JOHN BROWN; LISA FAGAN; MICHAEL FAGAN; JEFFREY FORDE; MICHAEL MORGAN; JOSHUA PAWELEK; AND JOHN STOEHR, as individuals and on behalf of all others similarly situated, *Plaintiffs,*	DOCKET NO. HHD-CV22-6152239-S SUPERIOR COURT JUDICIAL DISTRICT OF HARTFORD AT HARTFORD
v.	
HARTFORD HEALTHCARE CORPORATION *Defendant*	April 12, 2022

FIRST AMENDED CLASS ACTION COMPLAINT

Plaintiffs John Brown, Lisa Fagan, Michael Fagan, Jeffrey Forde, Michael Morgan, Joshua Pawelek and John Stoehr, individually, and on behalf of all others similarly situated, bring this action against Defendant Hartford HealthCare Corporation ("HHC") and state as follows:

I. NATURE OF THE ACTION

1. This is an action for restraint of trade, unlawful monopolization, and unfair methods of competition seeking classwide damages and injunctive and equitable relief under the Connecticut Antitrust Act, Conn. Gen. Stat. §§ 35-24 *et seq.*, and the Connecticut Unfair Trade Practices Act, Conn. Gen. Stat. §§ 42-110a *et seq*.

2. For the past several years, HHC has used unlawful and anticompetitive methods to restrain trade, to acquire a monopoly on acute inpatient hospital services in many key regions in the State, and to abuse that monopoly by using it to extract higher prices from insurers, employers, and patients throughout the areas it does business. HHC's conduct, which violates the Connecticut

Antitrust Act and the Connecticut Unfair Trade Practices Act, has led directly to Plaintiffs and other Connecticut residents enrolled in commercial health plans paying drastically inflated prices for their healthcare.

3. HHC owns the largest hospital in Hartford (Hartford Hospital), as well as a large network of outpatient facilities throughout the State. HHC also owns and operates several "must-have" hospitals in Connecticut that commercial health plans must include in their networks in order for their insurance products to be commercially viable. HHC leverages its monopoly power over those facilities to force insurers, employers, and patients to pay unreasonably high prices for care—not only at those facilities but also at other facilities, like Hartford Hospital, that operate in more competitive markets. HHC does this by negotiating with commercial health plans on an "all-or-nothing" basis, telling insurers that if they want HHC's "must-have" hospitals in their insurance networks (which HHC knows they need) the insurers must also include in their networks other HHC facilities and services at substantially inflated prices.

4. HHC further uses anticompetitive contracting and negotiating tactics to limit the ability of commercial health plans to provide truthful information and monetary incentives to encourage their members to obtain care from HHC's competitors, which offer cheaper and/or higher quality alternative care options. Through these tactics and others described herein, HHC has attempted to stamp out potential competition and extract supracompetitive profits throughout Connecticut.

5. HHC's anticompetitive conduct has forced patients and employers in Connecticut to pay higher prices for routine services that are often available at other hospitals only minutes away for substantially less. As a result, Connecticut patients and employers are overcharged tens

of millions of dollars every month by HHC. These overcharges come in the form of premiums, deductibles, coinsurance, and copays that are substantially higher than they would be absent HHC's anticompetitive conduct.

6. HHC's flagship hospital, Hartford Hospital, has significantly higher prices than competitors in Hartford. Inpatient prices for many routine procedures are thousands of dollars higher. HHC's outpatient prices are also significantly higher than competitors. At the same time, HHC's quality of care is no better—and, in many instances, it is worse—than that of nearby competitors.

7. In a healthy and functioning market, HHC's price and quality disparities would be disciplined through competition. Commercial health plans would threaten to take HHC's overpriced facilities out of their network and would provide patients with incentives to choose higher quality and more cost-effective care from HHC's nearby competitors. HHC would then be forced to reduce its prices to competitive levels and improve its quality of care.

8. However, HHC has gone to extraordinary lengths to prevent such competition in the regions where it operates. For example, unlike some other hospital systems in Connecticut, HHC engages in "all-or-nothing" negotiating—insisting in its negotiations with commercial health plans that the plans must include all of HHC's facilities if they want to (or must) include any. According to a New York Times investigation, HHC's actions specifically have the effect of "forcing health insurers to include all of their hospitals in a network or risk losing access in areas where there are no alternatives." HHC further limits the ability of insurers to direct patients to more affordable care with monetary incentives.

9. And HHC uses non-compete provisions and punitive referral tactics with affiliated physicians, and gag clauses with insurers, all of which are designed to further stifle competition and transparency. These tactics include the use of improper financial incentives to coerce independent physicians to refer within the HHC system instead of to the highest quality or best value provider, which may be a non-HHC facility.

10. HHC's market share and monopoly power in many of the markets in which it operates was not built by outcompeting other providers but by acquiring existing competitors who had their own outsized market power, which HHC now leverages to engage in these kinds of anticompetitive tactics. The result is that hundreds of thousands of Connecticut residents and their employers pay artificially inflated rates for their health insurance and the care they receive from HHC.

11. Despite claiming non-profit status, HHC's profit margins are projected to be over 8% in the coming years, which will result in HHC extracting roughly $400 million per year in profits from Connecticut residents. This profit margin is largely a result of HHC's practice of illegally using its market power to force employers, patients, and insurers to accept supracompetitive prices for lower-quality care.

12. In addition to funding acquisitions to further grow its market power, HHC uses these large profits to pay the executives of a supposed charitable institution staggering sums. The CEO of HHC paid himself over $4 million from the "charity" in the most recent full year of reporting. At least six other executives were paid over $1 million per year in 2019, and dozens of other executives earn over half a million dollars per year.

13. Section 35-26 of the CAA forbids any "contract, combination, or conspiracy in restraint of any part of trade or commerce," and Section 35-27 declares that "monopolization of any part of trade or commerce is unlawful." Section 42-110b of CUTPA prohibits "unfair methods of competition and unfair or deceptive acts" in commerce. These statutes prohibit HHC's anticompetitive conduct and give a remedy to those, like Plaintiffs and the putative class, whom HHC has harmed with its unlawful acts.

14. Plaintiffs bring this action on behalf of themselves and other commercially insured individuals whom HHC has forced to pay higher premiums, coinsurance payments, deductibles, copays, and other direct payments to HHC. They seek damages to compensate for the amount they have been illegally overcharged, punitive damages for HHC's willful misconduct, an injunction prohibiting HHC from continuing to abuse its monopoly power through anticompetitive contracting, and other equitable and declaratory relief designed to put an end to HHC's misconduct.

II. PARTIES

A. Plaintiffs

15. Plaintiff **John Brown** is a resident of Sherman, Connecticut. He is enrolled in a commercial health plan administered by ConnectiCare, for which he pays monthly insurance premiums.

16. Plaintiff **Lisa Fagan** is a resident of Farmington, Connecticut. She is enrolled in a commercial health plan administered by ConnectiCare, for which her household pays monthly insurance premiums.

17. Plaintiff **Michael Fagan** is a resident of Farmington, Connecticut. He is enrolled in a Medicaid health plan. His household pays monthly commercial insurance premiums.

18. Plaintiff **Jeffrey Forde** is a resident of Monroe, Connecticut. He is enrolled in a commercial health plan, for which his household pays monthly insurance premiums.

19. Plaintiff **Michael Morgan** is a resident of West Simsbury, Connecticut. He is enrolled in a commercial health plan administered by UnitedHealthcare, for which his household pays monthly insurance premiums.

20. Plaintiff **Reverend Joshua Pawelek** is a resident of Glastonbury, Connecticut. He is enrolled in a commercial health plan administered by Anthem, for which his household pays monthly insurance premiums.

21. Plaintiff **John Stoehr** is a resident of New Haven, Connecticut. He is enrolled in a commercial health plan administered by ConnectiCare, for which his household pays monthly insurance premiums.

22. Plaintiffs have all been injured in their business or property due to HHC's anticompetitive conduct, through the payment of higher insurance premiums and deductibles caused by the price increases HHC's unlawful acts have caused and, for some Plaintiffs, through higher direct payments to HHC through copays, coinsurance, and otherwise. Plaintiffs are efficient enforcers of the CAA, because the CAA protects consumer welfare and Plaintiffs have been injured by HHC as consumers of healthcare products and services.

B. Defendant

23. Defendant **Hartford HealthCare Corporation** is a Delaware corporation with its principal place of business at One State Street, Suite 19, Hartford, CT 06103. It may be served

with process through its agent for service of process at Corporation Service Company, 225 Asylum Street, 20th Floor, Hartford CT 06103. Per its own website, HHC has 33,000 employees, 400 locations, and total operating revenue of $4.9 billion. HHC is the second largest employer in Connecticut, and it interacts with approximately 17,000 patients daily.

24. HHC has been named as a respondent in prior antitrust proceedings, including a suit filed by St. Francis Hospital and Medical Center on January 11, 2022, alleging that HHC used an unlawful scheme to monopolize regional medical care in Connecticut by acquiring physician practices and bullying doctors into exclusive referral agreements.

III. JURISDICTION AND VENUE

25. The Court has subject matter jurisdiction over Plaintiffs' CAA claims under Conn. Gen. Stat. § 35-33. The Court has subject matter jurisdiction over Plaintiffs' CUTPA claims under Conn. Gen. Stat. § 42-110g.

26. The Court has general personal jurisdiction over HHC because it is domiciled in the State and/or has transacted business in the State relevant to this antitrust action.

27. Venue is proper in this Court because a substantial part of the events giving rise to Plaintiffs' claims occurred in this judicial district.

28. This class action falls under the local controversy exception to federal jurisdiction under the Class Action Fairness Act. 28 U.S.C. § 1332(d)(4), because HHC is a citizen of Connecticut and more than two thirds of the putative class are citizens of Connecticut.

IV. OVERVIEW OF HOSPITAL/INSURANCE MARKETS AND EFFECTS OF CONSOLIDATION

A. Hospital/Insurance Negotiations in a Competitive Market

29. The market for hospital services is different from other product/services markets because the person consuming the hospital services (the patient) does not negotiate—and in many cases, does not even know beforehand—the prices of the services they are consuming.

30. Instead, commercial health plans purchase medical services for the benefit of their insured members, the consumers. Commercial health plans negotiate with hospitals for the prices of medical services before they are consumed by members. These negotiated prices for in-network care are called "allowed amounts."

31. Commercial health plans do not negotiate with hospitals on a service-by-service basis. Rather, plans negotiate with hospitals for bundles of services that they will offer to members as "in-network" benefits. If a commercial health plan and hospital reach a deal for a bundle of services (for instance, all acute inpatient hospital services), the hospital will be considered in-network for every service in that bundle. This means that for any service in that bundle, if a commercial health plan's member receives that service from the hospital, the commercial health plan will pay the hospital the allowed amount those two parties negotiated for that service.

32. In competitive markets—markets with multiple hospitals providing the services commercial health plans need or want to offer their members— a commercial health plan will contract with a hospital for a bundle of services only when the hospital offers competitively priced and sufficiently high-quality services. The health plan may choose to include as in-network only some bundles of services at any given hospital For instance, the plan may choose to have one hospital be in-network for all acute inpatient hospital services, but may choose not to include that hospital in-network for some acute outpatient hospital services (visits not requiring an overnight stay) because the plan could purchase higher quality and/or less expensive versions of those

outpatient services from a nearby competing hospital or other outpatient provider. Similarly, in a competitive market, a commercial health plan may decline to purchase any services from a hospital if that hospital's price or quality of care are not competitive with other providers in the region.

33. If a commercial health plan wishes to be a viable product that consumers wish to purchase for themselves (or employers wish to purchase for their employees), the plan must include a comprehensive bundle of services that members can access in their region. A commercial health plan will not be viable if it does not offer in-network services that individuals commonly desire or need. Similarly, a commercial health plan will not be viable if it only offers certain services (such as acute inpatient hospital services) in-network at a hospital that is a long distance from many individuals' residences, because individuals may not be able or willing to travel so far to receive those services. State laws regarding network adequacy may also require commercial health plans to offer coverage in every region in the State.

34. The costs that commercial health plans pay hospitals for in-network services are ultimately passed onto their members, such as the Plaintiffs, in the form of commercial health insurance premiums. A significant body of academic research has demonstrated that there is a direct connection between higher hospital prices and higher insurance premiums, and that one of the primary drivers of an increase in premiums is consolidation in the relevant hospital market.[1] Thus, the insurance premiums paid by commercial health plan members increase when the plans are forced to purchase services from hospitals at higher rates. Health plan members also pay

[1] *See, e.g.*, Richard Scheffler, et al., *Consolidation Trends in California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices*, Health Affairs 37, no. 9: 1409-16 (September 1, 2018), *available at* https://doi.org/10.1377/hlthaff.2018.0472 (finding that an increase in share of physicians in practices owned by a hospital was associated with 12% increase in premiums for commercial health plans).

directly for the costs of medical services provided by hospitals in the form of co-insurance payments and other out of pocket payments, such as copays.

35. In a competitive market, hospitals compete to be selected for inclusion in commercial health plans. Then, commercial health plans compete to be selected by employers to offer to their workers, or they compete to be selected by individuals.

B. Hospital/Insurance Negotiations in the Absence of Competition

36. The unique mechanics of the healthcare market provide an opportunity for hospital conglomerates with significant market power to illegally restrain trade through unduly restrictive negotiations and agreements with commercial health plans that extract supracompetitive prices. Supracompetitive prices are rates that are higher than what would be found in the context of normal competition. In the market for hospital services, supracompetitive prices come in the form of inflated allowed amounts, which directly lead to higher insurance premiums, coinsurance payments, and other financial harms.

37. When a commercial health plan is constructing a network in a region where a significant geographic area is controlled by a single hospital, that hospital is in effect a "must-have" for that plan. Individuals and employers seeking insurance in that region will not choose any health plan that does not include necessary services provided by that hospital. In some instances, state laws such as network adequacy requirements legally require a commercial health plan to offer in-network services in a region dominated by a single provider, which is another way in which a hospital can be a "must-have" facility for a commercial health plan.

38. A system that includes a must-have hospital and engages in anticompetitive behavior can cause significant financial harm to commercial health plans and to employers and

individuals purchasing those plans. First, a hospital system with a must-have facility can demand from commercial health plans allowed amounts that are grossly above what the hospital could obtain if it faced competition. This is true both by virtue of the hospital's extant market power, as well as the enormously high barriers to entry when it comes to many services hospitals provide, such as acute inpatient hospital services. These barriers to entry, which include the costs of building facilities and hiring skilled staff (such as surgeons and anesthesiologists) as well as regulatory hurdles such as obtaining a certificate of need from the State before opening a new facility, prevent new entrants from entering the market and reining in prices that must-have hospitals can charge.

39. Second, if the must-have facility is part of a hospital system that has other facilities that *do* face competition, the hospital system can refuse to offer in-network services at the must-have facility unless commercial health plans also agree to include in their networks services at the system's other facilities. By tying their must-have facilities to the rest of their locations through this kind of "all-or-nothing" negotiating, hospital systems with must-have facilities can extract supracompetitive prices from commercial health plans, employers, and patients, even at the system's facilities that do face competition.

40. These factors and others have led to a consensus in the field of healthcare economics that monopolization of hospital markets and all-or-nothing contracting significantly increase prices for hospital services paid by commercial health plans, and by employers and individuals, in the form of higher direct payments to hospitals and higher insurance premiums. And the economic literature strongly suggests that there are no concomitant improvements in quality from such monopolization.

41. Another anticompetitive tactic used by dominant hospitals to extract supracompetitive prices is the imposition of "anti-steering" and "anti-tiering" provisions in their contracts with commercial health plans. In a competitive market, a commercial health plan may include both high-cost and low-cost hospitals in-network but the plan can take measures to incentivize members to choose the lower-cost, higher-quality provider where possible. These incentives can include providing truthful information about the cost of care and offering financial benefits (e.g., lower co-pays or more preferential risk-sharing) when patients choose lower-cost providers. Such measures undertaken by insurers are called "steering." Another form of steering is the creation of "tiered" insurance plans, in which low-cost, high-quality providers are in a higher tier than more expensive and/or lower quality competitors, and the plan's members are financially incentivized to choose providers in a higher tier. This form of steering is often referred to as "tiering."

42. Academic research by health economists has demonstrated that when commercial health plans are free to engage in steering and tiering, both the plans and their members pay significantly lower costs for healthcare, with no corresponding reduction in health outcomes.

43. When a dominant hospital system—particularly a system with one or more must-have facilities—negotiates with commercial health plans, the system can force the insurer not to engage in these cost-saving measures by requiring insurers to include "anti-steering" or "anti-tiering" provisions in their payer/provider contracts. Such provisions essentially require insurers to grant the dominant provider a "most favored nation" status, preventing commercial health plans from favoring other systems through financial incentives, information sharing, or placing any other system in a plan's higher "tier."

44. In 2016, President Obama's Department of Justice brought a Sherman Act suit against a dominant North Carolina hospital system that imposed anti-steering and anti-tiering provisions on commercial health plans. The government alleged that the system "prevent[ed] insurers from offering tiered networks that feature hospitals that compete with [the system] in the top tiers, and prevent[ed] insurers from offering narrow networks that include only [the system's] competitors." The government further alleged that these and other "steering restrictions reduce competition resulting in harm to Charlotte area consumers, employers, and insurers." The government also alleged that the system had the market power necessary to be able to force these provisions on unwilling insurers, because the system controlled approximately 50 percent of the relevant market (acute inpatient hospital services). After a federal court held that the system's use of anti-steering provisions was plausibly anticompetitive under the Sherman Act, the case settled and the system agreed not to impose anti-steering and anti-tiering provisions on commercial health plans going forward.

45. Former President Trump's Principal Deputy Assistant Attorney General for Antitrust also criticized anti-steering provisions: "Without these provisions, insurers could promote competition by 'steering' patients to medical providers that offer lower priced, but comparable or higher-quality services. Importantly, that practice benefits consumers, but the anti-steering restrictions prevented it."

46. President Biden's Secretary of Health and Human Services Xavier Becerra, wrote in his previous role as California Attorney General that contracting practices that "prevented insurers from using steering and tiering" were among types of "anticompetitive conduct" that "discouraged competition, impaired price-conscious consumer choice, and resulted in inflated

prices on a system-wide basis that exceed its competitors and exceed the prices its hospitals and its other providers could charge in a free, competitive market."

47. Likewise, Senator Chuck Grassley, then chairman of the US Senate Judiciary Committee, said such anti-steering practices were "restrictive contracts deliberately designed to prevent consumers' access to quality, lower cost care."

V. BACKGROUND ON HHC'S ABUSE OF ITS DOMINANT MARKET POSITION

48. HHC owns multiple hospitals across Connecticut, including monopoly hospitals. Its monopoly hospitals include facilities providing inpatient services in Willimantic, Norwich, and Torrington. Through all-or-nothing negotiating and anti-steering and anti-tiering restrictions, HHC leverages its monopoly power in Willimantic, Norwich, and Torrington to grow both its inpatient and outpatient services in these regions as well as in Hartford and Bridgeport, typically competitive markets.

49. HHC built its monopoly in the regions above not through fair competition but by acquiring existing competitors and by unfairly forcing on commercial health plans terms that disadvantaged other competitors. It exploits its monopoly power by charging supracompetitive prices for its care, including for routine procedures, emergency and trauma services, and outpatient procedures. Indeed, in many instances the care provided in HHC facilities is significantly worse than nearby peers.

50. HHC also maintains and extends its monopoly power through the use of other anticompetitive practices including, but not limited to, using all-or-nothing negotiation tactics, anti-tiering and anti-steering contracting terms, gag clauses, non-compete clauses, and restrictions on the manner in which its physicians can make referrals.

51. As one of Connecticut's major hospital networks, the result of HHC's anticompetitive conduct has been a dramatic increase in prices on acute care and in the cost of commercial health insurance for commercially insured individuals and their employers.

VI. RELEVANT MARKETS AND MARKET POWER

A. Relevant Markets

52. Judgment may be entered against HHC for the illegal conduct described in this complaint without defining the particular economic markets that HHC's conduct has harmed. With respect to Plaintiffs' CUTPA claim, no definition of a relevant market is necessary to adjudicate HHC's conduct as an unfair and/or deceptive trade practice. With respect to Plaintiffs' CAA claims, HHC's ability to impose anticompetitive contract terms in all, or nearly all, of its agreements with commercial health plans and HHC's ability to persistently charge supracompetitive prices are direct evidence of HHC's market power that obviates any need for further analysis of competitive effects in particular defined markets. Moreover, market definitions are unnecessary to enter judgment in Plaintiffs' favor on its CAA claims because HHC's anticompetitive behavior is a per se violation of Conn. Gen. Stat. § 35-26 *et seq*.

53. Notwithstanding the foregoing, the markets that are relevant to the illegal conduct described in this Complaint are properly defined herein. For each, the product market includes only the purchase of medical services by commercial health plans, including individual, group, fully insured, and self-funded health plans, as well as related payments by patients directly to providers through copays, coinsurance, or otherwise. The relevant product markets do not include sales of such services to government payers, e.g., Medicare, Medicaid, and TRICARE (covering

military families), because a healthcare providers' negotiations with commercial health plans are separate from the process used to determine the rates paid by government payers.

1. The Relevant Product Markets

54. The primary relevant product markets in this action are the clusters of inpatient and outpatient acute hospital care services offered by HHC. These inpatient and outpatient markets, which are distinct product markets from each other for reasons discussed below, include sales of such services to insurers' individual, group, fully insured, and self-funded health plans, as well as to those directly compensating HHC through coinsurance or otherwise. HHC sells these services at each of its facilities, although not every facility offers the same bundle of services.

55. ***Relevant Product Market #1: Acute inpatient hospital services.*** Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other (e.g., orthopedic surgery is not a substitute for gastroenterology), commercial health plans typically contract for various individual acute inpatient hospital services as a bundle in a single negotiation with a hospital. Moreover, non-hospital facilities, such as outpatient facilities, specialty facilities (such nursing homes), and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services are not viable substitutes for acute inpatient hospital services. Consequently, commercial health plans' and consumers' demand for acute inpatient hospital services is generally inelastic because such services are often necessary to prevent death or long-term harm to health. Thus, such inpatient services can be treated analytically as a single product market.

56. ***Relevant Product Market #2: Outpatient medical services.*** Outpatient medical services encompass all the medical services a hospital provides that are not inpatient medical services (i.e., services that do not require an overnight stay). The market includes sales of such services to commercial insurers' individual, group, fully insured, and self-funded health plans, as well as to patients directly compensating HHC through coinsurance or otherwise. Although individual outpatient medical services are not substitutes for each other (e.g., a CT scan is not a substitute for an annual physical), commercial health plans typically contract for various individual outpatient medical services as a bundle in a single negotiation with a hospital system, and that is how HHC negotiates with insurers with respect to outpatient hospital services.

57. Unlike for acute inpatient hospital services, non-hospital facilities—such as independent primary care providers, specialty facilities, ambulatory surgical centers, nursing homes and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services—can be substitutes for outpatient medical services provided at a hospital. Consequently, commercial health plans' and consumers' demand for outpatient medical services *from a hospital* is generally more elastic because, if given the opportunity, they could obtain some of these services from non-hospital providers. But demand for outpatient medical services *in general* is inelastic because such services are often necessary to prevent illness, loss of physical mobility, or long-term harm to health. Thus, outpatient medical services can be treated analytically as a single product market.

58. These two product markets—acute inpatient hospital services and outpatient medical services—are separate. Commercial insurance plans often purchase outpatient medical services from different providers (i.e., non-hospital providers) than those from which they

purchase acute inpatient hospital services, which can only be purchased from hospitals. The existence of non-hospital competitors would, absent anticompetitive behavior, reduce the price insurance plans would pay a hospital system for outpatient medical services, but those competitors would not affect the price a hospital could charge for acute inpatient hospital services. There are also numerous procedures that can only be performed in an inpatient setting instead of an outpatient setting.[2] The markets are therefore distinct.

2. The Relevant Geographic Markets

59. Patients generally seek inpatient and outpatient care from hospitals in the areas where they live and work and where their local physicians have admitting privileges. As stated in an FTC study, "In healthcare markets, distance to medical provider is one of the most important predictors of provider choice." Given this, patients do not typically regard hospitals located many miles away from them as substitutes for local ones, particularly when they have little or no financial incentive to travel greater distances. Consequently, an insurer that does not satisfy patient demand for access to conveniently located hospitals will not be commercially viable. HHC is clearly aware of this phenomenon: A HHC executive told a state legislative panel that if a Connecticut provider changes to a location too far away, "the patients won't follow them." And in a 2017 lawsuit, HHC cited "proximity" to a hospital as a reason some patients are "forced to seek" certain types of care at a specific inpatient facility.

[2] HHC has noted this point in a 2017 court filing where it said that there are procedures where it is "medically necessary" for them to be performed only in a hospital, instead of an outpatient facility. *See* Memorandum of Law in Opposition to Defendant's Emergency Motion to Dismiss the Amended Complaint, *Hartford Healthcare Corp. v. Anthem Health Plans, Inc.*, ECF 80, at 14 (D. Conn. Oct. 31, 2017).

60. In Connecticut, commercial health plans are required by law to "[m]aintain adequate arrangements to assure that such health carrier's covered persons have reasonable access to participating providers located near such covered persons' places of residence or employment." Conn. Gen. Stat. § 38a-472f(e)(1)(A).

a. The Tying Geographic Markets: Willimantic, Norwich, Torrington, and Meriden

61. In multiple different geographies, HHC has a regional monopoly consisting of one or more must-have facilities that commercial health plans have no choice but to include in networks offered in those geographies in order to comply with state network-adequacy requirements and/or to offer plans that are commercially attractive to members in those geographies. Specifically, HHC operates general acute care hospitals with sufficient capacity to reasonably handle the anticipated healthcare requirements of all enrollees in three regional Hospital Services Areas ("HSA") where HHC faces little to no competition from other providers. HSA is a widely accepted definition of a geographic market for general acute care hospital services.

62. The HSA regions where HHC operates general acute care hospitals and faces little to no competition are: 1) the Willimantic HSA; 2) the Norwich HSA; and 3) the Torrington HSA. HHC also operates a general acute care hospital in the Meriden HSA where it has dominant market share.

63. In the ***Willimantic HSA***, HHC controls a monopoly for inpatient services, with 80% of inpatient admissions, primarily through Windham Community Memorial Hospital, which HHC acquired in 2009. HHC's share in this market is significant enough to stifle competition and

restrict freedom of commerce, and, during the relevant period, HHC has had the ability to control the price for acute inpatient hospital services in this market.

64. For most residents of Willimantic the next nearest hospital is over 30 minutes away without any traffic, a practical impediment for many acute care services and almost all emergency services. And for many residents the nearest next hospital is another HHC facility, magnifying HHC's monopoly power. Additionally, for many patients, traveling long distances to an inpatient facility may be unsafe or medically inappropriate, and the financial burden of transportation to and potentially lodging near an inpatient facility can eliminate the option of traveling for many elderly or lower income patients. For these reasons, and/or due to Connecticut regulations related to minimum network adequacy, Windham Community Memorial Hospital is a must-have facility for most commercial health plans, particularly with respect to acute inpatient hospital services. Consequently, competition from providers of acute inpatient hospital services located outside the Willimantic HSA would not likely be sufficient to prevent a hypothetical monopolist provider of acute inpatient hospital services located in the Willimantic HSA from profitably imposing small but significant price increases for those services over a sustained period of time.

65. HHC faces more competition in the Willimantic HSA with respect to outpatient services. Numerous independent providers for outpatient services exist there, meaning that Defendant does not have a pure monopoly. However, as described further below, HHC has tied its Willimantic outpatient services and facilities to its monopoly over the market for acute inpatient hospital services via Windham Community Memorial Hospital. By doing so, HHC has been able to extract supracompetitive prices despite nominally facing competition for outpatient services in the Willimantic HSA.

66. In the ***Norwich HSA*****,** HHC controls a monopoly for acute inpatient hospital services. HHC did not build this monopoly by outcompeting competitors: It simply acquired Backus Hospital, the only hospital in the community, in 2013. Currently, HHC controls 84% of inpatient admissions in the Norwich HSA. HHC's share in this market is significant enough to stifle competition and restrict freedom of commerce, and, during the relevant period, HHC has had the ability to control the price for acute inpatient hospital services in this market.

67. For many residents of Norwich and other communities in Eastern Connecticut, the next nearest hospital after HHC's Backus Hospital is 30 minutes or more away by car without traffic. Furthermore, for a significant number of residents of Eastern Connecticut communities, the next closest hospital after Backus would be another HHC inpatient facility in Windham, further magnifying the must-have nature of those two HHC facilities. HHC itself states that Backus is "the only trauma center in all of Eastern Connecticut." As explained above, consumers are often unwilling and, in many cases, unable to travel long distances for inpatient services, especially for emergency or trauma care. For these reasons, and/or due to Connecticut regulations related to minimum network adequacy, Backus Hospital is a must-have facility for most commercial health plans, particularly with respect to acute inpatient hospital services. Consequently, competition from providers of acute inpatient hospital services located outside the Norwich HSA would not likely be sufficient to prevent a hypothetical monopolist provider of acute hospital services located in the Norwich HSA from profitably imposing small but significant price increases for those services over a sustained period of time.

68. HHC faces slightly more competition for outpatient services in the Norwich HSA. However, as described further below, HHC has tied its Norwich outpatient services and facilities

to its monopoly over acute inpatient hospital services. By doing so, HHC has been able to extract supracompetitive prices despite nominally facing competition for outpatient services in Norwich.

69. In the ***Torrington HSA***, HHC controls a monopoly for inpatient services, with over 79% of inpatient admissions. HHC did not build this monopoly by outcompeting rivals with high value inpatient care. Instead, in 2017 it purchased Charlotte Hungerford Hospital, the only hospital in Torrington. As reported at the time, HHC executives stated that the company "stands to gain from expanding its reach and recruiting other area health care providers into its network." HHC's market share in this market is significant enough to stifle competition and restrict freedom of commerce, and, during the relevant period, HHC has had the ability to control the price for this market.

70. For many residents of Torrington, the nearest inpatient facility other than Charlotte Hungerford Hospital is about 30 minutes or more away without traffic – assuming, of course, access to a vehicle. This distance is even greater for many residents of nearby communities like Winstead, where the next nearest hospital is more than 40 minutes away without traffic. As explained above, consumers are often unwilling and, in many cases, unable to travel long distances for inpatient services, particularly for emergency or trauma care. For these reasons, and/or due to Connecticut regulations related to minimum network adequacy, Charlotte Hungerford Hospital is a must-have facility for most commercial health plans, particularly with respect to acute inpatient hospital services. Consequently, competition from providers of acute inpatient hospital services located outside the Torrington HSA would not likely be sufficient to prevent a hypothetical monopolist provider of acute inpatient hospital services located in the Torrington HSA from

profitably imposing small but significant price increases for those services over a sustained period of time.

71. HHC faces some competition in the outpatient market in the Torrington HSA. However, as described further below, HHC has tied its Torrington outpatient services and facilities to its monopoly over acute inpatient hospital services via Charlotte Hungerford Hospital. By doing so, HHC has been able to extract supracompetitive prices despite nominally facing competition for outpatient services in Torrington.

72. In the ***Meriden HSA***, HHC is the dominant provider of inpatient services, with over 66% of inpatient admissions. It owns the only inpatient facility in Meriden, the MidState Medical Center. HHC's market share in Meriden is high enough to stifle competition and restrict freedom of commerce, and, during the relevant period, HHC has had the ability to control the price for this market.

73. In the Meriden HSA, HHC faces more competition in the outpatient market than it does for acute inpatient hospital services. While local reporting has described HHC's work to acquire independent outpatient practices to eliminate competition in Meriden as "part of Hartford Hospital's plan to expand its reach into medical specialty services," numerous independent providers for outpatient services still exist in Meriden, meaning that HHC does not have a monopoly on outpatient services. However, as described further below, HHC has tied its Meriden outpatient services and facilities to its dominance over the market for acute inpatient hospital services via MidState Medical Center. By doing so, HHC has been able to extract supracompetitive prices for outpatient services in Meriden despite nominally facing competition for such services.

b. <u>The Tied Geographic Markets: Hartford and Bridgeport</u>

74. Other relevant geographic markets at issue in this case are (1) the Hartford HSA and (2) the Bridgeport HSA. These markets include the areas served by HHC's larger facilities in Hartford and Bridgeport. The relevant products in these geographic markets—acute inpatient hospital services and outpatient medical services—are defined the same as above and those definitions in the preceding paragraphs are realleged here.

75. Unlike the facilities in Windham, Norwich, and Torrington, HHC's facilities in Hartford and Bridgeport face competition for all acute hospital services from other hospitals and non-hospital providers in their geographic regions. Due to this heightened level of competition, commercial health plans seeking to build a viable insurance network may would not, absent HHC's anticompetitive conduct, be required to include HHC's facilities in-network in order to be viable, or commercial health plans would be able to negotiate a lower price for acute inpatient hospital services or outpatient medical services at these facilities. In both the Hartford and Bridgeport HSAs, providers of acute inpatient hospital services located outside the respective HSAs would not likely be sufficient to prevent a hypothetical monopolist provider of acute hospital services located in the HSA from profitably imposing small but significant price increases for those services over a sustained period of time. The same is true for both respective HSAs with respect to outpatient medical services.

76. As to the Hartford HSA inpatient acute care market: HHC is the largest provider of acute inpatient hospital services in Hartford, with approximately 40-50% inpatient market share. This is primarily a result of its flagship facility, Hartford Hospital, and the nearby Hospital of Central Connecticut, a facility HHC acquired in 2011.

77. As to the Hartford outpatient market: HHC is the largest provider of outpatient care in the area but faces significantly more competition for outpatient services than it does for inpatient services because of the presence of independent providers and outpatient services from other hospital systems. According to St. Francis, HHC has acquired numerous independent providers with dozens of physicians over the past four years to reduce competition in the Hartford outpatient market and intends to "acquire numerous additional physician practices." And, as described below, HHC has used its Integrated Care Partners program to foreclose outpatient competition through improper incentive payments to physicians.

78. In the Bridgeport HSA, HHC is not the largest provider of acute inpatient hospital services. It controls under 43% of inpatient admissions. This market share is primarily attributable to its 2019 acquisition of St. Vincent's Medical Center from Ascension, a health system without any other hospitals in Connecticut. As HHC wrote at the time, "Over the years, Hartford HealthCare has established a connected system of care throughout Connecticut. The notable exception was Fairfield County — where Hartford HealthCare had limited services and presence. Not any longer. Hartford HealthCare has crossed the final Connecticut frontier with the October 1 acquisition of St. Vincent's Medical Center in Bridgeport."

79. On information and belief, a significant reason that HHC acquired St. Vincent Medical Center was to gain market share and raise prices by imposing anticompetitive contracting provisions on individual providers and commercial health plans, including all-or-nothing negotiating, anti-steering provisions, and anti-tiering provisions. The previous owner of St. Vincent would have had more difficulty imposing these provisions because it did not own any must-have facilities in Connecticut. In 2017, just one year before announcing the sale to HHC, the

previous owner of St. Vincent had been reported to be exploring "steps to gain advantages of larger regional groups." In announcing the sale to HHC, the then-owner of St. Vincent's Medical Center specifically cited HHC's other facilities and "comprehensive healthcare network" across Connecticut as one reason the facility was being sold to HHC.

80. In only two years since the acquisition, margins at St. Vincent have increased from negative to a 2% profit in the third quarter of 2021. On information and belief, a significant portion of that profit margin was attributable to HHC's ability to impose anticompetitive contractual provisions on insurers and individual providers, raise prices, and/or reduce quality.

81. As to the Bridgeport HSA outpatient market: HHC faces significant competition for outpatient services in the Bridgeport outpatient market both from numerous other hospital systems and from independent providers. Its current outpatient services in Bridgeport are primarily a result of HHC's 2019 acquisition of St. Vincent's Medical Center's outpatient facilities. Yet, as discussed below, HHC is able to charge supracompetitive prices in what would appear to be a highly competitive market because it ties outpatient services in competitive markets like Bridgeport to its monopoly "must have" inpatient facilities and its broader inpatient market power elsewhere in Connecticut.

B. HHC's Market Power

82. HHC operates an unregulated monopoly in Willimantic, Norwich, and Torrington, particularly with respect to acute inpatient hospital services. HHC has leveraged its monopolistic market power to increase its dominance and pricing in the markets for outpatient medical services in those areas, and for both inpatient and outpatient services in Hartford and Bridgeport. This has

resulted in a situation where, throughout its services areas in Connecticut, HHC is able to dictate the prices paid by commercial health plans.

83. As referenced earlier, HHC has significant market share for acute inpatient hospital services in many of its areas of operation: 80% in Willimantic, 84% in Norwich, 79% in Torrington, and 66% in Meriden. While not as high, HHC holds significant market share in the Hartford and Bridgeport acute inpatient hospital services markets (about 40-50% and 43% respectively) and in the Willimantic, Norwich, Torrington, and Meriden outpatient services markets.

84. Statewide, HHC controls about 30% of all inpatient admissions in Connecticut, up from about 12% in 2008.

85. HHC has maintained and grown its market share in all regions over both inpatient and outpatient services because of the anticompetitive negotiating and contracting practices at issue in this suit, including unreasonably dealing with commercial health plans in negotiations based on the must-have status of care in Willimantic, Norwich, and Torrington; tying arrangements between those facilities and the Hartford and Bridgeport facilities; anti-steering and anti-tiering provisions; affiliation agreements that facilitate improper payments in exchange for referrals away from competitors; and gag clauses and other anticompetitive practices that prevent patients from fully comparing inpatient care options and prevent insurers from directing patients to cheaper and closer options. These anticompetitive practices, described in more detail hereafter, have led directly to significant price increases at all HHC facilities for both inpatient and outpatient care, and these higher prices have led directly to severely increased premiums and direct payments to HHC paid by Plaintiffs and the putative class.

VII. HHC'S ANTICOMPETITIVE PRACTICES HAVE HARMED COMPETITION, RESULTING IN HIGHER PRICES AND WORSE QUALITY

86. During the pertinent times and within the last four years, HHC has engaged in anticompetitive negotiating tactics with commercial health plans and/or insisted on contract terms including one or more anticompetitive provisions with insurers. These negotiating tactics and contract clauses have included: unlawful tying through all-or-nothing arrangements, the imposition on commercial health plans of anti-steering and anti-tiering provisions, gag clauses, non-compete clauses in its agreements with physicians, and anticompetitive referral restrictions and payments.

87. Individually and in combination, these contract provisions are designed to suppress transparency and price and quality competition in the relevant product markets and increase the prices HHC can charge commercial health plans. HHC uses its market power to force insurers to accept these restrictions, which have the following anticompetitive effects:

- protecting HHC's market power and enabling HHC to raise prices and reduce quality of acute inpatient hospital services substantially beyond what would be tolerated in a competitive market, to the detriment of consumer welfare;
- substantially lessening competition among providers in their sale of acute inpatient hospital services;
- preventing the entry of potential competitors into the market by forcing insurers to agree to terms that bar them from sharing competitive pricing information;
- preventing the entry of potential competitors into the market by forcing insurers to agree to terms that limit their ability to direct consumers to lower cost providers;
- limiting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services, such as tiered plans and narrow networks;

- reducing consumers' incentives and ability to seek or even be aware of acute inpatient hospital services from more cost-effective providers; and

- depriving consumers of the benefits of a competitive market for their purchase of inpatient hospital services.

88. When forced on commercial health plans by a dominant provider, these types of arrangements and agreements have been found to be illegal even in markets with more robust provider competition than exists here, due to the severe harm they inflict on consumer welfare and competition.

89. Anticompetitive contract provisions and negotiating tactics are particularly problematic when a hospital system controls a must-have facility, as HHC does in multiple regions in Connecticut. It is practically impossible to assemble a commercially viable insurance plan in Connecticut that excludes those facilities. In a market with a must-have hospital, even the limited use of these contract provisions or negotiating tactics causes much greater harm to consumers and potential competitors than the use of such practices and provisions in a competitive market.

A. HHC Has Willfully and Unlawfully Acquired, Maintained, and Attempted to Grow its Monopoly Power

90. HHC did not acquire monopoly power by outcompeting rivals on price and quality as our antitrust laws envision. Instead, HHC became a monopoly by acquiring must-have hospitals and engaging in anticompetitive behavior that allowed it to expand its market power, stifle competition even in competitive geographic markets, raise prices, and diminish quality of care. This has directly harmed HHC's competitors, such as St. Francis and smaller, independent providers who cannot overcome the obstacles HHC's contracting restrictions have imposed. These harms to competition and consumer welfare are precisely what Connecticut's antitrust and unfair trade practice laws prohibit.

91. Indeed, a coalition of unions representing 45,000 workers with unique insight into the workings of healthcare in Connecticut have cited "Hartford Healthcare's use of ever increasing amounts of healthcare dollars in what appears at least to be driven more by an attempt to gain market share and power than an effort to improve medical services for patients and communities."

92. A competitor hospital wrote that HHC's recent "acquisitions therefore have overcome the ability of competing hospitals to compete effectively on price and quality and thereby subverted the competitive process."

93. HHC has aggressively acquired outpatient facilities and practices in Hartford and Bridgeport, where HHC does not control a monopoly for inpatient care, and in Willimantic, Norwich, Torrington, and Meriden, where HHC has a monopoly or dominance for inpatient care.

94. For example, reporting indicates that HHC purchased eight outpatient eye surgery centers in Connecticut because HHC would have "greater purchasing power with insurers" than the previous owner. Similarly, HHC has acquired dozens of physicians who were formerly independent or affiliated with smaller hospitals. After such acquisitions, HHC is able to force commercial insurance plans to pay HHC's substantially higher prices for services *from the same physician.* Absent HHC's restrictions on commercial health plans that keep such insurers from excluding these costlier services from their networks, or directing their patients to cheaper alternatives, HHC would not be able to continue to charge these artificially inflated rates.

95. Since acquiring outpatient facilities, HHC often imposes hospital "facility fees" on top of the bill for outpatient services. These fees, which can amount to hundreds of dollars per visit, are often imposed by HHC after it acquires independent outpatient facilities that previously did not charge facility fees for the same services. Therefore, these fees are one specific way that

HHC uses its market power to impose supracompetitive prices on consumer and commercial insurance plans. As explained previously, because of HHC's all-or-nothing negotiating and anticompetitive contractual provisions, commercial insurance plans have no choice but to accept these new facility fees after an HHC acquisition. Commercial health plans then pass these overcharges onto their members, both individuals and employers, in the form of higher insurance premiums.

96. As described further below, HHC has also used its Integrated Care Partners program to facilitate improper payments to physicians who affiliate with HHC and agree to refer within HHC. The physicians enrolled in this program are effectively part of the HHC system and Integrated Care Partners is a part of HHC's attempt to monopolize the outpatient care markets.

B. HHC's Abuse of its Monopoly Power Allows it to Charge Supracompetitive Prices in Hartford and Bridgeport

97. As described above, HHC has a monopoly over acute inpatient hospital services in Willimantic, Torrington, and Norwich, and near-monopoly power in Meriden. Commercial health plans have no choice but to include HHC's must-have facilities in these regions in their insurance networks. But HHC's monopoly power over those regions, without more, should not affect prices or quality of care in other regions. However, publicly available pricing data make clear that HHC charges supracompetitive prices in large regions where it *does* face competition—namely, Hartford and Bridgeport. And in Hartford, publicly available quality metrics indicate that HHC offers a lower quality of care than nearby competitors who are less expensive.

98. These data make clear that HHC leverages its monopoly power in some areas of the state to inflict price and quality harms on Hartford and Bridgeport through anticompetitive contracting restraints such as tying its must-have facilities to others through all-or-nothing

contracting, and imposing on commercial health plans anti-steering and anti-tiering provisions. Under federal and state antitrust and unfair trade practices precedents, higher prices and lower quality are direct evidence that challenged restraints like these and the others HHC has engaged in are anticompetitive.

1. HHC Charges Supracompetitive Prices for Lower Quality Care in Hartford

a. Quality of Care is Lower at HHC Than Competitors

99. Per the Center for Medicare & Medicaid Services ("CMS") Quality Rating System, HHC provides a lower quality of care than its closest competitor in Hartford.

100. According to the leading independent organization that evaluates hospital safety, Hartford Hospital has had lower average annual safety ratings than its nearby and primary competitor, St. Francis Hospital, for each of the last four years.

101. A 2017 independent analysis concluded that HHC's Hartford Hospital provided "a general lack of value for patients getting care at that facility" especially "given its low quality scores."

102. HHC has also reduced quality at acquired hospitals through drastic service cuts. For example, at Windham Hospital, HHC stopped providing obstetrics services and eliminated the hospital's Intensive Care Unit. In explaining planned changes to the hospital, HHC executives said Windham would offer "cornerstone services" while functioning as a "gateway" to the rest of the system.

b. Prices are Much Higher at HHC Relative to Hartford Competitors

103. HHC charges extremely high prices relative to competitors in Hartford, whether looking at average prices across procedures or at the individual procedure level, from expensive and high-margin surgeries to low-cost but high-volume procedures like tests.

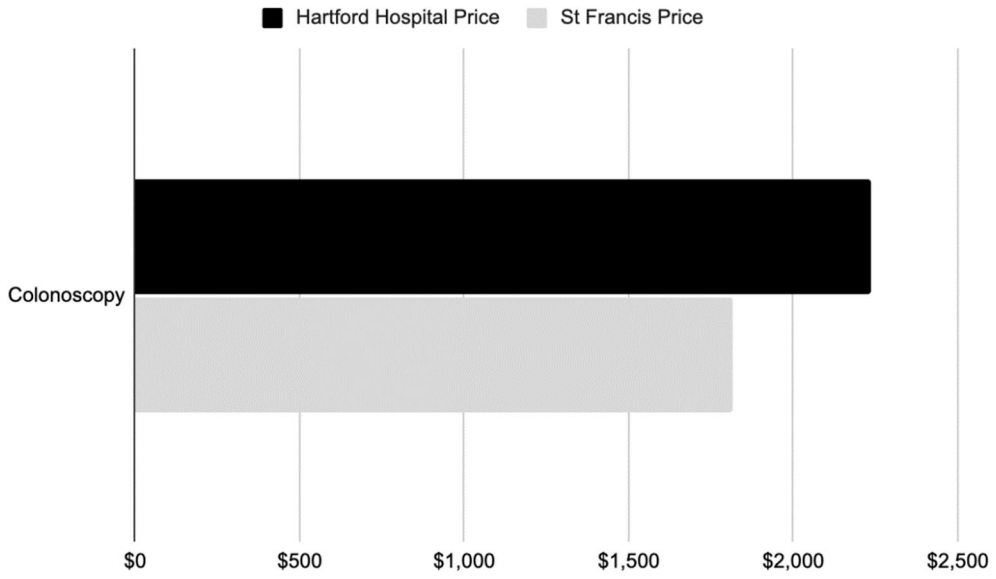
104. Overall, prices for inpatient care at HHC's Hartford facilities are more than double the rate of Medicare and HHC's prices for inpatient procedures are higher than all other hospitals in Hartford.

105. Absent HHC's use of anticompetitive tactics, HHC would be forced by commercial health plans to lower these prices to a competitive level—i.e., the level that other hospitals in Connecticut find to be adequate to cover their costs and still earn a profit.

106. The average price for an inpatient stay at HHC's Hartford Hospital is about $4,000 more than an inpatient stay two miles away at St. Francis Hospital.

107. When evaluating prices for specific procedures, academic literature suggests one useful analysis is comparing "generally homogenous" procedures -- those that generally have little to no variation on quality and occur with sufficient frequency to support empirical analysis.

108. One such example is a colonoscopy. HHC's Hartford Hospital's price is about $2,200 for this procedure. At nearby St. Francis Hospital in Hartford, which is rated as safer and higher quality, the price of this procedure is only about $1,800. Charging about 23% more than a nearby competitor for this generally standardized procedure could not be feasible without the restraints HHC has placed on competition, price discovery, and steering and tiering.



109. HHC's supracompetitive prices extend to other very common procedures. For example, a blood transfusion costs about four times as much at HHC's Hartford Hospital as it does at St. Francis Hospital.

110. Additionally, HHC extracts supracompetitive prices by performing common surgeries in higher cost settings. Across the country, there has been a significant shift towards performing many common surgeries in a lower cost and safer outpatient setting instead of a higher cost inpatient setting. This is especially true for orthopedic surgeries. However, according to St. Francis Hospital, "in 2017, both Hartford Hospital and Saint Francis had more inpatient commercially insured orthopedic surgery cases than outpatient cases. By 2020, Saint Francis was performing more than four times as many outpatient commercially insured orthopedic surgery cases as inpatient. On the other hand, Hartford Hospital was still performing more inpatient cases than outpatient cases." This conduct by HHC substantially raises prices and insurance premiums and would not be possible absent HHC's restraints on competition: If commercial insurance plans

were permitted to steer patients towards lower cost outpatient care, HHC would either be forced to follow the national trend towards lower cost outpatient surgical care or would lose patients to competitors. Neither has happened because of HHC's anticompetitive contracting and negotiating practices.

111. A 2017 independent analysis concluded that HHC's Hartford Hospital had prices higher than the state average for all procedures evaluated and concluded that Hartford Hospital's "combination of higher prices and lower than average quality . . . suggests a general lack of value for patients getting care at that facility." The study contended that it would be "especially" difficult for Hartford Hospital to justify further price increases "given its low quality scores and already high prices relative to the state average." Despite that, HHC has continued to raise prices.

112. HHC's Hospital of Central Connecticut in New Britain also has supracompetitive prices relative to HHC's competitors in the region. According to a recent study, the Hospital of Central Connecticut's prices are about 70% higher for inpatient procedures relative to its closest competitor, John Dempsey Hospital, which is less than six miles away.

113. According to the non-partisan Health Care Cost Institute, overall inpatient prices in Hartford rose 27% from 2015 to 2019. HHC's supracompetitive prices and continuing price increases are a key reason for that overall price increase in the market.

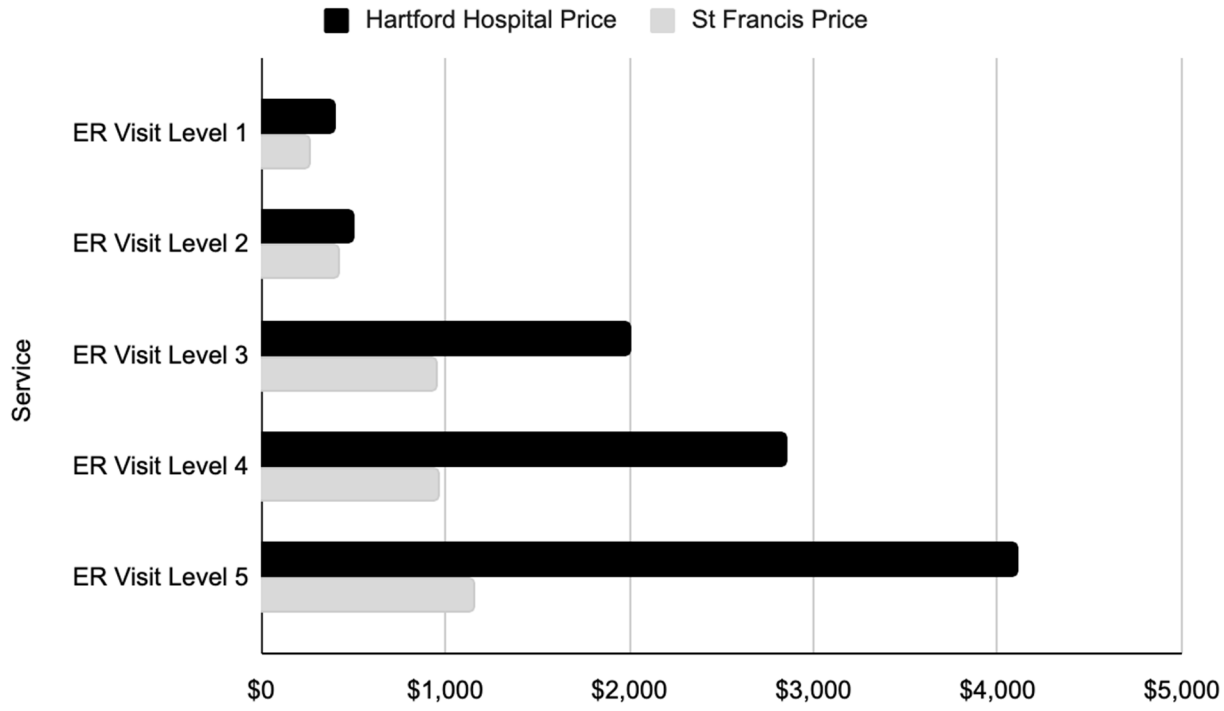
114. According to a 2017 analysis, HHC increased its prices by 65% from 2010 to 2017.

c. HHC Charges Supracompetitive Prices for Emergency and Trauma Services in Hartford and Elsewhere

115. HHC charges supracompetitive prices for emergency services and trauma services at its Hartford facilities and elsewhere. Emergency room bills have a variety of components, but

one baseline element is the price of the ER visit based on the seriousness of the patient's condition, rated on a 1-5 scale.

116. HHC's prices for ER visits are extraordinarily high. For example, *the price for a Level 1 ER visit – the least serious kind – is over 50% higher at HHC's Hartford Hospital than at nearby St. Francis.* A level 5 visit is nearly three times as expensive, and results in a nearly $3,000 overcharge by HHC relative to St. Francis for every Level 5 ER visit.



117. These emergency visit overcharges are particularly concerning since patients often have to make sudden life-or-death decisions on emergency care and certainly do not expect that prices for the same service could be triple at HHC relative to nearby St. Francis.

2. HHC's St. Vincent Medical Center Charges Supracompetitive Prices Relative to Competitors in Bridgeport

118. As explained previously, HHC acquired St. Vincent's Medical Center in 2019, giving it significant market share in Bridgeport. HHC now charges supracompetitive prices at St. Vincent's. For example, St. Vincent's price for a colonoscopy is about $3,800, about 170% higher than nearby Bridgeport Hospital's $1,400 price. Additionally, St. Vincent's price for a Level 1 emergency visit is about 150% higher than nearby Bridgeport Hospital, and a Level 5 emergency visit price is about 250% higher at St. Vincent's than Bridgeport Hospital, which is less than 3 miles away.

119. As with its overcharges in Hartford, HHC's overcharges in Bridgeport are not due to HHC offering superior quality at St. Vincent's but rather due to HHC's leveraging of its monopoly power over other regions to extract supracompetitive prices for services in Bridgeport.

3. HHC Charges Supracompetitive Prices for Outpatient Procedures at its Facilities Throughout Central Connecticut

120. Overall, HHC's prices are about 2.5 times the Medicare reimbursement rate for outpatient procedures and HHC is by far the most expensive large provider of outpatient services in Central Connecticut.

121. HHC has supracompetitive prices for outpatient procedures in markets where it controls an inpatient monopoly but faces outpatient competition. For example, in Eastern Connecticut, HHC prices are by far the highest rate for outpatient procedures of any major provider.

122. Despite the perception of the outpatient market for healthcare services as more competitive, HHC is able to extract these supracompetitive prices because of its use of

anticompetitive contracting and negotiating tactics, including the all-or-nothing and inpatient-to-outpatient tying schemes described below.

C. HHC Has Engaged in Illegal Tying of Services Through All-or-Nothing Contracting Practices, as well as Other Anticompetitive Vertical Restraints

123. HHC has engaged in unlawful tying arrangements, through which it leverages its monopoly over acute inpatient care services in Willimantic, Norwich, and Torrington to extract profits in other geographic markets, most notably Hartford and Bridgeport.

124. Under antitrust law, tying occurs when an entity leverages its power in one market to reap profits in another market. The market in which the defendant has an existing monopoly is called the "tying" market, and the separate market in which the defendant extracts profits is called the "tied" market. Where the defendant has significant market power or a monopoly in the tying market, such tying arrangements are considered anticompetitive and unlawful under the antitrust laws, both as per se violations and under the Rule of Reason.

125. Even where the dominant market participant does not strictly tie two products together—only selling one when the purchaser agrees to buy the other—dominant market participants can extract supracompetitive profits through other, similar vertical restraints, such as exclusively dealing contracts or contracts that otherwise inhibit the purchaser's ability to shop between competitors based on price and quality. Like tying restrictions, these vertical restraints—if imposed on purchasers by a monopolist or dominant market participant—are unlawful under the Rule of Reason when their anticompetitive effects (such as price increases) outweigh any procompetitive benefits.

126. When a commercial health plan seeks to offer a plan in a region where significant areas have only one hospital facility, that facility is in effect a must-have hospital for that health

plan: Individuals and employers seeking insurance will not choose any health plan that does not include necessary services provided by that hospital. State network-adequacy laws may also require the inclusion of such facilities, adding to the contracting leverage of the system that controls that facility.

127. A hospital system with a must-have hospital can cause significant financial harm to both commercial health plans as well as employers and individuals purchasing such plans through various types of anticompetitive behavior. First, a hospital system with a must-have facility—and especially one with multiple must-have facilities, like HHC—can demand from commercial health plans allowed amounts that are grossly above what the hospital could obtain if it faced competition. This is true both by virtue of the hospital's extant market power, as well as the enormously high barriers to entry when it comes to many services hospitals provide. These barriers to entry, which include the costs of building facilities and hiring skilled staff (such as surgeons and anesthesiologists) as well as regulatory hurdles such as obtaining a certificate of need from the State before opening a new facility, prevent new entrants from entering the market and reining in the price the must-have hospital can charge.

128. Second, if the must-have facility is part of a larger hospital system like HHC's that has other facilities that do face competition, the hospital system can refuse to offer commercial health plans in-network medical services at the must-have facility unless those health plans also agree to include in their networks medical services from the system's other facilities at supracompetitive prices dictated by the hospital system. This kind of "all-or-nothing" negotiating, when forced on commercial health plans by a dominant hospital system, is a form of unlawful tying and an anticompetitive vertical restraint constituting an abuse of monopoly power. The

"tying" product is the must-have facility (or, in HHC's case, multiple must-have facilities) that commercial health plans must include in their networks in order for the plans to be viable and/or comply with state network-adequacy requirements. The "tied" product is the hospital system's facilities that face more significant competition, which a commercial health plan would, absent the tying arrangement, have leverage to negotiate lower allowed amounts or, if the system refused to lower prices, keep out of network altogether.

129. HHC has engaged in all-or-nothing negotiating tactics with commercial health plans, forcing insurers to either include all of HHC's facilities and services in their network or none of them, and in doing so demanding higher rates for inpatient and outpatient services than commercial health plans would be willing to pay absent this unlawful tying arrangement. Indeed, a New York Times investigation concluded that HHC "negotiate[s] prices as a single entity, forcing health insurers to include all of their hospitals in a network or risk losing access in areas where there are no alternatives."

130. Because HHC owns at least three inpatient facilities that are must-have facilities for any commercial health plan wishing to offer a viable insurance product, insurers are left with no choice: If they want to offer a commercially viable plan, they need to include HHC's must-have facilities. And HHC insists that if insurers want their must-have facilities in-network, they must also include in their network HHC's facilities like Hartford Hospital and The Hospital of Central Connecticut, which operate in competitive markets but charge higher prices for lower quality care than competitors. Commercial health plans must also include in-network outpatient medical services at all of HHC's facilities at supracompetitive rates that the health plans would not accept but for HHC's unlawful vertical restraints.

131. According to a New York Times investigation, other hospital systems with similarly large networks, including Yale New Haven, do not choose to engage in this aggressive all-or-nothing contracting and negotiating practice.

132. HHC is aware of the must-have nature of several of its inpatient facilities, including describing itself as "Connecticut's only truly integrated health care system" and marketing individual facilities as the only choice for many types of medical care.

133. Connecticut press has reported that going to a non-HHC hospital is "easier said than done however for some residents who live in parts of the state only served by the network." Similarly, one of the largest healthcare research foundations in Connecticut stated that because of HHC's acquisitions, an insurer not including HHC in their network would leave "patients with nowhere to go" and could result in patients having to "avoid the emergency room because the nearest hospital is owned by Hartford HealthCare." And Connecticut Healthcare Advocate Ted Doolittle has explained that the absence of HHC from commercial insurance networks would create a "dead zone" in much of northeast Connecticut.

134. HHC has imposed on commercial health plans two separate but related schemes that either constitute tying or an otherwise unlawful vertical restraint. For both, the "tying" product is acute inpatient hospital services at its facilities in Windham, Torrington, and Norwich. In each of these geographic markets, HHC has a market share of approximately 80% for acute inpatient hospital services—i.e., a monopoly. The "tied" products in the two schemes are, respectively, (1) acute inpatient hospital services and outpatient medical services in Hartford and Bridgeport, and (2) outpatient medical services in all of the regions in which HHC operates. In the alternative,

HHC's linking of these two products to the sale of acute inpatient hospital services at its facilities in Windham, Torrington, and Norwich constitutes an unlawful vertical restraint.

1. Tying Must-Have Monopoly Facilities in Willimantic, Torrington, and Norwich to Facilities in Hartford and Bridgeport

135. By engaging in all-or-nothing negotiating tactics and contracting practices, HHC uses its monopoly market power in several acute care markets to force insurers to purchase both inpatient and outpatient services at supracompetitive prices in high-population inpatient markets where it faces significant competition, including Hartford and Bridgeport. Specifically, when HHC negotiates with a commercial health plan, it will refuse to offer its acute inpatient hospital services at its facilities in Willimantic, Torrington, and Norwich unless commercial health plans also agree to include in their network both acute inpatient hospital services and outpatient medical services at HHC's facilities in Hartford and Bridgeport.

136. This tying scheme has several anticompetitive effects. First, it leverages HHC's monopoly power in Willimantic, Torrington, and Norwich to allow it to extract rents in separate geographic markets. This raises the prices commercial health plans pay to HHC for inpatient and outpatient services in Hartford and Bridgeport, which causes Plaintiffs and the putative class to pay more in premiums, copays, coinsurance, and deductibles. Second, it harms HHC's hospital competitors, such as St. Francis, by preventing those competitors from fairly competing with HHC's facilities in Hartford and Bridgeport on price and quality. Third, HHC's tying scheme also harms independent physicians who are unable to obtain the patient volume necessary to remain financially viable. On information and belief, multiple independent practices have gone out of business, been forced to sell to HHC, or have been unable to open facilities that would compete with HHC and reduce the price that patients like Plaintiffs and the putative class pay for healthcare.

137. Through these practices, HHC has unlawfully restrained competition and has attempted to monopolize the market for acute inpatient hospital services in the relevant geographic markets in which it does not yet have a monopoly.

2. Tying Inpatient Services to Outpatient Services

138. HHC has significant market power over acute inpatient hospital services throughout Central Connecticut. That is true both because of its monopoly power over such inpatient services in Willimantic, Torrington, and Norwich and also because of its large overall share of about half of inpatient care in the entire Central Connecticut region for inpatient services.

139. HHC does not yet have dominant market power in outpatient services in almost any market where it operates, despite its attempts to restrict or purchase outpatient competitors. Significant independent outpatient practices and outpatient facilities of other hospital systems exist in every market where HHC operates. But because of its unlawful tying scheme, HHC can still charge supracompetitive prices and possess significant market share in outpatient markets.

140. Specifically, when HHC negotiates with a commercial health plan, it will refuse to offer its acute inpatient hospital services at its facilities in Willimantic, Torrington, and Norwich unless commercial health plans also agree to include in their network outpatient medical services at HHC facilities at rates the health plans would not otherwise agree to. This causes commercial health plans to pay more for outpatient services at all HHC's facilities than those health plans would be willing to pay absent HHC's tying scheme.

141. This tying scheme has several anticompetitive effects. First, it leverages HHC's monopoly power over acute inpatient hospital services in Willimantic, Torrington, and Norwich to allow it to extract rents in separate product markets: outpatient medical services in those areas

and elsewhere in Central Connecticut. This raises the prices commercial health plans pay to HHC for outpatient services, which causes Plaintiffs and the putative class to pay more in premiums, copays, coinsurance, and deductibles. Second, it harms HHC's hospital competitors, such as St. Francis, by preventing those competitors from fairly competing with HHC's facilities on price and quality with respect to outpatient services. Third, HHC's tying scheme also harms independent physicians who are unable to obtain the patient volume necessary to remain financially viable. On information and belief, multiple independent practices have gone out of business, been forced to sell to HHC, or have been unable to open facilities that would compete with HHC and reduce the price that patients like Plaintiffs and the putative class pay for healthcare.

142. Through these practices, HHC has unlawfully restrained competition and has attempted to monopolize the market for outpatient services in the relevant geographic markets.

D. HHC Has Used Anti-Steering and Anti-Tiering Contracting Terms

143. In a steering arrangement, a commercial health plan incentivizes plan members to receive care from a lower-cost in-network facility rather than a higher-cost facility. Commercial health plans may seek to steer patients by including language in insurance plan documents encouraging subscribers to choose one facility rather than another or conditioning the selection of a higher-cost facility on a higher copay or coinsurance obligation from the patient.

144. In addition, or alternatively, commercial health plans may seek to place providers in tiers, with the insurance plan subscriber being encouraged through a variety of means to choose the provider in the tier of better-value providers over a discouraged tier of higher-priced and/or lower-quality providers.

145. Steering is an important tool commercial health plans can use to control healthcare costs, particularly in consolidated markets. Under President Obama, the U.S. Department of Justice brought suit under the Sherman Act against a dominant hospital system in North Carolina to enjoin it from forcing commercial health plans to accept anti-steering and anti-tiering provisions. In that case, the court held that these restrictions plausibly violated the Sherman Act. Former President Trump's Assistant Attorney General for Antitrust criticized the type of contracting provisions and negotiating tactics HHC uses, saying, "Without these provisions, insurers could promote competition by 'steering' patients to medical providers that offer lower priced, but comparable or higher-quality services. Importantly, that practice benefits consumers, but the anti-steering restrictions prevented it." Likewise, Senator Chuck Grassley, then chairman of the Senate Judiciary Committee said anti-steering practices of, "restrictive contracts deliberately designed to prevent consumers' access to quality, lower cost care."

146. During the pertinent times, on information and belief, HHC has required one or more insurers not to use steering or tiering language, or to use weaker language or provisions than the insurers would have desired to use, as a condition of obtaining access to its must-have facilities for their commercial health plans. This kind of vertical restraint, when imposed on purchasers (i.e., insurers) by a dominant provider such as HHC, is invalid under the Rule of Reason and constitutes an abuse of monopoly power.

147. Through its contracting practices with commercial health plans, HHC deliberately limits the use of tiered plans by insurance plans in order to lessen the competition it faces from higher quality, less expensive rivals. According to the second largest hospital in Hartford, "HHC

has required in its contracts with these payors that they limit or eliminate any use of tiered networks in markets in which HHC operates."

148. HHC's anti-tiering tactics have been particularly aggressive. In late 2020, Anthem began offering a new tiered plan called "State BlueCare Prime Plus Point of Service," which offered members the opportunity to "save on premiums when receiving care only from high-quality doctors, specialists and locations in the new State BlueCare Prime network." In response, HHC sent a letter to primary care physicians "stating that if they did participate in the program, they would lose their hospital privileges at Hartford HealthCare facilities, making them ineligible to see patients at those facilities." Because of HHC's dominance in Central Connecticut and monopoly hospitals in several specific markets, this threat was particularly harmful to competition, and on information and belief, many doctors with admitting privileges at HHC facilities declined to participate in Anthem's program.

149. Because of HHC's dominant market position in Hartford and its monopoly power in three other Connecticut markets, insurers are forced to accept this kind of anti-steering and anti-tiering language. As stated by St. Francis, the second largest hospital system in Hartford, "HHC would not be able to refuse to offer bundled pricing and other innovative rate proposals, and would not be able to insist on anti-tiering provisions in its contracts with health plans, but for its dominant market power, enhanced by its other anticompetitive practices."

150. On information and belief, HHC has used anti-steering and anti-tiering language in its contracts with commercial health plans because without such restrictions HHC would be consistently ranked in a lower tier than its competitors in Hartford. This would allow patients to better select higher value healthcare and would either force HHC to lower its prices to competitive

levels or patients would overwhelmingly select higher value care elsewhere. In other words, it would allow a market to function.

E. HHC Anticompetitively Forces Physicians to Sign Non-Compete Clauses and Penalizes Referrals to Non-HHC Providers

151. HHC has forced physicians to agree to onerous non-compete agreements that limit their ability to work for other hospital systems in Connecticut or to open up independent practices. The goal of these non-competes, according to HHC executive Cynthia Heller is to ban a doctor from "put[ting] up his own shingle, not that far away" from HHC facilities.

152. HHC lobbied the Connecticut legislature in opposition to legislation that would limit non-competes. An HHC executive said that the system uses non-competes in order to, for example, bar a physician from "open[ing] a shingle across the street and steal[ing] the limited number of bariatric weight loss surgery patients."

153. According to St. Francis Hospital, HHC also penalizes physicians who refer patients to non-HHC providers. This has the impact of limiting price and quality competition and transparency for individuals, employers, and commercial health insurance plans. On information and belief, physicians are forced to accept these terms because of HHC's market power and history of threatening and pressuring physicians who refuse to comply with their effort to reduce competition.

154. These non-compete provisions have directly harmed competing hospitals with whom the physicians subject to the provisions would otherwise contract with and/or make referrals to. It also harms the physicians themselves, because they are unable to provide services in locations in which they have previously operated. On information and belief, some independent physicians' practices have closed and/or decided not to compete with HHC due to these restrictions. And

because they have reduced price and quality competition in this way, these non-compete provisions have also harmed Plaintiffs and the putative class by raising the price of healthcare.

F. HHC's Integrated Care Partners Program Suppresses Competition and Raises Prices for Plaintiffs

155. HHC has implemented a program called Integrated Care Partners ("ICP.") HHC describes ICP as something akin to a membership program where physicians agree to affiliate with HHC but maintain their own practices. HHC aggressively markets the program to physicians by promising that "members are rewarded for their participation in our value-based initiatives and achieving goals for providing high-quality patient care." HHC promises that, at no cost to physicians, it "negotiates contracts with all major payers on behalf of [ICP] member practices," provides expensive electronic medical records software free or at a discount, and provides valuable training and technical support.

156. HHC claims it asks for nothing in exchange. In reality, on information and belief, HHC uses the program to improperly compensate physicians for referrals and to further reduce competition in the markets where HHC operates.

157. On information and belief, ICP's "rewards" for "high-quality patient care" are often not what they appear. The quality incentive metrics are often set at levels that any physician would achieve, meaning that in effect the "rewards" are simply incentive payments for physicians to affiliate with HHC with the goal of reducing competition and in likely violation of federal prohibitions on payments for referrals.

158. Furthermore, on information and belief, HHC has classified an overly broad number of ICP-affiliated physicians as "Medical Directors," even though they have little executive experience and perform little or no executive work. This allows HHC to substantially increase

payments to physicians through Professional Services Agreements. As discussed below, HHC appears to be mischaracterizing payments to physicians in order to evade federal rules limiting compensation of medical professionals for referrals.

159. On information and belief, this program for mischaracterized compensation agreements was designed by HHC senior executive Jim Cardon, who has aggressively pressured independent physicians to affiliate through ICP and implied in presentations to physicians that the incentive structure HHC has designed for ICP is not open for discussion or change.

160. In addition to providing free or discounted software and apparently pretextual "quality" payments designed to incentivize physicians to refer to HHC (and not to HHC competitors), HHC also uses the ICP program to punish physicians who do not refer patients to HHC. According to St. Francis, which is HHC's largest hospital competitor in Hartford:

> HHC is "[r]equiring physicians involved in ICP to send the vast majority of their referrals to Hartford HealthCare with financial penalties if they failed to do so....Within the last four years, ICP has implemented what it refers to as a 'network engagement' strategy, to ensure that these independent physicians belonging to ICP refer as many cases as possible to Hartford HealthCare specialists, hospitals and other facilities irrespective of quality, cost or competitive issues. Physicians receive scores on their levels of referrals, and receive significant financial incentives (or are paid significantly less) depending upon whether these referrals are kept within the ICP and Hartford HealthCare systems. Physicians are required to explain every referral that does not stay inside the ICP network. The results are reviewed by a performance management committee. Physicians agree to adhere to these procedures in order to remain in ICP. ICP has increased its efforts, and increased its success, in controlling referrals over time."

161. Therefore, ICP's compensation to physicians appears to be determined in a manner that takes into account the volume or value of referrals. The pretextual "quality" payments, the free or discounted software upgrades, the improper payments to physicians designated as "Medical Directors," and the network engagement financial incentives raise separate serious concerns about

HHC's compliance with the federal Stark Law that bars payments for referrals of government health plan beneficiaries.

162. And for consumers, such as Plaintiffs, HHC's ICP program raises prices, reduces quality, and reduces choices for care. The program raises prices by using improper financial incentives to coerce physicians to direct patients towards overpriced care at HHC facilities instead of directing them towards the highest value care. The program reduces quality by financially incentivizing referrals instead of quality outcomes.

163. The program also obviously reduces competition among providers as part of HHC's attempt to monopolize the outpatient care markets. Additionally, by inaccurately describing ICP as a membership program, HHC appears to be circumventing Connecticut Certificate of Need rules and merger reporting requirements.

G. HHC Uses Gag Clauses to Further its Anticompetitive Schemes

164. HHC reinforced the anticompetitive effects of the contractual restrictions described above by also including in its payer/provider agreements gag clauses that prevent commercial health plans from revealing the terms of HHC's payer/provider agreements. The effect of this gag clause language is anticompetitive because it prevents competitors, insurers, and consumers from understanding HHC's pricing and other terms and arrangements.

165. In properly functioning markets pricing information is freely available, allowing purchasers to determine the prices they will be obligated to pay their suppliers if they purchase the suppliers' products and services. The ability to determine the amount of the purchase price before the purchase decision is made allows the customer to compare the prices offered by various competitors and allows the purchase decision to be influenced by price competition. However, to

prevent commercial health plans and the individuals who enroll in them from searching out or demanding better pricing, HHC has required terms in its agreements with insurers that forbid them from disclosing the allowed amounts that HHC has negotiated for the healthcare services and products offered through the insurance plans.

166. Because HHC's gag clauses prevented commercial health plans and their enrollees from determining what they will be obligated to pay HHC for healthcare services (and how much those prices exceed the prices charged by HHC's competitors), they were less able to exert commercial pressure on HHC to moderate its inflated pricing.

167. Together with HHC's all-or-nothing tying schemes, its imposition of anti-steering and anti-tiering language, HHC's use of gag clauses has effectively eliminated price competition for healthcare in the Connecticut regions HHC serves. On information and belief, these gag clauses are also partially intended to prevent scrutiny of HHC's other anticompetitive contracting terms, like all-or-nothing, anti-tiering, anti-steering, and contract termination penalties

H. The Combination of These Anticompetitive Practices Is Illegal and Especially Harmful When Undertaken by a System with Dominant Market Power

168. Market power aggravates the anticompetitive nature of HHC's contracting and negotiating tactics. The use of all-or-nothing negotiating and anti-tiering/anti-steering is problematic any time it is imposed on insurers by a dominant provider since it limits the ability of insurers and patients to competitively select healthcare options. However, in the context of a hospital system with both significant market power in cities like Hartford and Bridgeport and monopoly market power in three other markets, these contract provisions have an especially harmful impact on price and quality. This is particularly true—and such restrictions are particularly

anticompetitive—when they are forced on unwilling insurers and employers. That is exactly what HHC has done.

169. Because it is not possible to assemble a commercially viable health insurance plan in Connecticut that excludes HHC, these provisions give HHC the ability to both limit the ability of insurers and patients from competitively selecting healthcare and allow HHC to raise prices to supracompetitive levels.

170. HHC's anticompetitive restrictions on commercial health plans cause greater harm in concert than any of them would in isolation. For example, if HHC engaged only in all-or-nothing contracting but did not impose anti-steering or anti-tiering restrictions on commercial health plans, those health plans could mitigate harm caused by HHC's tying schemes by incentivizing patients to obtain in-network care from one of HHC's competitors. Thus, while each contractual restriction described herein is unlawful in isolation, taken together their impact is especially harmful to patients such as Plaintiffs and the putative class, as well as to competitors.

I. HHC's Anticompetitive Practices Lead to Higher Premiums, Deductibles, Copays, and Other Costs Borne by Plaintiffs and the Putative Class

171. HHC's anticompetitive practices directly contribute to the premiums paid by Connecticut families. As an example, 2022 premiums for a common individual plan drop by about 30% when one crosses the state line out of HHC's service area into Western Massachusetts. Similarly, when one crosses the state line out of HHC's service area in Western Connecticut into Rhode Island, premiums drop for a common individual plan by over 35%.

172. This is primarily because commercial insurance companies directly pass on higher prices charged by hospitals to individuals and employers through rising premiums, deductibles, and copays. A Harvard University analysis concluded that, "Variation in spending in the

commercial insurance market is due mainly to differences in price markups by providers rather than to differences in the utilization of health care services . . . . 70 percent of variation in total commercial spending is attributable to price markups, most likely reflecting the varying market power of providers." And the US Government's official guide for purchasing individual health insurance indicates that "differences in competition" are one of the primary drivers of variation in insurance premiums.

173. In 2017, a Connecticut Anthem executive identified "consolidation" as the first in a list of factors "creating cost pressures that have contributed increases in the per member cost for healthcare."

VIII. CLASS ALLEGATIONS

A. Class Definition

174. Plaintiffs define the putative class in this litigation as follows:

> Any person who, during the relevant period, was enrolled in a commercial health plan in the relevant commercial health insurance market who paid some portion of premiums for a self-insured or fully insured product offered by or administered by a commercial health plan, or made any direct payment to HHC, such as through co-insurance, a copay, or otherwise.

175. The geographic component of the "relevant commercial health insurance market" in this case is the Connecticut counties where HHC provides healthcare services, which, on information and belief, may include all or substantially all counties in Connecticut. The product component of the "relevant commercial health insurance market" includes all commercial health plans for which the insured individual pays any premium, including health plans that are fully insured and those that are self-funded by an individual's employer.

176. Excluded from the class are the Presiding Judge, employees of this Court, and any appellate judges exercising jurisdiction over these claims as well as employees of that appellate court(s).

B. Certification Requirements

177. This action is suitable for resolution on a class-wide basis under the requirements of Connecticut Practice Book Sections 9-7 *et seq*.

178. Numerosity: The class is composed of thousands of class members who are indirect purchasers, the joinder of whom in one action is impractical. The class is ascertainable and identifiable from HHC's records and documents, as well as those possessed by commercial health plans.

179. Commonality: Questions of law and fact common to the class exist as to all members of the class and predominate over any questions affecting only individual members of the class. These common issues include, but are not limited to:

a. Whether Defendant has a monopoly;

b. Whether Defendant has acted willfully or otherwise unlawfully in attempting to acquire or maintaining its monopoly;

c. Whether Defendant has used its market power and anticompetitive means to impose prices far above those that would be charged in a competitive market, causing harm to Plaintiffs and others;

d. Whether Defendant has engaged in improper tying practices with regard to its provider agreements with insurance companies and third party administrators;

e. Whether Defendant has otherwise engaged in improper anticompetitive practices with regard to the terms and provisions that it has required to be included in their payer/provider agreements;

f. Whether Defendant has willfully abused its monopoly power by reducing output and quality, including by reducing budgets and staffing at certain of their facilities.

g. Whether Defendant's conduct has violated Conn. Gen. Stat. § 35-24, *et seq*.

h. Whether Defendant's breaches of federal and state law caused antitrust injury to the Plaintiffs and class members; and

i. Whether the Plaintiffs and the class members are entitled to an award of compensatory damages or other relief.

180. Typicality: Plaintiffs' claims are typical of the claims of the other class members. Plaintiffs and the other class members have been injured by the same wrongful practices. Plaintiffs' claims arise from the same practices and course of conduct that give rise to the other class members' claims and are based on the same legal theories.

181. Adequate Representation: Plaintiffs will fully and adequately assert and protect the interests of the other class members. In addition, Plaintiffs have retained class counsel who are experienced and qualified in prosecuting class action cases. Neither Plaintiffs nor their attorneys have any interests conflicting with class members' interests.

182. Predominance and Superiority: This class action is appropriate for certification because questions of law and fact common to the members of the class predominate over questions affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of this controversy, since individual joinder of all members of the class is impracticable. Should individuals be required to bring separate actions, courts would be confronted with a multiplicity of lawsuits burdening the court system while also creating the risk of inconsistent rulings and contradictory judgments. This class action presents fewer management difficulties while providing unitary adjudication, economies of scale and comprehensive supervision by a single Court.

183. Injunctive Relief: The prosecution of the claims of the putative class in part for injunctive relief is appropriate because HHC has acted, or refused to act, on grounds generally applicable to the putative class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the putative class as a whole.

IX. CLAIMS FOR RELIEF

COUNT ONE
MONOPOLIZATION IN VIOLATION OF STATE ANTITRUST LAW
(Conn. Gen. Stat. § 35-24 *et seq.*)

184. The above-alleged paragraphs are incorporated by reference.

185. Conn. Gen. Stat. § 35-27, entitled, "Monopolization or attempt to monopolize unlawful," provides: "Every contract, combination, or conspiracy to monopolize, or attempt to monopolize, or monopolization of any part of trade or commerce is unlawful…."

186. Conn. Gen. Stat. § 35-27, entitled, "Treble damages for injury to business or property," states: "The state, or any person, including, but not limited to, a consumer, injured in its business or property by any violation of the provisions of this chapter shall recover treble damages, together with a reasonable attorney's fee and costs.

187. Defendant has monopolized, and continue to monopolize, the relevant market alleged herein in violation of Connecticut General Statutes § 35-24 *et seq.*

188. During the pertinent times including the last four years, HHC possessed monopoly power in the relevant market.

189. During the pertinent times, Defendant has engaged in the willful and unlawful attempt to maintain and increase its monopoly power.

190. Wherefore, Plaintiffs and class members are entitled to an award of treble damages individually or in the aggregate in excess of $75,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT TWO
ATTEMPTED MONOPOLIZATION
(Conn. Gen. Stat. § 35-27)

191. The above-alleged paragraphs are incorporated by reference.

192. Conn. Gen. Stat. § 35-27 declares that "every … attempt to monopolize … any part of trade or commerce is unlawful."

193. During the pertinent times, including within the last four years, HHC possessed monopoly power in the tying markets, including the market for acute inpatient hospital services in the Willimantic, Torrington, and Norwich.

194. During the pertinent times, HHC engaged in the willful and unlawful attempt to maintain or expand its monopoly power. Specifically, HHC attempted to monopolize the market for acute inpatient hospital services in regions outside of Willimantic, Torrington, and Norwich, such as in Meriden, Hartford, and Bridgeport. HHC also attempted to monopolize the market for outpatient medical services in all geographic markets in which it operates.

195. During the pertinent times, HHC attempted to acquire or expand its monopoly through illegitimate means, including but not limited to through tying and unlawful restraints such as anti-steering and anti-tiering provisions, as well as through acquisitions, non-compete agreements, improper and mischaracterized payments to physicians for referrals, and unduly restrictive referral practices.

196. Wherefore, Plaintiffs and class members are entitled to an award of treble damages individually or in the aggregate in excess of $75,000.

COUNT THREE
RESTRAINT OF TRADE IN VIOLATION OF STATE ANTITRUST LAW
(Conn. Gen. Stat. § 35-27)

197. The above-alleged paragraphs are incorporated by reference.

198. Conn. Gen. Stat. § 35-27 states: "Every contract, combination, or conspiracy to monopolize, or attempt to monopolize, or monopolization of any part of trade or commerce is unlawful." Further, Conn. Gen. Stat. § 35-26 affirms that: "Every contract, combination, or conspiracy in restraint of any part of trade or commerce is unlawful."

199. During the pertinent times, HHC has engaged in the use of contracts and agreements in restraint of trade as alleged hereinabove. HHC has negotiated and enforced contracts containing anticompetitive provisions restrictions with insurers which are contracts, combinations, and conspiracies within the meaning of Conn. Gen. Stat. § 35-26, 27.

200. The challenged contractual restrictions unreasonably restrain trade in violation of Conn. Gen. Stat. § 35-26.

201. Given HHC's monopoly power in the relevant tying markets, the system's unlawful tying practices, through the use of all-or-nothing contracting, is a per se violation of the antitrust laws. Those practices, as well as the other anticompetitive contracting practices described herein, are also unlawful under the Rule of Reason, because they unreasonably restrain trade and are not outweighed by any procompetitive benefits.

202. HHC's unlawful restraint of trade has harmed Plaintiffs and the putative class in their business or property by causing them to pay significantly higher costs for healthcare, both in

the form of higher insurance premiums and in direct payments to HHC through copays, coinsurance, and otherwise.

203. Wherefore, Plaintiffs and class members are entitled to an award of treble damages individually or in the aggregate in excess of $75,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT FOUR
UNFAIR OR DECEPTIVE TRADE PRACTICE IN VIOLATION OF THE CONNECTICUT UNFAIR TRADE PRACTICES ACT
(Con. Gen. Stat. §§ 42-110a *et seq.*)

204. The above-alleged paragraphs are incorporated by reference.

205. The Connecticut Unfair Trade Practices Act prohibits "unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." Conn. Gen. Stat. § 42-110b. It also permits any individual harmed by such practices to sue on behalf of herself and a class of similarly situated people to recover actual damages, and punitive damages in the Court's discretion. *Id.* § 42-110g(a)-(b).

206. HHC's contracting practices and leveraging of its monopoly power are unfair trade practices, and HHC's use of gag clauses to hide its contracting and pricing practices are deceptive trade practices.

207. HHC's conduct offends public policy, because it violates federal and state statutes relating to abuse of market power, as well as established common law principles of fair competition.

208. HHC's conduct is immoral, unethical, oppressive, and/or unscrupulous, because it was undertaken to maximize HHC's profit at the expense of Plaintiffs and the putative class and their right to a healthcare market free from the unreasonable impediments to competition HHC has

erected. HHC's practices do not conform to industry standards, as evidenced by the fact that other systems in Connecticut do not engage in the same oppressive and anticompetitive contracting tactics.

209. HHC's conduct has caused substantial injury to consumers such as Plaintiffs and the putative class, by significantly and unreasonably inflating the amounts they pay for healthcare, through increased premiums, coinsurance, copays, and other direct and indirect payments to HHC.

210. The harm to Plaintiffs and the putative class caused by HHC's unlawful acts is sufficiently direct to be actionable under CUTPA. A significant body of economic literature demonstrates that when hospital systems such as HHC charge supracompetitive prices to commercial health plans, those health plans pass all or most of those overcharges to insured members through higher premiums. The extent to which commercial health plans passed on these overcharges to Plaintiffs and the putative class is readily ascertainable through established methodologies that have been accepted by other courts.

211. Moreover, in addition to paying higher premiums, Plaintiffs and the putative class have made direct payments to HHC that no other person could recover for. Thus, there is no risk of a double recovery.

212. Wherefore, Plaintiffs and class members are entitled to an award of actual damages individually or in the aggregate in excess of $75,000, as well as punitive damages; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT FIVE
INJUNCTIVE, EQUITABLE, DECLARATORY RELIEF

213. The above-alleged paragraphs are incorporated by reference.

214. The Court has authority to award injunctive relief pursuant to Conn. Gen. Stat. § 35-34.

215. Plaintiffs show that to the extent the facts and law allow for the imposition of equitable, declaratory or injunctive remedies, they plead recourse to any and all such remedies.

216. Plaintiffs request that the Court order the reformation of HHC's practices, and/or contractual and agreement terms, including, for example, to require greater pricing transparency, express language against use of "all or nothing" arrangements, express provisions committing not to use anti-tiering or anti-steering provisions, and other such remedies.

217. Plaintiffs in addition to their damages claims, request injunctive, declaratory or equitable relief and show that the injunctive relief will prevent HHC from imposing anticompetitive all-or-nothing, anti-tiering, and anti-transparency provisions in their contracts, thus allowing health plans to steer patients away from lower value providers.

218. Plaintiffs and the Class members have standing to and do seek equitable relief against HHC, including an injunction to prohibit HHC's illegal conduct as well as an order of equitable restitution and disgorgement of the monetary gains that HHC obtained from its unfair competition.

X. JURY DEMAND

219. Plaintiffs demand a trial by jury.

XI. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that this Court enter judgment on their behalf and that of the proposed class and adjudge and decree as follows:

A. certifying the proposed class, designating the named Plaintiffs as class representatives and the undersigned counsel as class counsel, and allowing the Plaintiffs and the class to have trial by jury;

B. finding that Defendant HHC has monopolized, and continue to monopolize, the relevant market alleged herein in violation of Conn. Gen. Stat. § 35-24 *et seq*, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

C. finding that Defendant HHC has engaged in a trust, contract, combination, or conspiracy in violation of Conn. Gen. Stat. § 35-27, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

D. finding that Defendant HHC has engaged in an unfair trade practice in violation of Conn. Gen. Stat. § 42-110b, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

E. ordering that Plaintiffs and members of the class recover threefold the damages determined to have been sustained by them as a result of Defendant HHC's misconduct complained of herein, and that judgment be entered against Defendant HHC for the amount so determined;

F. entering judgment against Defendant HHC and in favor of Plaintiffs and the class awarding restitution and disgorgement of ill-gotten gains to the extent such an equitable remedy may be allowed by law;

G. awarding reasonable attorney's fees, costs, expenses, prejudgment and post-judgment interest, to the extent allowable by law;

H. awarding equitable, injunctive and declaratory relief, including but not limited to declaring Defendant HHC's misconduct unlawful and enjoining it, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts competition in the manner as alleged hereinabove; and

I. awarding punitive damages under Con. Gen. Stat. § 42-110g; and,

J. awarding such other and further relief as the Court may deem just and proper.

Dated: April 12, 2022

/s/ Peter Gwynne
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**Pro hac vice application forthcoming*

JOHN BROWN; LISA FAGAN; MICHAEL FAGAN; JEFFREY FORDE; MICHAEL MORGAN; JOSHUA PAWELEK; AND JOHN STOEHR, as individuals and on behalf of all others similarly situated, *Plaintiffs,*	SUPERIOR COURT JUDICIAL DISTRICT OF HARTFORD At Hartford
v.	
HARTFORD HEALTHCARE CORPORATION *Defendant*	April 12, 2022

STATEMENT OF AMOUNT IN DEMAND

The amount in demand, exclusive of interest and costs, is greater than Fifteen Thousand Dollars ($15,000.00).

Plaintiffs,
JOHN BROWN
LISA FAGAN
MICHAEL FAGAN
JEFFREY FORDE
MICHAEL MORGAN
JOSHUA PAWELEK
JOHN STOEHR

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JOHN BROWN; LISA FAGAN; MICHAEL FAGAN; JEFFREY FORDE; MICHAEL MORGAN; JOSHUA PAWELEK; AND JOHN STOEHR, as individuals and on behalf of all others similarly situated, *Plaintiffs,* v. HARTFORD HEALTHCARE CORPORATION *Defendant*	SUPERIOR COURT JUDICIAL DISTRICT OF HARTFORD AT HARTFORD April 12, 2022

CERTIFICATION OF SERVICE

I certify that a copy of the above was mailed or electronically delivered on April 12, 2022, to all counsel and self-represented parties of record and that written consent for electronic delivery was received from all counsel and self-represented parties of record who were electronically served:

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/s/ Peter Gwynne
Peter A. Gwynne

CONTINUATION OF PARTIES
JD-CV-67 Rev. 5-21

STATE OF CONNECTICUT
SUPERIOR COURT
www.jud.ct.gov

First named plaintiff *(Last, first, middle initial)*

Brown, John M.

First named defendant *(Last, first, middle initial)*

Hartford Healthcare Corporation

Additional Plaintiffs

Name *(Last, first, middle initial, if individual)*	Address *(Number, street, town and zip code)*
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Additional Defendants

Name *(Last, first, middle initial, if individual)*	Address *(Number, street, town and zip code)*

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Docket number

CONTINUATION OF PARTIES

Print Form Reset Form