC may have been experts in most industries but was losing hospital merger challenges. After losing a series of provider merger challenges in the mid- and late-1990s, often involving highly concentrated markets, the FTC undertook to study whether those mergers subsequently resulted in higher prices, and whether the FTC's market definition methodology used to challenge the transactions was to blame.¹⁶⁴ The FTC's study, aided by top academic economists who wrote several related papers on the issue, concluded that those mergers resulted in higher health care prices and the market definition analyses relied on by the Commission, and often, by the courts, was faulty.¹⁶⁵ Thereafter, the FTC worked with economists to revise its market

161. ABA SECTION OF ANTITRUST LAW, MARKET DEFINITION IN ANTITRUST: THEORY AND CASE STUDIES 277 (2012).

162. *See id.* at 277–78.

163. Carl Shapiro, *Mergers with Differentiated Products*, ANTITRUST, Spring 1996, at 23.

164. Brill, *supra* note 15, at 1 n.2 (citing the following FTC losses: Fed. Trade Comm'n v. Hosp. Bd. of Dirs. of Lee Cty., 38 F.3d 1184, 1186 (11th Cir. 1994); Fed. Trade Comm'n v. Freeman Hosp., 69 F.3d 260, 273 (8th Cir. 1995); Fed. Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285, 1303 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997); Fed. Trade Comm'n v. Tenet Health Care Corp., 186 F.3d 1045, 1047 (8th Cir. 1999); California v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000), *and amended by* 130 F. Supp. 2d 1137 (N.D. Cal. 2001)).

165. Brill, *supra* note 15, at 2, 2 n.5, 2–3 n.6 (citing the following papers: Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction* 22 (Fed. Trade Comm'n Bureau of Econ., Working Paper No. 293, 2009), <http://www.ftc.gov/be/workpapers/wp>

definition analyses for provider mergers and developed new models that have been the basis of the market definitions used in a string of victories by the FTC.¹⁶⁶

The key feature of the new ways to define health care markets is that they consider the roles of the various players in health care markets. Importantly, they take into account the key distinction between health care and other types of markets: the role of the health insurer. As explained by economist Gregory Vistnes in a seminal article in 2000, “Hospital competition is modeled as a two-stage game. In the first stage, hospitals compete to be included in a plan’s hospital network. In the second stage, hospitals compete for a plan’s individual enrollees, with that competition affected by whether a hospital is in the plan’s network.”¹⁶⁷ In health care, from the consumer perspective, “patients commit to a network of medical providers at the time they purchase their health insurance,

293.pdf; Patrick S. Romano & David J. Balan, *A Retrospective Analysis of Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 INT’L J. ECON. BUS. 45, 61 (2011); Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT’L J. ECON. BUS. 17, 30 (2011); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction*, 18 INT’L J. ECON. BUS. 91, 99 (2011); Orley Ashenfelter et al., *Retrospective Analysis of Hospital Mergers*, 18 INT’L J. ECON. BUS. 5, 14 (2011); Cory S. Capps et al., *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, 47 ANTITRUST BULL. 677, 713 (2002); Cory S. Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* 27–28 (Northwestern Univ. Ctr. for the Study of Indus. Org., Working Paper No. 0017, 2001); Cory S. Capps, *From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement*, 59 ANTITRUST BULL. 443, 476 (2014); Cory S. Capps, *Economic Analysis of Hospital Mergers in the 21st Century: A New Economic Toolkit for Assessing Hospital Mergers at the American Bar Association Antitrust Law Section Conference on Antitrust in Healthcare* (May 4, 2012)).

166. Brill, *supra* note 15, at 3, 3–4 n.9 (citing the following FTC victories: In the Matter of Inova Health Sys. Found. & Prince William Health Sys., Inc., No. 9326, 2008 WL 2556051, at *1 (Fed. Trade Comm’n June 17, 2008) (dismissing FTC complaint after the parties abandoned the merger); In the Matter of Reading Health Sys. & Surgical Inst. of Reading, No. 9353, 2012 WL 6188557, at *1 (Fed. Trade Comm’n Dec. 7, 2012) (dismissing FTC complaint after the parties abandoned the merger); Fed. Trade Comm’n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1071, 1095 (N.D. Ill. 2012) (granting FTC preliminary injunction); Fed. Trade Comm’n v. Phoebe Putney Health Sys., Inc., 133 U.S. 1003, 1016 (2013); Fed. Trade Comm’n v. Phoebe Putney Health Sys., Inc., No. 1:11-CV-00058-WLS, at 1 (M.D. Ga. June 5, 2013), <http://www.ftc.gov/sites/default/files/documents/cases/2013/06/130606phoebestip.pdf>; *Statement of FTC Competition Director Richard Feinstein on Today’s Announcement by Capella Healthcare that It Will Abandon Its Plan to Acquire Mercy Hot Springs*, FED. TRADE COMM’N (June 27, 2013), <https://www.ftc.gov/news-events/press-releases/2013/06/statement-ftc-competition-director-richard-feinstein-todays> (last visited Nov. 12, 2017)).

167. Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 672 (2000).

but before they know their specific medical needs.”¹⁶⁸ This shift in thinking, which led analysts to focus on insurer-provider negotiations and consumer preferences as they related to networks, was instrumental in developing more accurate ways to define health care markets. Before that, the two main methods of defining hospital markets in merger enforcement challenges, Elzinga-Hogarty and Critical Loss Analysis, had been overestimating the size of geographic markets, causing courts to find lower market shares and lower risks of resulting market power than they should have.¹⁶⁹ Dissatisfied with the results of the older analyses, economists developed new market definition models. Some economists distinguish these models as “structural” in comparison to the previously used “quantitative” models,¹⁷⁰ which essentially means that they take into account the role of the health insurer in determining health care prices.¹⁷¹

As another economist explains, health insurers, which typically charge the patient only a small portion of the provider’s price, cause patients to be unresponsive to the true prices of the services they consume, and therefore any accurate model must take them into account.¹⁷² But that does not mean that competition does not play a role in determining health care markets.¹⁷³ However, instead of doing so exclusively through consumer choice, competition in health care markets “does this through the selective contracting practices of insurance plans, which construct networks that attempt to optimize the tradeoff between comprehensiveness and costliness.”¹⁷⁴ The substitution analysis then focuses on the networks, i.e., “[w]hether an insurer includes attractive providers in the network, and at what price, depends upon the availability of substitutable providers.”¹⁷⁵ The newer analyses then also consider other stages of

168. Cory Capps et al., *Competition and Market Power in Option Demand Markets*, 34 RAND J. ECON. 737, 737–74 (2003).

169. Martin S. Gaynor et al., *A Structural Approach to Market Definition with an Application to the Hospital Industry*, 61 J. INDUS. ECON. 243, 248 (2013).

170. *Id.* at 245, 249, 256.

171. The new models included an analysis called “Willingness-to-Pay,” which is uniquely tailored to the health care industry based on a bargaining model of the negotiation between insurance companies and hospitals, a “Bertrand model,” and a market power measure for hospitals called the “Logit Competition Index.” See Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods* 6 (Fed. Trade Comm’n Bureau of Econ., Working Paper No. 326, 2015) (citing Robert Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON., 733, 733–53 (2001); Cory Capps et al., *Competition and Market Power in Option Demand Markets*, 34 RAND J. ECON. 737, 737–63 (2003)); see also David Dranove & Andrew Sfekas, *The Revolution in Health Care Antitrust: New Methods and Provocative Implications*, 87 MILBANK Q. 607, 614 (2009).

172. Brett W. Wendling & Nathan E. Wilson, *The Importance of Substitution in Assessing Health Care Provider Mergers*, 59 ANTITRUST BULL. 515, 516 (2014).

173. See *id.* at 516–17.

174. *Id.* at 517.

175. *Id.*

competition, including hospitals' subsequent competition for patients or insurers' competition for inclusion in plans offered to employees.¹⁷⁶

Plaintiffs and, correspondingly, courts have been borrowing from these analyses in defining markets in recent private cases—e.g., in the multi-district antitrust litigation against BCBS. Paraphrasing Vistnes' article from 2000, the court recently explained, "Healthcare providers participate in what is known as two-stage competition; first they compete for inclusion in the provider networks of insurers' plans, and then they compete for patients within a plan."¹⁷⁷ The related-but-distinct concept of a "two-sided market" recently received considerable attention following the Second Circuit's ruling in *United States v. American Express Co.* There, the court reversed the district court's ruling in favor of DOJ that American Express's "non-discrimination provisions" in its contracts with merchants, which prevented the merchants from steering consumers to use credit cards with lower fees (to be paid by the merchants), were anti-competitive.¹⁷⁸ In so ruling, the Second Circuit made clear that market definition in such markets should not be limited to one side of the market; instead the analysis must look at the anti-competitive effects on the consumer and not just the merchant. The admonition that antitrust protects competition (and consumers) as opposed to competitors is not new, but competitor plaintiffs must make certain to clarify that their interests align with those of consumers by showing that the anti-competitive effects extend to consumers in the form of higher prices or diminished quality. For example, in *Methodist*, where the plaintiff hospital argued that exclusive dealing by its competitor with insurers destroyed competition in the relevant tri-county health care services market, both the district court and Seventh Circuit were unconvinced that harm extended beyond the hospital-insurer stage of the market to the hospital-patient stage.¹⁷⁹ Accordingly, the court concluded that the only "victim" was the plaintiff who had the opportunity to improve and compete against competitor hospitals for contracts with insurers.¹⁸⁰

Specifically as to product markets, the FTC has long been using "cluster markets" in which groups of health services are grouped together—a tactic that

176. Petitioner's Response to Defendant's Motion for Judgment on the Pleadings at 9–10, *Methodist Health Servs. Corp. v. OSF Healthcare Corp.* 2014 WL 1612838 (No. 13-cv-1054) (citing Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 672 (2000)).

177. *In re Blue Cross Blue Shield Antitrust Litig.*, No. 2:13-CV-20000-RDP, 2017 WL 2797267, at *5 (N.D. Ala. June 28, 2017). This concept of a "two-sided market" recently received considerable attention following the Second Circuit's reversal in *United States v. American Express Co.* *United States v. American Express Co.*, 838 F.3d 179, 185–86 (2d Cir. 2016) (noting that credit card companies compete for merchants as well as for consumers), *cert. granted*, 138 S. Ct. 355 (2017) (mem.).

178. *American Express Co.*, 838 F.3d at 184–86, 206.

179. *Methodist Health Servs. Corp.*, 859 F.3d at 410–11.

180. *Id.* at 411.

has become popular in private cases.¹⁸¹ Of course, due to dissimilarities among most health care services, the most accurate product markets might be defined as singular services.¹⁸² No one would argue that bypass surgery and hip replacement are the same offering. Nonetheless, the procedures both have features that make them comparable for antitrust analysis, e.g., they are inpatient procedures typically covered by both Medicare and commercial insurance plans. Moreover, cases are often about how a defendant's conduct and market position affects the prices of multiple types of health care services, and defining a distinct market for each would be cumbersome and confusing. And unlike in most industries where "cluster markets are most often used as a convenience and not because they are analytically rigorous,"¹⁸³ the existence of networks means that goods are already clustered. Cluster markets make considerable sense in an industry characterized by network effects, i.e., as the number and type of health care providers included in the network increases, the more valuable the network is to consumers.¹⁸⁴

c. Market Definition at the Pleading Stage

Private enforcement differs from public enforcement in the degree to which defining markets at the pleading stage matters. As explained above, when the FTC files a challenge to a hospital merger, it typically does so with the benefit of pre-merger discovery and after having had a chance to do a full economic analysis of the merger's potential effects on competition. In contrast, in a private case, the plaintiff usually has insufficient information about anti-competitive effects until the post-pleading discovery process begins. Accordingly, surviving a motion to dismiss is crucial. And because pleading standards have become more difficult to satisfy, this is no simple task.

d. The *Twiqbal* Effect on Market Definition

Defining relevant markets is a highly fact-specific inquiry, which makes doing so in a complaint, before the benefit of discovery, particularly challenging. And because market definition is a factual as opposed to a legal issue, it cannot be resolved at the pleading stage.¹⁸⁵ Yet, in light of *Twombly* and *Iqbal*'s higher pleading standards, plaintiffs treat market definition as a discovery-phase fact issue at their peril. *Twiqbal*'s plausibility standard has crept (albeit

181. See Fed. Trade Comm'n v. Advocate Health Care Network, 841 F.3d 460, 467–68 (7th Cir. 2016) (collecting hospital merger cases); Omni Healthcare, Inc. v. Health First, Inc., No. 6:13-CV-1509-ORL, 2015 WL 275806, at *11 (M.D. Fla. Jan. 22, 2015); *In re Blue Cross Blue Shield Antitrust Litig.*, 2017 WL 2797267, at *5.

182. See ABA SECTION OF ANTITRUST LAW, *supra* note 161, at 280–81.

183. *Id.* at 280.

184. See SHEARMAN & STERLING LLP, 2017 ANNUAL REPORT: 23 MAJOR TRENDS IN ANTITRUST LAW 84 (2017) (discussing the network effects associated with the credit card industry).

185. See *Eastman Kodak Co. v. Image Tech. Servs. Inc.*, 504 U.S. 451, 482 (1992).

inconsistently) into courts' evaluations of relevant market definitions at the early stages of cases over the past several years. Even before the *Twiqbal* holdings, some courts already used a plausibility standard to evaluate market definition at the pleading stage.¹⁸⁶ Back then, many courts used "plausible" and "viable" interchangeably to describe the standard for relevant market definition at pleading.¹⁸⁷ Now with *Twiqbal* in effect, some commentators have noted the more express application of the "plausibility" standard to the non-conspiracy elements of antitrust claims, including market definition.¹⁸⁸

In reality post-*Twiqbal* courts have required varying degrees of plausibility in regard to market definition in health care cases. Some courts have demanded *Twiqbal*-style allegations of plausible relevant markets,¹⁸⁹ while others apply more forgiving standards.¹⁹⁰ There are three main categories of such cases: (1) cases in which courts expressly require that plaintiffs plead "plausibility" under *Twiqbal*,¹⁹¹ (2) cases that more generally cite to the *Twiqbal* standard as applying to all of the claims, but not expressly to market definition (and even in some cases citing to pre-*Twiqbal* cases in the market definition analysis);¹⁹² and (3) cases in which the plaintiff seems to luck out by drawing a judge whose standard for market definition appears closer to notice pleading than either pre-*Twiqbal* analyses that call for "plausibility" or "viability," or post-*Twiqbal*

186. *E.g.*, *Ferguson Med. Grp., L.P. v. Mo. Delta Med. Ctr.*, No. 1:06 CV 8 CDP, 2006 WL 2225454, at *3, *5 (E.D. Mo. Aug. 2, 2006).

187. *E. & G. Gabriel v. Gabriel Bros.*, No. 93 CIV. 0894 (PKL), 1994 WL 369147, at *2-3 (S.D.N.Y. July 13, 1994); *Theatre Party Assocs., Inc. v. Shubert Org., Inc.*, 695 F. Supp. 150, 154, 156 (S.D.N.Y. 1988) (granting defendant's motion to dismiss where plaintiff failed to allege "viable" or "plausible" relevant market).

188. Stephen P. Safranski, "*Plausibility*" and the Non-Conspiracy Elements of Antitrust Claims, ROBINS KAPLAN, LLP (June 5, 2014), <http://www.robinskaplan.com/resources/articles/plausibility-and-the-non-conspiracy-elements-of-antitrust-claims> (last visited Nov. 30, 2017).

189. *E.g.*, *Sidibe v. Sutter Health*, 51 F. Supp. 3d 870, 883 (N.D. Cal. 2014), *rev'd*, 667 F. App'x 641 (9th Cir. 2016); *see also* Safranski, *supra* note 188 ("Sidibe embodies the level of precision that federal courts may now demand in antitrust litigation under the *Twombly* plausibility standard when it comes to pleading the existence of a relevant market.").

190. *See, e.g.*, *Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I.*, 997 F. Supp. 2d 142, 163 (D.R.I. 2014) ("Geographic markets need not be alleged or proven with 'scientific precision,' nor be defined 'by metes and bounds as a surveyor would lay off a plot of ground.' The complaint need only present sufficient information to plausibly suggest the contours of the relevant geographic market.") (quoting *United States v. Blue Cross Blue Shield of Mich.*, 809 F. Supp. 2d 665, 673 (E.D. Mich. 2011)).

191. *E.g.*, *Sidibe*, 51 F. Supp. 3d at 882; *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 596 (8th Cir. 2009); *N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, 54 F. Supp. 3d 1189, 1199 (D.N.M. 2014).

192. *E.g.*, *Steward Health Care Sys., LLC*, 997 F. Supp. 2d at 151, 160; *Powderly v. Blue Cross & Blue Shield of N.C.*, No. 3:08-CV-00109-W, 2008 WL 4129767, at *1-2 (W.D.N.C. Sept. 4, 2008).

“plausibility” tests.¹⁹³ Under the circumstances, plaintiffs should assume a court will use greater scrutiny to examine pleading stage relevant market definitions. In one notable recent district court case, *Sidibe*, the court’s dismissal of the plaintiffs’ claims on a motion to dismiss the third amended complaint was based entirely their failure to allege *plausible* relevant geographic markets under *Twiqbal*.¹⁹⁴ That case was reversed and remanded to district court when the Ninth Circuit Court of Appeals decided, based on a 2008 case contemporaneous to *Twombly* but pre-*Iqbal* Ninth Circuit case, that fewer facts were required of plaintiffs in market definition at the pleading stage.¹⁹⁵ However, the Ninth Circuit’s opinion was unpublished and may be cold comfort for plaintiffs who opt to avoid *Twiqbal* plausibility when pleading relevant markets.

e. Recent Trends in Product Market Definition

Product market can be a subject of greater contention in private enforcement cases in health care than in public hospital merger challenges because the FTC and merging hospitals so often agree on the relevant product market (and conflict on geographic market).¹⁹⁶ Yet, like in public enforcement cases, product market is less contentious than the more often dispositive issue of geographic markets, and fewer cases tend to be dismissed on this issue early on in litigation.¹⁹⁷ Like the FTC and DOJ, most plaintiffs also distinguish health services paid for with government insurance from those paid for with commercial insurance in defining product markets,¹⁹⁸ but this issue has come up in some recent cases. For example, in *Marion HealthCare, LLC v. Southern Illinois HealthCare*, the

193. *E.g.*, *Am. Med. Ass’n v. United Healthcare Corp.*, 588 F. Supp. 2d 432, 447 (S.D.N.Y. 2008); *Deborah Heart & Lung Ctr. v. Penn Presbyterian Med. Ctr.*, No. CIV. 11-1290 RMB KMW, 2011 WL 6935276, at *4 (D.N.J. Dec. 30, 2011); *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-cv-1509-Orl-37DAB, 2015 WL 275806, at *11–12 (M.D. Fla. Jan. 22, 2015).

194. *Sidibe*, 51 F. Supp. 3d at 883, 886–87 (noting that the district court explained it was “not requiring heightened pleading”).

195. *Sidibe v. Sutter Health*, 667 F. App’x 641, 643 (9th Cir. 2016).

196. *Gaynor et al.*, *supra* note 160, at 3, 3 n.6, but see *Promedica Health System, Inc. v. Fed. Trade Comm’n*, 749 F.3d 559, 565 (6th Cir. 2014), a case in which the product market was a subject of contention.

197. Recent cases where defendants have challenged a product market in health care as too narrow include a case where the court found the product market should extend to all medical services provided to inmates in all locked facilities, not just prisons, *Colonial Med. Grp., Inc. v. Catholic Health Care W.*, 444 Fed. App’x 937, 938 (9th Cir. 2011), and a case in which the district court conflated the product market with the geographic market, demanding that the “product market” should extend to similar products in other geographic areas, *Rocky Mountain Med. Mgmt., LLC v. LHP Hosp. Grp., Inc.*, No. 4:13-cv-00064-EJL, 2013 WL 5469890, at *14 (D. Idaho Sept. 30, 2013).

198. *See, e.g.*, *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, No. 1:13-cv-01054-SLD-JEH, 2015 WL 1399229, at *2 (C.D. Ill. Mar. 25, 2015); *In re Blue Cross Blue Shield Antitrust Litig.*, No. 2:13-CV-20000-RDP2017, 2017 WL 2797267, at *5 (N.D. Ala. June 28, 2017).

plaintiff's product market definition included only hospital services paid for by commercial insurers but not government payors.¹⁹⁹ The district court granted the defendant's motion to dismiss, finding that a product market that included only hospital services paid for by commercial insurance, but not those same services when paid for by Medicare or Medicaid, was implausibly narrow.²⁰⁰ In doing so, the court relied on the Eighth Circuit's 2009 decision in *Little Rock Cardiology Clinic PA v. Baptist Health*, a case that declined to distinguish health care services markets based on payors, reasoning that, from the doctor's perspective, the consumer's method of payment was irrelevant and therefore could not be the basis of a market definition.²⁰¹ Those cases appear to be the exception, however, and other courts in contemporaneous cases have limited product markets to health care services purchased by commercial payors despite defendants' arguments for all payors' inclusion.²⁰²

Plaintiffs have also been successful in using the cluster market approach in health care. For example, the court accepted this strategy in the recently settled case of *Omni Healthcare* in which physician groups sued a health care corporation comprised of a hospital and an insurance plan, alleging the health care giant used its market power, gained in part from anti-competitive mergers, to obtain exclusive referral arrangements aimed at eliminating competitors.²⁰³ In declining to exclude the plaintiff's expert economist's report, which clustered health services into product markets, the court explained that "[t]he Supreme Court has also recognized that there is 'no barrier to combining in a single market a number of different products or services where that combination reflects commercial realities.'"²⁰⁴ Even more recently, a court in the antitrust

199. *Marion HealthCare, LLC v. S. Ill. HealthCare*, No. 12–CV–00871–DRH–PMF, 2013 WL 4510168, at *2 (S.D. Ill. Aug. 26, 2013). The court dismissed the complaint without prejudice, *id.* at *11–12, and after refileing the case with a product market definition broadened to include all payors, several counts of the complaint survived a subsequent motion to dismiss, *Marion HealthCare, LLC v. S. Ill. Healthcare & Health Servs. Corp.*, No. 12–cv–871–SMY–PMF, 2015 WL 3466585, at *8 (S.D. Ill. May 29, 2015).

200. *Marion HealthCare, LLC*, 2013 WL 4510168, at *10–11.

201. *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 597–98 (8th Cir. 2009).

202. *See, e.g.*, *Methodist Health Services Corporation's Opposition in Response in Opposition* at 9–10, *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, No. 13–cv–1054 (C.D. Ill. Apr. 11, 2014) (relying on Economist Gregory Vistnes's work and *In re ProMedica Health System, Inc.* to argue that exclusion of government payors resulted in the most accurate product market definition because the prices government payors pay for medical services do not significantly constrain those paid by commercial insurers, who negotiate their rates with providers separately and individually); *In re Blue Cross Blue Shield Antitrust Litig.*, 2017 WL 2797267, at *9; *Steward Health Care Sys., LLC v. Blue Cross Blue Shield of R.I.*, 997 F. Supp. 2d 142, 161 (D.R.I. 2014) (finding that a product market with only commercial payors was plausible because of lack of interchangeability with Medicare- and Medicaid-purchased health care services).

203. *Omni Healthcare Inc. v. Health First, Inc.*, No. 613CV1509ORL37DAB, 2016 WL 4272164, at *2, *22 (M.D. Fla. Aug. 13, 2016).

204. *Id.* at *8 (quoting *United States v. Grinnell Corp.*, 384 U.S. 563, 572 (1966)).

litigation against BCBS noted that a “cluster market” is “a concept widely accepted in healthcare antitrust cases and scholarly economic analyses.”²⁰⁵ Because of the existence of networks in health care, this clustering finds a natural fit in health care product markets. In this sense, cluster markets are more a market reality than a litigant’s convenience and are likely to continue to gain traction as the plaintiff’s preferred methodology for product market definition.

f. Recent Trends in Geographic Market Definition

Recent antitrust health care cases also highlight the aspects of geographic market definition that courts appear to be most focused on at the pleading stage. Of course, courts demand good faith and are inclined to dismiss a complaint when they determine that a plaintiff’s proposed geographic market definition is more a gerrymandered, results-driven presentation of the facts rather than an accurate picture of the market at issue.²⁰⁶ Beyond that, plaintiffs must frame their geographic market definition, just as with product market definition,²⁰⁷ in terms of substitutes available to the buyer. This distinction is not new, and the notion of available substitutes was articulated in the seminal (but non-health care) case of *Brown Shoe* in 1962.²⁰⁸ Once the product market is determined, it serves to define the geographic market, which “extends to the area of effective competition where buyers can turn for alternative sources of supply” of the product at issue.²⁰⁹

In a number of private antitrust cases over the past several years, court decisions have favored plaintiffs’ geographic market definitions that described where customers *could* receive health care services over those that described where patients *actually* received services. In a 2002 monopolization and tying case before the Fifth Circuit, the court explained that the plaintiff’s expert had defined the defendant hospital’s service area as coextensive with its geographic market instead of “where people could practicably go for inpatient services.”²¹⁰ This defect was fatal, as the court explained, “‘trade area is not necessarily the relevant geographic market for purposes of antitrust analysis’ because

205. *In re Blue Cross Blue Shield Antitrust Litig.*, 2017 WL 2797267, at *5.

206. *See, e.g.,* *Ferguson Med. Grp., L.P. v. Mo. Delta Med. Ctr.*, No. 1:06CV8 CDP, 2006 WL 2225454, at *3 (E.D. Mo. Aug. 2, 2006); *Little Rock Cardiology Clinic PA*, 591 F.3d at 599.

207. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES 8 (2010), <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>. Recall that product market definition involves “demand substitution factors,” or “customers’ ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service.” *Id.* at 7.

208. *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).

209. *Sidibe v. Sutter Health*, 51 F. Supp. 3d 870, 883 (N.D. Cal. 2014) (quoting *Tanaka v. Univ. of S. Cal.*, 252 F.3d 1059, 1063 (9th Cir. 2001)), *rev’d*, 667 F. App’x 641 (9th Cir. 2016).

210. *Surgical Care Ctr. of Hammond, L.C. v. Hosp. Serv. Dist. No. 1 of Tangipahoa Par.*, 309 F.3d 836, 840 (5th Cir. 2002).

geographic market evidence must take into account ‘where consumers could practicably go, not on where they actually go.’”²¹¹ In 2014, the district court in *Sidibe* articulated the same reason for dismissing the plaintiffs’ geographic market definition—the Dartmouth Atlas’ hospital service areas (routinely used in the health care insurance industry)—saying the definition did not work “for antitrust purposes” because the relevant geographic market should encompass the area where patients *could go*, not just where they typically already did go.²¹² But that case was reversed on appeal by the Ninth Circuit.²¹³ And in the BCBS multi-district litigation, a court recently accepted Dartmouth Atlas Hospital Referral Regions and Dartmouth Atlas Hospital Service Areas as relevant geographic markets “for the product market defined as the purchase of goods and services from healthcare facilities by commercial buyers.”²¹⁴ Accordingly, the notion of where a plaintiff *could go* versus *does go* may be evolving as courts continue to consider how the role of the insurer affects how health care markets function. In other words, the network controls the geographic scope of markets more so than in other antitrust cases where consumers could act on preferences without such constraints. Plaintiffs who focus on the geographic boundaries related to how the network directs patients may therefore be the most successful in defining markets.

2. Claim Selection

Determining which claims to include in one of these cases based on cases already filed is not exactly a scientific exercise. For one, the number of cases filed is small. And of the cases filed, many settle before their claims are litigated.²¹⁵ It is often easier to identify losing strategies than winning ones, but even then all that can be learned from a lower court opinion is how one district court judge saw the issue. For example, many of the cases involving providers and insurers involve similar facts: smaller provider sues larger provider(s) (and often one or more insurer) for keeping it from competing in the market for certain health care services in a given location. Such a case could be styled as a conspiracy to boycott under Sherman Act Section 1, an exclusive dealing arrangement under Sherman Act Section 1 or Section 2 or Clayton Act Section 3, and/or monopolization or a conspiracy to monopolize under Sherman Act

211. *Id.* (quoting *Minn. Ass’n of Nurse Anesthetists v. Unity Hosp.*, 208 F.3d 655, 662 (8th Cir. 2000)).

212. *Sidibe*, 51 F. Supp. 3d at 884.

213. *Sidibe v. Sutter Health*, 667 F. App’x 641, 642 (9th Cir. 2016).

214. *In re Blue Cross Blue Shield Antitrust Litig.*, No. 2:13-CV-20000-RDP, 2017 WL 2797267, at *6 (N.D. Ala. June 28, 2017).

215. *See, e.g.*, Joint Stipulation of Final Dismissal, *Arapahoe Surgery Center, LLC v. Cigna Healthcare, Inc.*, 80 F. Supp. 3d 1257 (D. Colo. 2016) (No. 1:13-CV-03422); Order of Dismissal with Prejudice, *Omni Healthcare, Inc. v. Health First, Inc.*, 2015 WL 275806 (M.D. Fla. Jan. 22, 2015) (No. 6:13-cv-1509-Orl-37DAB).

Section 2, as well as anti-competitive under the relevant state antitrust statutes, and so on. The plaintiff's selections determine whether the case will be examined under the per se doctrine or the rule of reason, what effects must be shown including whether the plaintiff must show it was foreclosed from dealing in the relevant market, and more. Of course, each case has its own specific facts (e.g., a plaintiff may have evidence of an outright conspiracy in one case, whereas another plaintiff may only have the option of suing based on the contracts at issue), as well as other unique circumstances like the political environment involved and the judge assigned. Furthermore, a plaintiff's attempts to choose claims more favorable to the plaintiff's case than the court believes the facts provide for can be fatal, as was the case in *Elizabeth Place*, where the court essentially held that the plaintiffs had tried to shoehorn a case about vertical restraints (restrictions on agreements between providers and payors, which would require more evidence of anti-competitive effects through a rule of reason analysis) into a horizontal conspiracy claim, that they might stand to win under per se treatment.²¹⁶ Accordingly, plaintiffs are ultimately left to determine which claims most accurately reflect the facts of their cases, including the realities of the markets in which they buy or sell health care services or insurance. As courts continue to develop a more sophisticated understanding of how these markets work, plaintiffs will likely be rewarded for such a strategy.

IV. CONCLUSION

Private antitrust enforcement is an indispensable tool in the fight against market power and high prices in health care. Unlike public enforcement, private enforcement allows health care entities to police their own markets and consumers to seek redress from the effects of market power among providers and insurers. Besides, public enforcement is incapable of doing the entire job due to limited resources and or a lack of political will. Despite criticisms that private suits are self-interested and therefore anti-competitive, these lawsuits can be both self-interested *and* pro-competitive. The antitrust laws were written to take advantage of private plaintiffs' incentives and information. Properly optimized, private antitrust enforcement has the potential to provide a truly effective complement to public antitrust enforcement as a means to addressing health care prices.

216. *Medical Ctr. at Elizabeth Place, LLC v. Atrium Health Sys.*, 817 F.3d 934, 946 (6th Cir. 2016).