DOCKET NO. HHD-CV22-6152239-S	:	SUPERIOR COURT
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,	:	J.D. OF HARTFORD
Plaintiffs,	:	AT HARTFOD
v.	:	
HARTFORD HEALTHCARE CORPORATION	:	
Defendant.	:	August 12, 2022

COVER SHEET TO PLAINTIFFS' OBJECTIONS TO DEFENDANT HARTFORD HEALTHCARE CORPORATION'S REQUEST TO REVISE

Pursuant to Practice Book § 10-37, Plaintiffs John Brown, Lisa Fagan, Michael Fagan, Jeffrey Forde, Michael Morgan, Joshua Pawelek, and John Stoehr ("Plaintiffs") hereby submit their Objections to Defendant Hartford HealthCare Corporation's ("Defendant") Request to Revise (the "Requested Revisions"). The objections and the reasons therefore are appended to this cover sheet and have been electronically inserted into each Requested Revision. The Plaintiffs object to all ten of Defendant's Requested Revisions.

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DOCKET NO. HHD-CV22-6152239-S	:	SUPERIOR COURT
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,	:	J.D. OF HARTFORD
Plaintiffs,	:	AT HARTFOD
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HARTFORD HEALTHCARE CORPORATION	:	
Defendant.	:	August 12, 2022

PLAINTIFFS' OBJECTIONS TO DEFENDANT HARTFORD HEALTHCARE CORPORATION'S REQUEST TO REVISE

Pursuant to Practice Book § 10-37, Plaintiffs John Brown, Lisa Fagan, Michael Fagan, Jeffrey Forde, Michael Morgan, Joshua Pawelek, and John Stoehr ("Plaintiffs") hereby submit the following Objections to Defendant Hartford HealthCare Corporation's ("Defendant") Request to Revise (the "Requested Revisions").

FIRST REQUESTED REVISION:

Portion of the Pleading Sought to be Revised:

All Counts, Paragraph 15.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 15 to plead:

- Whether Mr. Brown or any other person covered by his insurance policy received healthcare services from Hartford HealthCare during the relevant time period; and

- Whether Mr. Brown made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Mr. Brown made such payment; and

- The manner in which Mr. Brown claims that he was injured by his payment of commercial insurance premiums.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman v. Camillo*, No. CV075006202S, 2008 WL 2375564, at *1 (Conn. Super. Ct. May 27, 2008) ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Mr. Brown fails to adequately plead facts that would enable Defendant to understand his purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. 672, 690, 217 A.3d 953, 965 (2019) (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Mr. Brown claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Mr. Brown and Hartford HealthCare that would entitle Mr. Brown to have antitrust standing.

In other words, Mr. Brown pleads that the Defendant's conduct "led directly to [him] . . . paying drastically inflated prices for [his] healthcare," (Compl. ¶ 2), but fails to supply adequate factual allegations that establish the manner in which he claims he was injured and thus the grounds under which he contends that he has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Mr. Brown is actually a patient that received healthcare services from Hartford HealthCare, whether Mr. Brown made any direct payment to Hartford HealthCare for healthcare services, or whether Mr. Brown has some other purported basis for his alleged injury. Without understanding the nature behind Mr. Brown's alleged injury, and thus the grounds under which he contends he was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Mr.

Brown has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Mr. Brown's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. Defendant's First Requested Revision should be denied because the Complaint adequately puts Defendant on notice of the nature of Plaintiffs' claims and the manner in which Plaintiffs were financially harmed. Each Plaintiff has established standing by alleging that they have paid higher health insurance premiums during the relevant period as a direct result of Defendant's anticompetitive conduct. Because Connecticut's antitrust statute permits "indirect purchasers" to sue—individuals who were harmed financially by a defendant's misconduct but did not make payments directly to that defendant—this suffices to establish their entitlement to relief.

Defendant's First Requested Revision (as well as its Second through Seventh Requested Revisions, which repeat the First for the other named Plaintiffs), reflect a fundamental mischaracterization of the nature of the Complaint's claims. As Plaintiffs have alleged, Defendant's abuse of its market power and use of anticompetitive negotiating and contracting tactics lead to higher insurance premiums for everyone in the community, not just individuals who have received healthcare services from the hospital in question. *See, e.g.*, Compl. ¶ 85 (Defendant's restraints "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."). As an individual with commercial health insurance who lives within Defendant's service area, Mr. Brown has paid inflated insurance premiums as a direct result of the anticompetitive restraints that the Defendant has imposed on insurers. And the Complaint alleges that some Plaintiffs have

made direct payments to Defendant, in the form of inflated copays and coinsurance. *See, e.g.*, *id.* ¶ 22. Because these payments are not negotiated with Defendant by any individual patient, but rather are the result of negotiations between Defendant and commercial health insurers, the specifics of any individual patient/provider interactions are simply not relevant to Plaintiffs' claims. Defendant is on notice that Plaintiffs allege the direct payments they made to Defendant and the premiums they paid to their insurers were artificially high due to Defendant's misconduct; calculating the amount of overpayment will require expert testimony assessing the impact Defendant's anticompetitive scheme has had on prices and premiums.

Defendant suggests that the Complaint's allegations are insufficient to establish Plaintiffs' antitrust standing. But the Connecticut legislature has explicitly provided that plaintiffs like Mr. Brown can sue for financial harms that are caused by an antitrust defendant's unlawful conduct even if they did not make direct payments to that defendant. In October 2017, the Legislature passed a statute allowing plaintiffs "that the defendant did not deal directly with" to sue for antitrust damages. Conn. Gen. Stat. § 35-46a(1). This law was passed after decades of increasing public concern in Connecticut regarding the consequences of *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977), which held that only direct purchaser plaintiffs have standing for federal antitrust claims. While it appears no Connecticut court has yet interpreted this recently enacted provision, other courts have recognized that it permits so-called "indirect purchaser" plaintiffs to sue. *See, e.g.*, *In re Xyrem (Sodium Oxybate) Antitrust Litig.*, 555 F. Supp. 3d 829, 885 (N.D. Cal. 2021) ("Connecticut passed a law abrogating any [direct purchaser] requirement."). That is Plaintiffs' primary theory of harm here: that as indirect purchasers, they were forced to pay more for health insurance than they would have due to Defendant's anticompetitive conduct.

The Complaint contains many allegations about how Defendant's all-or-nothing contracting caused insurers to pay Defendant drastically inflated prices for healthcare services, by reducing price competition. *See, e.g.*, Compl. ¶¶ 3, 8, 39-40, 48, 87, 135-36. The Complaint further details that, because of Defendant's anti-steering restrictions, insurers are not able to direct their patients to cheaper, high-quality competitors, which means that more patients receive care from Defendant than they would if insurers were permitted to incentivize patients to obtain cheaper care elsewhere. *Id.* ¶¶ 146-50. And the Complaint notes that when insurers pay more to hospitals, as Defendant's restraints cause them to, these overpayments get passed down to insured individuals like Plaintiffs in the form of higher premiums. *See, e.g.*, Compl. ¶ 34 ("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. Thus, the insurance premiums paid by commercial health plan members increase when the plans are forced to purchase services from hospitals at higher rates." (footnote omitted)).

Thus, no allegation regarding whether Mr. Brown received care or whether he made direct payments to Defendant are necessary at this stage of the proceedings to establish standing, and Defendant is fully on notice of what the Complaint alleges caused Mr. Brown's injuries: the anticompetitive contractual restrictions Defendant has imposed on insurers in the relevant market.

Accordingly, Defendant is not entitled to the further specifics it requests, because they are not necessary for Defendant to mount a defense to the Complaint's claims and, in any event, the information can (and should) be obtained through discovery. *See Pfister v. Madison Beach Hotel, LLC*, No. CV156055458S, 2016 Conn. Super. LEXIS 1637, at *1-3 (Super. Ct. June 6,

2016) ("The plaintiffs have properly alleged their claims under Practice Book §10-1, which requires pleadings to contain a plain and concise statement of material facts, and any alleged 'confusion' can be cleared up through discovery. Indeed, the right of a litigant to state its case in its own way is to be respected.") (internal citations omitted); *see also McDermott Rd., LLC v. Hammonasset Constr., LLC*, No. NNHCV136035719S, 2014 Conn. Super. LEXIS 2279, at *3 (Super. Ct. Sep. 17, 2014) ("The purpose of a request to revise is to secure a statement of the material facts upon which the adverse party bases his complaint or defense . . . . The test is *not whether the pleading discloses all that the adversary desires to know in aid of his own cause*, but whether it discloses the material facts which constitute the cause of action or ground of defense." (emphasis added)); *Vaccaro v. United States Bank, N.A.*, No. NNHCV146050373S, 2015 Conn. Super. LEXIS 1002, at *3-4 (Super. Ct. May 5, 2015) ("The defendant is not entitled to know the plaintiff's proof but only what he claims as his cause of action.").

Therefore, no amendment or revision is necessary, and Defendant's request should be denied. However, should the Court disagree, Plaintiffs would amend the Complaint to note that Mr. Brown received care from Hartford Healthcare, and made direct payments to Hartford Healthcare for that care, during the relevant time period (February 14, 2018 through February 14, 2022).

SECOND REQUESTED REVISION:

Portion of Pleading Sought To Be Revised:

All Counts, Paragraph 16.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 16 to plead:

- Whether Ms. Fagan or any other person covered by her insurance policy received healthcare services from Hartford HealthCare during the relevant time period;
- Whether Ms. Fagan made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Ms. Fagan made such payment; and
- The manner that Ms. Fagan claims that she was injured by her household's payment of commercial insurance premiums.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has

failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Ms. Fagan fails to adequately plead facts that would enable Defendant to understand her purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Ms. Fagan claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Ms. Fagan and Hartford HealthCare that would entitle Ms. Fagan to have antitrust standing.

In other words, Ms. Fagan pleads that the Defendant's conduct "led directly to [her] . . . paying drastically inflated prices for [her] healthcare," (Compl. ¶ 2), but fails to supply adequate factual allegations that establish the manner in which she claims she was injured and thus the

grounds under which she contends that she has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Ms. Fagan (or a member of her household) is actually a patient that received healthcare services from Hartford HealthCare, whether Ms. Fagan made any direct payment to Hartford HealthCare for healthcare services, or whether Ms. Fagan has some other purported basis for her alleged injury. Nor does Ms. Fagan explain how she is injured by premium payments allegedly made by her household. Without understanding the nature behind Ms. Fagan's alleged injury, and thus the grounds under which she contends she was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Ms. Fagan has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Ms. Fagan's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Second Requested Revision should be denied for the same reasons stated in Plaintiffs' Response to the First Requested Revision.

However, should the Court disagree, Plaintiffs would amend the Complaint to note that Ms. Fagan or a family member covered by her health insurance policy received care from Hartford Healthcare, and made direct payments to Hartford Healthcare for that care, during the relevant time period (February 14, 2018 through February 14, 2022).

THIRD REQUESTED REVISION:

Portion of Pleading Sought To Be Revised:

All Counts, Paragraph 17.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 17 to plead:

- Whether Mr. Fagan or any other person covered by his insurance policy received healthcare services from Hartford HealthCare during the relevant time period;
- Whether Mr. Fagan made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Mr. Fagan made such payment;
- The relationship, if any, between Mr. Fagan's enrollment in a Medicaid health plan, his household's alleged payment of commercial insurance premiums, and his own alleged injury.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has

failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Mr. Fagan fails to adequately plead facts that would enable Defendant to understand his purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (2019) (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Mr. Fagan claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Mr. Fagan and Hartford HealthCare that would entitle Mr. Fagan to have antitrust standing.

In other words, Mr. Fagan pleads that the Defendant's conduct "led directly to [him] . . . paying drastically inflated prices for [his] healthcare," (Compl. ¶ 2), but fails to supply adequate factual allegations that establish the manner in which he claims he was injured and thus the

grounds under which he contends that he has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Mr. Fagan (or a member of his household) is actually a patient that received healthcare services from Hartford HealthCare, whether Mr. Fagan made any direct payment to Hartford HealthCare for healthcare services, or whether Mr. Fagan has some other purported basis for his alleged injury. Further, Mr. Fagan alleges that he was enrolled in a Medicaid health plan, but then claims that his household paid for commercial insurance, and he does not explain the connection between those facts, if any, and his alleged injury. Without understanding the nature behind Mr. Fagan's alleged injury, and thus the grounds under which he contends he was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Mr. Fagan has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Mr. Fagan's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Third Requested Revision should be denied for the same reasons stated in Plaintiffs' Response to the First Requested Revision.

However, should the Court disagree, Plaintiffs would amend the Complaint to note that Mr. Fagan or a family member covered by his health insurance policy received care from Hartford Healthcare, and made direct payments to Hartford Healthcare for that care, during the relevant time period (February 14, 2018 through February 14, 2022).

FOURTH REQUESTED REVISION:

Portion of Pleading Sought To Be Revised:

All Counts, Paragraph 18.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 18 to plead:

- Whether Mr. Forde or any other person covered by his insurance policy received healthcare services from Hartford HealthCare during the relevant time period;
- Whether Mr. Forde made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Mr. Forde made such payment;
- The manner that Mr. Forde claims that he was injured by his household's payment of commercial insurance premiums; and
- The identity of the commercial health plan for which Mr. Forde's household allegedly pays monthly insurance premiums.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to

apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Mr. Forde fails to adequately plead facts that would enable Defendant to understand his purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Mr. Forde claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Mr. Forde and Hartford HealthCare that would entitle Mr. Forde to have antitrust standing.

In other words, Mr. Forde pleads that the Defendant's conduct "led directly to [him] . . . paying drastically inflated prices for [his] healthcare," (Compl. ¶ 2), but fails to supply adequate

factual allegations that establish the manner in which he claims he was injured and thus the grounds under which he contends that he has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Mr. Forde (or a member of his household) is actually a patient that received healthcare services from Hartford HealthCare, whether Mr. Forde made any direct payment to Hartford HealthCare for healthcare services, or whether Mr. Forde has some other purported basis for his alleged injury. Nor does Mr. Forde explain how he is injured by premium payments allegedly made by his household, or even identify the commercial health plan for which Mr. Forde's household allegedly pays monthly insurance premiums. Without understanding the nature behind Mr. Forde's alleged injury, and thus the grounds under which he contends he was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Mr. Forde has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Mr. Forde's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Fourth Requested Revision should be denied for the same reasons stated in Plaintiffs' Response to the First Requested Revision.

However, should the Court disagree, Plaintiffs would amend the Complaint to note that Mr. Forde received care from Hartford Healthcare, and made direct payments to Hartford Healthcare for that care, during the relevant time period (February 14, 2018 through February 14, 2022).

FIFTH REQUESTED REVISION:

Portion of Pleading Sought To Be Revised:

All Counts, Paragraph 19.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 19 to plead:

- Whether Mr. Morgan or any other person covered by his insurance policy received healthcare services from Hartford HealthCare during the relevant time period;
- Whether Mr. Morgan made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Mr. Morgan made such payment; and
- The manner that Mr. Morgan claims that he was injured by his household's payment of commercial insurance premiums.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has

failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Mr. Morgan fails to adequately plead facts that would enable Defendant to understand his purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Mr. Morgan claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Mr. Morgan and Hartford HealthCare that would entitle Mr. Morgan to have antitrust standing.

In other words, Mr. Morgan pleads that the Defendant's conduct "led directly to [him] . . . paying drastically inflated prices for [his] healthcare," (Compl. ¶ 2), but fails to supply adequate factual allegations that establish the manner in which he claims he was injured and thus the

grounds under which he contends that he has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Mr. Morgan (or a member of his household) is actually a patient that received healthcare services from Hartford HealthCare, whether Mr. Morgan made any direct payment to Hartford HealthCare for healthcare services, or whether Mr. Morgan has some other purported basis for his alleged injury. Nor does Mr. Morgan explain how he is injured by premium payments allegedly made by his household. Without understanding the nature behind Mr. Morgan's alleged injury, and thus the grounds under which he contends he was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Mr. Morgan has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Mr. Morgan's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Fifth Requested Revision should be denied for the same reasons stated in Plaintiffs' Response to the First Requested Revision.

However, should the Court disagree, Plaintiffs would amend the Complaint to note that Mr. Morgan received care from Hartford Healthcare, and made direct payments to Hartford Healthcare for that care, during the relevant time period (February 14, 2018 through February 14, 2022).

SIXTH REQUESTED REVISION:

Portion of Pleading Sought To Be Revised:

All Counts, Paragraph 20.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 20 to plead:

- Whether Mr. Pawelek or any other person covered by his insurance policy received healthcare services from Hartford HealthCare during the relevant time period;
- Whether Mr. Pawelek made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Mr. Pawelek made such payment; and
- The manner that Mr. Pawelek claims that he was injured by his household's payment of commercial insurance premiums.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has

failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Mr. Pawelek fails to adequately plead facts that would enable Defendant to understand his purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Mr. Pawelek claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Mr. Pawelek and Hartford HealthCare that would entitle Mr. Pawelek to have antitrust standing.

In other words, Mr. Pawelek pleads that the Defendant's conduct "led directly to [him] . . . paying drastically inflated prices for [his] healthcare," (Compl. ¶ 2), but fails to supply adequate factual allegations that establish the manner in which he claims he was injured and thus the

grounds under which he contends that he has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Mr. Pawelek (or a member of his household) is actually a patient that received healthcare services from Hartford HealthCare, whether Mr. Pawelek made any direct payment to Hartford HealthCare for healthcare services, or whether Mr. Pawelek has some other purported basis for his alleged injury. Nor does Mr. Pawelek explain how he is injured by premium payments allegedly made by his household. Without understanding the nature behind Mr. Pawelek's alleged injury, and thus the grounds under which he contends he was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Mr. Pawelek has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Mr. Pawelek's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Sixth Requested Revision should be denied for the same reasons stated in Plaintiffs' Response to the First Requested Revision.

However, should the Court disagree, Plaintiffs would amend the Complaint to note that Mr. Pawelek or a family member covered by his insurance policy received care from Hartford Healthcare, and made direct payments to Hartford Healthcare for that care, during the relevant time period (February 14, 2018 through February 14, 2022).

SEVENTH REQUESTED REVISION:

Portion of Pleading Sought To Be Revised:

All Counts, Paragraph 21.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraph 21 to plead:

- Whether Mr. Stoehr or any other person covered by his insurance policy received healthcare services from Hartford HealthCare during the relevant time period;
- Whether Mr. Stoehr made any direct payment to Hartford HealthCare during the relevant time period, and, if so, whether any such payments consisted of copays, coinsurance, deductibles, or some other manner of payment, and the identity of the Hartford HealthCare facility or entity to which Mr. Stoehr made such payment; and
- The manner that Mr. Stoehr claims that he was injured by his household's payment of commercial insurance premiums.

Reasons for Requested Revisions:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be state according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has

failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

For each Count of the Complaint, Mr. Stoehr fails to adequately plead facts that would enable Defendant to understand his purported grounds for having standing to assert the claims in the Complaint. Those Counts are: Count One (Monopolization in Violation of State Antitrust Law); Count Two (Attempted Monopolization); Count Three (Restraint of Trade in Violation of State Antitrust Law); and Count Four (Unfair or Deceptive Trade Practice in Violation of the Connecticut Unfair Trade Practices Act).

To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (internal citations omitted). In addition, "[e]ven a plaintiff that has suffered an antitrust injury must also demonstrate that it is a suitable plaintiff, i.e., an efficient enforcer of the antitrust laws." *Id.*

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient factual material for Defendant to understand the grounds under which Mr. Stoehr claims injury and antitrust standing, and most fundamentally fail to allege the nature of any alleged enforceable or actionable direct or indirect relationship between Mr. Stoehr and Hartford HealthCare that would entitle Mr. Stoehr to have antitrust standing.

In other words, Mr. Stoehr pleads that the Defendant's conduct "led directly to [him] . . . paying drastically inflated prices for [his] healthcare," (Compl. ¶ 2), but fails to supply adequate factual allegations that establish the manner in which he claims he was injured and thus the

grounds under which he contends that he has standing or is a proper or suitable Plaintiff under the state's antitrust laws.

Based on the current state of the pleadings, it is unclear whether Mr. Stoehr (or a member of his household) is actually a patient that received healthcare services from Hartford HealthCare, whether Mr. Stoehr made any direct payment to Hartford HealthCare for healthcare services, or whether Mr. Stoehr has some other purported basis for his alleged injury. Nor does Mr. Stoehr explain how he is injured by premium payments allegedly made by his household. Without understanding the nature behind Mr. Stoehr's alleged injury, and thus the grounds under which he contends he was injured and possesses standing, Hartford HealthCare cannot efficiently and reasonably address whether Mr. Stoehr has properly alleged grounds for standing and is otherwise unable to prepare its defenses to Mr. Stoehr's claims.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Seventh Requested Revision should be denied for the same reasons stated in Plaintiffs' Response to the First Requested Revision.

However, should the Court disagree, Plaintiffs would amend the Complaint to note that Mr. Stoehr did not receive care from Hartford Healthcare during the relevant time period (February 14, 2018 through February 14, 2022).

EIGHTH REQUESTED REVISION:

Portion of the Pleading Sought To Be Revised:

All Counts, Paragraph 22.

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.

Requested Revision:

Hartford HealthCare requests that this paragraph be revised to plead which Named Plaintiffs allege that they made a direct payments to Defendant, and whether such payments consisted of co-pays, coinsurance, deductibles, or otherwise. Hartford HealthCare further requests that All Counts, Paragraph 22 be revised to plead how or why each such Named Plaintiff contends that such payment would have been lower in the absence of the conduct challenged in the Complaint. In addition, the term "otherwise" should be revised to indicate with specificity how all such direct payments allegedly were made.

Reasons for Requested Revision:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564,

at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

Each Named Plaintiff who claims that he or she allegedly made direct payments to Hartford HealthCare fails to adequately plead the basis for his or her alleged injury, namely, why he or she believes that his or her payment to Hartford HealthCare would have been lower in the absence of the challenged conduct. To establish antitrust standing under Connecticut Law, "a private antitrust plaintiff must plausibly allege that [1] it suffered an antitrust injury and [2] it is an acceptable plaintiff to pursue the alleged antitrust violations." *Tremont Pub. Advisors, LLC v. Connecticut Res. Recovery Auth.*, 333 Conn. at 690 (internal citations omitted).

Consumers like the Named Plaintiffs, who allegedly are covered by health insurance, do not pay the full price of healthcare services provided to them by a healthcare provider. Instead, consumers share the costs with a health plan through payments made through fixed co-pays, deductibles, or otherwise. Accordingly, it is not necessarily the case that a higher price from Hartford HealthCare will lead to a higher cost paid by a Named Plaintiff.

For example, a consumer may pay a healthcare provider the same fixed co-pay (e.g., $30) regardless of the price of the services provided by the healthcare provider. Similarly, a consumer who has already exceeded his or her deductible for the year will not be harmed by an increase in the price of a healthcare service because that consumer will pay the deductible, and not more, regardless of the price.

Accordingly, each Named Plaintiff that claims injury as a result of a direct payment made to Hartford HealthCare has failed to plead sufficient facts for Hartford HealthCare to understand the grounds under which each Named Plaintiff contends that it was injured and/or has standing to assert its claims. Moreover, the complaint fails to supply adequate notice as to how those Plaintiffs who claim to have made direct payments have been harmed, inasmuch as the use of the word "otherwise" is too expansive and ambiguous to inform the Defendant of the Plaintiffs' claims.

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." All Counts fail to supply sufficient support for antitrust standing, and most fundamentally fail to allege an enforceable relationship between the parties. Plaintiff pleads that the Hartford HealthCare's conduct "led directly to Plaintiffs … paying drastically inflated prices for their healthcare," (Compl. ¶ 2), but each Named Plaintiff who claims that he or she made a direct payment to Defendant (who are not identified) fails to supply adequate allegations that allow Hartford HealthCare to understand the basis for each Named Plaintiff's claim that such payment would have been lower absent the challenged conduct, thus preventing Hartford HealthCare from fully considering the legal sufficiency of such allegations under the applicable law and from preparing an appropriate defense.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Eighth Requested Revision should be denied because Defendant prematurely seeks information that will be investigated and produced during discovery. As noted above, the Complaint alleges how Defendant's contractual restraints caused hospital prices to increase to supracompetitive levels; how more patients received care

from Defendant than they would have absent Defendant's insistence that insurers include anti-steering and anti-tiering provisions in their contracts with Defendant; and how direct payments to Defendant were inflated due to the restraints Defendant forces insurers to accept in their negotiations. This is sufficient to put Defendant on notice as to the basis of Plaintiffs' theory of harm.

As for Defendant's request that Plaintiffs now assert why "such payment[s] would have been lower in the absence of the conduct challenged in the Complaint," this is a matter for expert testimony. Precisely calculating how Defendant's many contractual restraints throughout its service area affected prices, and the share of direct payments to Defendant by patients in the form of, for example, co-insurance, will be a complex economic analysis involving years of claims data, and modeling what the market would look like absent Defendant's restraints. Plaintiffs are not required to prove these highly technical issues at the pleading stage.

The Request to Revise is not a means for obtaining further evidence. *See McDermott Rd., LLC*, 2014 Conn. Super. LEXIS 2279, at *3 ("The purpose of a request to revise is to secure a statement of the material facts upon which the adverse party bases his complaint or defense . . . . The test is *not whether the pleading discloses all that the adversary desires to know in aid of his own cause*, but whether it discloses the material facts which constitute the cause of action or ground of defense.") (emphasis added); *Vaccaro*, 2015 Conn. Super. LEXIS 1002, at *3 ("A request to revise is permissible to obtain information so that a defendant may intelligently plead and prepare his case for trial *but it is never appropriate where the information sought is merely evidential . . . The defendant is not entitled to know the plaintiff's proof but only what he claims as his cause of action.*") (emphasis added).

In any event, Plaintiffs have sufficiently pled how costs would have been lower absent Defendant's conduct. *See, e.g.*, Compl. ¶¶ 35-36 ("When a commercial health plan seeks to offer a plan in a region where a significant geographic area is controlled by a single hospital, that hospital is in effect a 'must-have' for that health plan . . . 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 . . . prevent new entrants from entering the market and [reigning] in prices that must-have hospitals can charge."). This is sufficient to put Defendant on notice of Plaintiffs' theory of monetary injury, and Plaintiffs are entitled to supplement these allegations upon discovery of new material and to assert their damages theory with the benefit of expert analysis and testimony.

NINTH REQUESTED REVISION

Portion of the Pleading Sought To Be Revised:

All Counts, Paragraphs 129–41.

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.

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.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraphs 129–41 to plead the name of any insurance carrier that it claims was subjected to vertical restraints or tying arrangements by Hartford HealthCare.

Reasons for Requested Revision:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

Plaintiffs must provide sufficient factual allegations to support a "plausible" explanation that Hartford HealthCare subjected insurance carriers to vertical restraints or tying arrangements that caused an actual effect on competition. *See Bell Atlantic Corp. v. Twombly*, 550 U.S. 544

(2007)[1]; *Edelman v. Laux*, No. CV115005710, 2013 WL 4504793, at *19 (Conn. Super. Ct. July 26, 2013) (Plausibility "requires that a complaint set forth a plausible basis for belief that a plaintiff may prove his case on the merits at trial."). As currently alleged, Plaintiffs' allegations do not support a plausible inference that any insurance carrier was interested in including none, or only a limited number, of Hartford HealthCare facilities into their networks, but was unable to do so because of Hartford HealthCare's supposed insistence that insurers include all Hartford HealthCare facilities into their networks. In fact, Plaintiffs' allegations indicate that insurers wanted to include a wide variety of Hartford HealthCare facilities in their networks in order to provide patients with the highest number of inpatient and outpatient healthcare services. Accordingly, without more information, especially the name of any insurance carrier that was allegedly subjected to vertical restraints or tying arrangements, Hartford HealthCare is unable to fully evaluate the alleged claim.

At the very least, the basis for Plaintiffs' pleading such allegations on "information and belief" must be articulated, or else they must be deleted. "[T]he phrase 'on information and belief' is hardly a definite statement of facts. Someone pleading with those words as a predicate should first ascertain as to whether what he is pleading is a provable fact, and if it is, leave out the predicate; if it is not, it shouldn't be pleaded." *First Fed. Sav. & Loan Ass'n. of E. Hartford v. Chappell*, No. CV 9661212S, 1997 WL 220223, at *2 (Conn. Super. Ct. Apr. 21, 1997).

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement."

[1] *See also* Conn. Gen. Stat. § 35-44b ("It is the intent of the General Assembly that in construing sections 35-24 to 35-46, inclusive, the courts of this state shall be guided by interpretations given by the federal courts to federal antitrust statutes.") and *Bridgeport Harbour Place I, LLC v. Ganim*, 303 Conn. 205, 213-14 (2011) (Citing *Bell Atlantic Corp. v. Twombly* for interpreting the Connecticut Antitrust Act.).

Plaintiffs allegations concerning vertical restraints and tying arrangements fail to fully disclose the grounds for the alleged anticompetitive conduct absent the further information requested.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. The Ninth Requested Revision should be denied for two reasons.

First, the Complaint adequately alleges that Defendant has imposed all-or-nothing conditions in its negotiations with all or substantially all health insurance companies during the relevant period. The Complaint notes that the New York Times has written about Defendant's all-or-nothing contracting, and the Complaint explains how Defendant's market power enables it to force these provisions on insurers. *See, e.g.*, Compl. ¶ 129 ("[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.'"); *id.* ¶ 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."). And elsewhere the Complaint makes clear that *all* insurers need some of Defendant's hospital facilities in their network. *See, e.g.*, *id.* ¶ 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.").

Paragraph 135, in particular, details that Defendant applies this restriction in all (or substantially all) of its negotiations with insurers. That paragraph notes: "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." This allegation, and the others discussing Defendant's forcing of all-or-nothing contractual restrictions on insurers, do not distinguish between insurers, because no insurer can refuse Defendant's demand. Defendant is thus on sufficient notice that the Complaint alleges that it forces all (or nearly all) insurers to accept its all-or-nothing condition.

Second, Defendant's Requested Revision ignores the fact that the Complaint alleges Defendant includes gag clauses in its contracts with insurers, which "prevent commercial health plans from revealing the terms of HHC's payer/provider agreements." *Id.* ¶ 164; *see generally id.* ¶¶ 164-67. Thus, Plaintiffs are unable to see any agreement Defendant enters into with health insurers—let alone all of them—precisely because Defendant insists that they be kept confidential. This Court has made clear that Requests to Revise should not be granted to require plaintiffs to include information that are more readily accessible to defendants, as HHC's payor/provider contracts are here. *See, e.g.*, *Sarah He Ppa Xiu Hin He v. Litchfield Cty. Obstetrics*, No. LLICV106002542S, 2011 Conn. Super. LEXIS 1123, at *5 (Super. Ct. May 9, 2011) (sustaining objections to requests to revise where defendant was "in a better position than

the plaintiffs to know" certain information). That is exactly the case here: Defendant has the contracts, refuses to disclose their terms, and actively prevents insurers from doing the same.

Plaintiffs have sufficiently alleged—and the New York Times has reported, Compl. ¶ 129—that Defendant can and does impose its all-or-nothing condition on insurers. To require Plaintiffs to identify individual payor/provider contracts that contain these terms—when Defendant actively prohibits the contracts' disclosure—would unfairly prejudice Plaintiffs and raise the pleading standard beyond what Connecticut law requires. Practice Book § 10-2 requires that "the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Plaintiffs' Complaint fairly apprises Defendant of Plaintiffs' intention to prove that Defendant imposes its all-or-nothing condition on substantially all insurers with which it contracts.

TENTH REQUESTED REVISION:

Portion of the Pleading Sought To Be Revised:

All Counts, Paragraphs 146–50.

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.

Requested Revision:

Hartford HealthCare requests that Plaintiffs revise All Counts, Paragraphs 146–50 to plead the name of any insurance carrier that it claims was subjected to anti-tiering language by Hartford HealthCare.

Reasons for Requested Revision:

Practice Book § 10-1 states that "[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies" and "[i]f any such pleading does not fully disclose the ground of claim or defense, the judicial authority may order a fuller and more particular statement." *See also* Practice Book § 10-20 (requiring a complaint to "contain a

concise statement of the facts constituting the cause of action"); *Guberman*, 2008 WL 2375564, at *1 ("The purpose of the request to revise is to secure a statement of the material facts upon which the plead[ing] is based."). Furthermore, Practice Book § 10-2 states that "[a]cts . . . may be stated according to their legal effect, but in so doing the pleading should be such as fairly to apprise the adverse party of the state of facts which it is intended to prove." Where a plaintiff has failed to include sufficient facts, or has included improper conclusory assertions, a request to revise is the appropriate mechanism to seek clarification. Practice Book § 10-35.

Plaintiffs must provide sufficient factual allegations to support a "plausible" explanation that the use of anti-tiering clauses caused an actual effect on competition. *See Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007); *Edelman v. Laux*, 2013 WL 4504793, at *19 (Plausibility "requires that a complaint set forth a plausible basis for belief that a plaintiff may prove his case on the merits at trial."). As currently alleged, Plaintiffs' allegations do not support a plausible inference that any insurers prior to late 2020 were interested in offering a tiered network, but were unable to do so because of Hartford HealthCare's supposed decision not to participate. In fact, Plaintiffs' allegations indicate that an insurer was able to launch a tiered network even without Hartford HealthCare's participation, and name no insurer that sought to do so but was unable to do so. Accordingly, without more information, especially the name of any health insurer that allegedly sought to launch an insurance product but was allegedly prevented from doing so due to anti-tiering language, Hartford HealthCare is unable to fully evaluate the alleged claim.

At the very least, the basis for Plaintiffs' pleading such allegations on "information and belief" must be articulated, or else they must be deleted. "[T]he phrase 'on information and belief' is hardly a definite statement of facts. Someone pleading with those words as a predicate

should first ascertain as to whether what he is pleading is a provable fact, and if it is, leave out the predicate; if it is not, it shouldn't be pleaded." *First Fed. Sav. & Loan Ass'n. of E. Hartford v. Chappell*, No. CV 9661212S, 1997 WL 220223, at *2 (Conn. Super. Ct. Apr. 21, 1997).

Practice Book § 10-1 expressly provides that if a pleading "does not fully disclose the ground of [a] claim . . . the judicial authority may order a fuller and more particular statement." Plaintiffs allegation concerning anti-tiering clauses fail to allege anticompetitive conduct absent the further information requested.

PLAINTIFFS' RESPONSE:

Plaintiffs object to this Requested Revision. Defendant's Tenth Requested Revision should be denied, for substantially the same reasons as the Court should deny Defendant's Ninth Requested Revision.

The Complaint alleges why Defendant is able to impose anti-steering and anti-tiering provisions on health insurers, and it alleges how this has affected all insurance plans and patients in its service area. *See, e.g.*, Compl. ¶ 110 ("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." (emphasis added)). And the Complaint also makes plain why Plaintiffs would not know the precise content of Defendant's anti-steering clauses, or the language it uses with any particular insurer—Defendant insists that all of its contracts with insurers are kept highly confidential, preventing Plaintiffs (or anyone else) from seeing Defendant's anticompetitive terms. *Id.* ¶¶ 164-67.

Defendant's Requested Revision also ignores the fact that Defendant is currently engaged in litigation with one of its primary competitors in Hartford, St. Francis Hospital and Medical Center, specifically about Defendant's use of anti-steering and anti-tiering provisions. *See* Compl. ¶ 24. As the Complaint notes, "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 [*i.e.*, steering methods insurers would like to use], 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." *Id.* ¶ 149. Like St. Francis, Plaintiffs here have plausibly alleged that Defendant has the ability and incentive to impose—and has in fact imposed—anti-steering and anti-tiering provisions in all or substantially all Defendant's contracts with health insurers.

The Complaint even offers a specific example of a health insurer (Anthem) attempting in late 2020 to offer a tiered insurance plan, and Defendant taking the drastic measure of telling its primary care physicians that if they accepted payment from this plan, "they would lose their hospital privileges at Hartford HealthCare facilities, making them ineligible to see patients at those facilities." *Id.* ¶ 148. Defendant—unable to deny this detailed allegation about its recent conduct—suggests that all this allegation implies is that, before late 2020, no insurer was "interested in offering a tiered network." Yet Plaintiffs' version of events is far more plausible: This event demonstrates that Defendant views steering and tiering as a threat to its regional dominance, and will go to great lengths to prevent this innovative form of competition. At the pleading stage, Plaintiffs have put Defendant on ample notice that the gravamen of this claim is that Defendant imposes anti-steering and anti-tiering restraints on all or substantially all insurers with which it contracts.

However, if the Court disagrees, Plaintiffs would amend their Complaint to include, *inter alia*, an allegation that St. Francis—a competitor that also negotiates with insurers and seeks to participate in tiered plans—has stated that:

> [T]he major managed care plans (Aetna, Cigna, United and Anthem) have not offered tiered networks in Hartford County or elsewhere in Connecticut even though each of these firms offers tiered networks in many other locations nationally. That is because Hartford HealthCare has required in its contracts with these payors that they limit or eliminate any use of tiered networks in markets in which Hartford HealthCare operates.

But Plaintiffs respectfully submit that such amendment is not necessary, because Defendant is on ample notice, both due to the Complaint's allegations and the litigation with St. Francis Hospital and Medical Center regarding these precise clauses, that it is charged with imposing these restrictions on all insurers with which it contracts. That is sufficient to put Defendant on notice of what Plaintiffs allege, and to give it the opportunity to deny these allegations or defend its anti-steering and anti-tiering restrictions on the merits after discovery.

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**Pro hac vice application forthcoming*

CERTIFICATE OF SERVICE

I certify that on August 12, 2022, a copy of the foregoing was or will immediately be mailed or electronically delivered to counsel of record as follows:

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