IN THE UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER, INC.,

Plaintiff,

v.

HARTFORD HEALTHCARE CORPORATION, HARTFORD HOSPITAL, HARTFORD HEALTHCARE MEDICAL GROUP, INC., INTEGRATED CARE PARTNERS, LLC,

Defendants.

Case No. 22-cv-00050

Judge Alfred Covello

MARCH 25, 2022

MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS PLAINTIFF'S AMENDED COMPLAINT

ORAL ARGUMENT REQUESTED

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Plaintiff Saint Francis Hospital and Medical Center, Inc. ("Saint Francis") submits this Memorandum in Opposition to Defendants' Motion to Dismiss.

I. INTRODUCTION

This action challenges anticompetitive conduct by Hartford HealthCare Corporation and its subsidiaries (hereafter "HHC") that has allowed it to dominate the market while providing higher cost and lesser quality health care than its competitors. Saint Francis's detailed Amended Complaint (Docket 33) makes clear that HHC's alleged actions do not constitute competition on the merits, but, rather, involve numerous clear antitrust violations. HHC's actions as alleged do not promote competition on price or quality, but instead, significantly interfere with it.

Defendants' Motion to Dismiss ignores both well-established antitrust principles and the specific factual allegations of the Amended Complaint. Their "Statement of Facts" barely references the allegations in the Amended Complaint, and instead tries to depict a completely different view of their actions. Defendants describe the issue of acquisition of physician practices, a well-established antitrust violation when it results in unduly high market shares, as ordinary competition. And they virtually ignore the allegations of threats, intimidation and control of physician referrals which are central to the allegations in the Amended Complaint.

Defendants' legal arguments are equally deficient. They do not dispute that the Amended Complaint alleges the control elements of an antitrust claim, including market power, anticompetitive effects and harm to consumers. Instead, they attempt to make technical arguments as to why the Amended Complaint does not pass muster. But each of these arguments is contrary to the allegations in the Amended Complaint and well-established antitrust principles.

II. STATEMENT OF ALLEGED FACTS

A. The Parties

HHC is one of the largest health care systems in Connecticut. *Id*. ¶ 20. Its subsidiaries include Defendants (i) Hartford Hospital, (ii) Hartford HealthCare Medical Group, and (iii) Integrated Care Partners, LLC ("ICP"), a physician hospital network. Am. Cplt. ¶¶ 20-21, 56, 73.

Hartford Hospital's closest competitor, by a substantial margin, is Saint Francis. *Id.* ¶ 22. Hartford Hospital and Saint Francis are only a few miles apart in the city of Hartford. *Id.* ¶ 23. Saint Francis is substantially less expensive and provides higher quality care than Hartford Hospital. *Id*. ¶ 2, 24-26, 85, 198. Nevertheless, HHC has been able to maintain and increase its dominant market share. *Id.* ¶ 2, 6, 24, 84, 159-165. Harm to Saint Francis will cause significant harm to competition, because only Saint Francis can provide a serious challenge to HHC's market position. *Id*. ¶ 7, 178, 188-189.

HHC executives have stated repeatedly that their plan was to "crush" or "bury" Saint Francis. One executive said that "we don't want Saint Francis in our backyard." *Id.* ¶ 7, 62.

B. Hartford HealthCare's Monopoly Power

HHC's hospitals have a greater than 55% share of commercially insured and Medicare Advantage general acute care discharges in Hartford County and a greater than 60% share in the Hartford Area (as defined in the Amended Complaint, ¶ 153). *Id.* ¶ 159. These shares, as high as they are, underestimate HHC's dominant market power, given the serious competitive limitations of the other hospitals in Hartford County. *Id*. ¶ 159; ¶¶ 27-38. As a result of HHC's power, it has been able to charge prices far above competitive levels. *Id*. ¶ 161, 172.

C. Hartford HealthCare's Anticompetitive Conduct

Hartford HealthCare Medical Group (the HHC entity that employs physicians) has very high market shares in a number of physician services markets, ranging from 45-80%. *Id*. ¶ 162-163.

In or about 2016, HHC adopted a plan to suppress competition and maintain and enhance its dominance. *Id.* ¶ 53. The actions planned and ultimately taken include the following:

1. Acquisition of large numbers of physician practices.
2. Actions to control physician referrals, including threats to numerous independent physicians that if they did not concentrate their referrals at HHC facilities, that HHC would retaliate against them.
3. Requiring physicians involved in ICP to send the vast majority of their referrals to HHC with financial penalties if they failed to do so.
4. Successful demands to obtain exclusive access to cutting edge equipment.
5. Interference with health plans' adoption of innovative networks, reducing competition and consumer choice.

Id. ¶ 53(A) – 53(E), 54-124.

1. Hartford HealthCare's Acquisition of Physicians and Their Patients, Facilities, and Equipment

When physician practices are acquired by HHC, it is understood that the physicians will bring with them to HHC a substantial portion of their patient base and often, other employees who work with them. *Id*. ¶ 56. Hartford HealthCare Medical Group typically takes over a physician's lease and staff when it employs the physician. *Id.* ¶ 56. After specialty physician practices focusing on care at Saint Francis were acquired by HHC, the patient volume seen by these physicians at Saint Francis was reduced by more than 95%. *Id*. ¶ 5, 86. When HHC acquires a physician's practice, it also often acquires the physician's facilities and equipment. *Id.* ¶ 61.

2. Hartford HealthCare's Control of Referrals

HHC physicians are required to minimize "leakage" of referrals outside of the HHC system, and most refer virtually all their patients to other HHC physicians without regard to the cost or quality of care. This prevents these physicians from making decisions in the best interests of the patient, and increases HHC's power. *Id.* ¶ 78. Numerous academic studies have found that

when hospitals with market power acquire physician practices, the result is higher prices to consumers. *Id*. ¶¶ 186-187.

HHC's acquisitions and control of referrals has been aided by its campaign of intimidation. *Id.* ¶¶ 62, 80-83. HHC has told some physicians that if they did not agree to join it, that HHC would "crush" them, and would recruit a physician to compete specifically against that doctor. *Id.* ¶ 62. In other cases, HHC has threatened specialist physicians with the loss of referrals from its more than 50 employed primary care physicians or the loss of hospital-referred cases. *Id.* ¶¶ 62, 80, 82. An executive from one independent practice who met with a rival network (SoNE) about working together later received a phone call from an HHC executive who told him that his group would suffer serious consequences if it proceeded to cooperate with SoNE. *Id.* ¶ 81.

HHC also controls its physicians' referrals through ICP, a physician hospital network which enters into contracts with managed care plans at higher than market rates, and without assuming the risk of high cost care or engaging in innovative practices such as bundled pricing or participation in tiered networks. *Id.* ¶ 73-78. This model can only work because ICP and HHC are able to impose contracts on managed care plans that do not require the most cost effective care. ICP physicians receive significant financial incentives to keep their referrals of patients for hospitalization and other services within HHC, and are required to explain any deviation from this practice. *Id*. ¶ 75.

3. Hartford HealthCare's Suppression of Health Care Innovation, Including Tiered Networks

Within the last four years, HHC and ICP have suppressed and impeded innovations that would encourage lower cost care. *Id.* ¶ 96. ICP and HHC have rejected requests by the State of Connecticut to adopt contracts that would involve "bundled" pricing as well as programs that would give patients incentives to utilize low cost, high quality physicians. *Id.* ¶ 97-103. Because

of HHC's market dominance, HHC's refusals to participate have made these programs unattractive to the many patients who wish to have access to HHC and its large complement of physicians, and has thereby interfered with the success of these programs. *Id.* ¶¶ 98, 104. This harms low cost, high quality partners like Saint Francis who would benefit from these programs. *Id.* ¶¶ 97-98, 103, 108**.**

HHC has also made affirmative efforts to coerce primary care physicians who are independent, but practice at HHC facilities, from participating in one of these programs by threatening them with the loss of their hospital privileges at HHC facilities. *Id.* ¶ 102.

HHC and ICP have also interfered with health plans' utilization of "tiered" networks which would incentivize patients to utilize low cost, high quality providers. *Id.* ¶ 105-106. The major managed care plans have not offered tiered networks in Connecticut, even though they offer them in many other locations nationally. *Id.* ¶ 110. Additionally, Saint Francis' affiliated physician hospital network, SoNE, has been able to convince employees in Connecticut to adopt such networks, but not the major payors. *Id.* That is because 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. *Id.*

4. Exclusive Use of Surgical Robots and Other Innovative Equipment

Within the last four years, HHC has also demanded, and received, exclusive access to innovative medical equipment, including surgical robots, thereby suppressing competition involving this equipment and depriving many patients of its use. *Id.* ¶ 116. HHC was able to demand this exclusivity because of its dominant market position, reflecting the fact that it had greater surgery volumes and therefore purchased more robots. *Id.* ¶ 118-119.

By demanding and obtaining these exclusive relationships, HHC has diminished the opportunities of other hospitals to improve their quality by utilizing this equipment. *Id.* ¶ 124.

HHC's resulting greater power in orthopedic surgery (because of this and its other anticompetitive practices) has allowed HHC to resist national trends toward more outpatient orthopedic care in favor of more expensive (and lucrative) inpatient care. *Id.* ¶¶ 190-195.

D. Anticompetitive Effects and Injury to Saint Francis and Competition

HHC's practices do not constitute competition on the merits, i.e. competition based on price and quality. Instead, they interfere with such competition, by allowing HHC to control large numbers of physicians and effectively locking up referrals of their patients. *Id.* ¶ 5. HHC's acquisitions and its actions have increased its market power, including its ability to maintain and increase unusually high prices for healthcare services. *Id.* ¶¶ 89, 114-115, 174, 187-189. *See* Laurence C. Baker, M. Kate Bundorf, Daniel P. Kessler, *The effect of hospital/physician integration on hospital choice*, Journal of Health Economics 50 (2016) 1-8, ("Patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital."). HHC's actions have imposed significant costs on Saint Francis and the other hospitals in the relevant markets and have also significantly reduced their volumes. *Id.* ¶¶ 91-95.

As a result of HHC's suppression of competition, HHC has become even more essential for managed care plans, because its weakened competitors have become less attractive alternatives to HHC. This has given HHC enhanced bargaining clout in contract negotiations and the ability to extract even higher rates for services. Thus, it has increased HHC's already significant monopoly power. *Id.* at ¶¶ 173-176, 189.

III. LEGAL STANDARD

A complaint is sufficient if, in light of its factual allegations, the claims asserted are at least "plausible." *Anderson News, L.L.C. v. Am. Media, Inc.*, 680 F.3d 162, 182 (2d Cir. 2012) (citing *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (1955)). A complaint that states a plausible version of the events should not be dismissed merely because the court finds a different version

more plausible. Rather, the court is required to proceed "on the assumption that all the [factual] allegations in the complaint are true." *Twombly*, 550 U.S. at 555. The court should construe all reasonable inferences that can be drawn from the complaint in the light most favorable to the plaintiff. *Anderson News, L.L.C.*, 680 F.3d at 185.

The "facts" added in Defendants' Memorandum (Docket 43) are not appropriately considered here. Defendants claim that these are facts of which the Court can take judicial notice. However, FRE 201 explains that judicial notice only applies to a fact "that is not subject to reasonable dispute", because it is either "generally known" or can be "readily determined from sources whose accuracy cannot reasonably be questioned." That does not apply to many of the "facts" that Defendants assert, many of which directly controvert the allegations in the Amended Complaint. Compare, for example, Defendants' Memorandum at 10 on the reasons for control of referrals ("Because the quality, coordination and cost saving benefits from Hartford HealthCare's integrated care system are most effective when a patient's care remains within the system, Hartford HealthCare may in some cases encourage that"), with Am. Cplt. ¶¶ 185 ("Because of Hartford HealthCare's control of physician referrals . . . Hartford HealthCare physicians . . . cause their patients to utilize Hartford HealthCare's facilities and services even where those facilities and services are higher cost, lower quality and may result in longer lengths of stay.").

Defendants go so far as to state in their Memorandum at 1 that they "assume the truth of the factual allegations in the Amended Complaint *except as otherwise noted*" (emphasis added). Defendants' efforts to argue the facts is wholly inappropriate at this stage of the litigation. *Twombly, Anderson News, supra.*

IV. ARGUMENT

A. Saint Francis Has Standing to Bring this Antitrust Action.

Contrary to Defendants' arguments, Saint Francis has plausibly alleged both components of antitrust standing: (1) antitrust injury, and (2) that it is an efficient enforcer of the antitrust laws. *Gelboim v. Bank of Am. Corp*., 823 F.3d 759, 772 (2d Cir. 2016).

Saint Francis has alleged an injury "of the type the antitrust laws were intended to prevent and that flows from that which makes the defendants' acts unlawful." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc*., 429 U.S. 477, 489 (1977). Saint Francis's allegations meet the Second Circuit's three-part test for antitrust injury: (1) Saint Francis has identified in detail HHC's anticompetitive conduct, (2) Saint Francis is in a worse position as a consequence of that conduct, and (3) the anticompetitive effects of HHC's conduct are causally linked to Saint Francis's actual injury. *See IQ Dental Supply, Inc. v. Henry Schein, Inc*., 924 F.3d 57, 62–63 (2d Cir. 2019).

1. Hartford HealthCare's Anticompetitive Conduct

First, HHC's alleged conduct is unquestionably anticompetitive. Defendants' repeated effort in their Memorandum to recast their behavior as ordinary competition deserves no consideration, since it is not based on the factual allegations of the Amended Complaint but on unsupported lawyers' argument. And, as explained below, that rhetoric ignores the well-accepted principle that when such "competition" results in the amassing of too much power, it harms consumers through higher prices and lower quality and thereby violates the antitrust laws.

HHC's acquisitions of the practices of various physicians and their patients, staff, equipment, and facilities violate Section 7 of the Clayton Act, which prohibits acquisitions when their effect "may be substantially to lessen competition, or tend to create a monopoly." Under Section 7, "Congress used the words 'may be' . . . to indicate that its concern was with probabilities, not certainties" and to "arrest restraints of trade in their incipiency and before they develop into full-fledged restraints[.]" *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 323 and n.39 (1962). As the government's Merger Guidelines (which apply to mergers and

acquisitions) explain, "mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise." US. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* § 1 (2010) ("*Horizontal Merger Guidelines*").

This analysis has been routinely applied to both hospital mergers and (of particular relevance here) to hospital acquisitions of physician practices. *Fed. Trade Comm'n v. Sanford Health, Sanford Bismarck,* 2017 WL 10810016 (D.N.D. Dec. 15, 2017), *aff'd sub nom. Fed. Trade Comm'n v. Sanford Health,* 926 F.3d 959 (8th Cir. 2019); *In the Matter of Renown Health, A Corp*., No. 111-0101, 2012 WL 6188550 (MSNET Dec. 4, 2012); *Saint Alphonsus Med. Ctr. - Nampa, Inc. v. St. Luke's Health Sys*., Ltd., 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775 (9th Cir. 2015). Each of these cases prohibited hospital acquisitions of physician practices which resulted in market dominance. The findings in *Saint Alphonsus* explain under "Anticompetitive Effects" how acquisitions of physician practices can result in higher prices and control of referrals:

> After the Acquisition, St. Luke's will have 80 percent of PCP services in Nampa, and the HHI in the Nampa market will be 6,219.
>
> This substantial market share will give St. Luke's a dominant bargaining position over health plans in the Nampa market.
>
> It is highly likely that St. Luke's will use its bargaining leverage over health plan payers to receive increased reimbursements that the plans will pass on to consumers in the form of higher health care premiums and higher deductibles.
>
> ***
>
> The Berkeley Forum Study concluded that the recent trend of physician employment by hospitals increases costs because "physicians may be influenced by hospitals to . . . increase referrals and admissions." *See Berkley Forum*, *supra* at p.38.
>
> ***

> After St. Luke's purchased five specialty practices, "their business at Saint Alphonsus Boise dropped dramatically [and] the amount of business that they did at St. Luke's facilities increased dramatically." *Trial Tr.* At 1501 (D. Haas-Wilson).

2014 WL 407446 at *13-14.

Here, Section 7 is violated both by the "horizontal" effects of HHC's acquisitions (purchase of physician practices by an entity that already owns many physician practices) and by "vertical" effects (a hospital's acquisition of physician practices, which affect the referral of patients to the hospital). A horizontal acquisition that allows a firm to control an "undue percentage" of a relevant market and that causes a "significant increase in . . . concentration . . . is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *U.S. v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963).

The market shares present here far exceed levels found to be unlawful by many courts. For example, in *Philadelphia National Bank*, the Supreme Court found that a combined market share of 30 percent, with many remaining competitors, violated the Clayton Act. *Phila. Nat'l Bank*, 374 U.S. at 364. Shares from 40% to 60% and greater have been found unlawful in the health care cases. *See e.g. FTC v. Univ. Health Inc.*, 938 F. 2d 1206, 1219 (11th Cir. 1991) (43%); *FTC v. ProMedica Health System, Inc.*, 2011 WL 1219281, at *20 (N.D. Ohio Mar. 29, 2011) (58%); *Fed. Trade Comm'n v. Advoc. Health Care*, 2017 WL 1022015, at *7 (N.D. Ill. Mar. 16, 2017) (60%). *See* Am. Cplt. ¶¶ 162, 167-169 (shares exceeding 40-60%), ¶ 180 (share increases far exceeding Merger Guidelines thresholds).

Antitrust concerns resulting from acquisitions are especially significant when engaged in by a dominant firm, and as part of a series of acquisitions. "[I]f concentration is already great, the importance of preventing even slight increases in concentration and so preserving the possibility

of eventual deconcentration is correspondingly great." *United States v. Aluminum Co. of Am.*, 377 U.S. 271, 279 (1964); *Crown Zellerbach Corp. v. F. T. C.*, 296 F.2d 800, 822 (9th Cir. 1961) ("[A] substantial lessening of competition [is] to be prohibited whether the acquiring corporation accomplish[es] these results by one immense gobble of another large producer or whether it set out to produce the same results by nibbling away at small producers."); *Kestenbaum v. Falstaff Brewing Corp.*, 575 F.2d 564, 571 (5th Cir. 1978) (increase in market dominance is anticompetitive).

Harm also results from "vertical" effects, the impact of physician acquisitions on hospital markets. In *Brown Shoe*, for example, the Supreme Court declared, "The primary vice of a vertical merger or other arrangement tying a customer to a supplier is that, by foreclosing the competitors of either party from a segment of the market otherwise open to them, the arrangement may act as a clog on competition . . . which deprive[s] . . . rivals of a fair opportunity to compete." 370 U.S. at 323-24 (internal quotation marks omitted). Significant foreclosure has been alleged here. Am. Cplt. ¶¶ 162-163, 166-188.

Other anticompetitive harms have also been identified from vertical transactions, including raising rival's costs. HHC's activities have also imposed significant costs on Saint Francis and the other hospitals in the relevant markets. Am. Cplt. ¶ 91-93. It is well-established that actions which raise a rival's costs can constitute anticompetitive conduct. *See Multistate Legal Stud., Inc. v. Harcourt Brace Jovanovich Legal & Pro. Publ'ns., Inc.*, 63 F.3d 1540, 1553 n.12 (10th Cir. 1995); *Premier Elec. Constr. Co. v. Nat'l Elec. Contractors Ass'n*, 814 F.2d 358, 368 (7th Cir. 1987).

These concerns have arisen in health care. For example, the FTC/DOJ *Statements of Antitrust Enforcement Policy in Health Care* state that "a hospital might use a multiprovider [physician] network to block or impede other hospitals from entering a market or from offering

competing services." U.S. Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 9 at 119 (https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf).

Likewise, HHC's anticompetitive acquisitions violate Sections 1 and 2 of the Sherman Act. *See, e.g. Yankees Entertainment and Sports Network, LLC v. Cablevision Systems Corp.*, 224 F. Supp. 2d 657, 666-67 (S.D.N.Y. 2002) ("[S]tandards of liability under the Clayton Act largely mirror those under the Sherman Act."); *United States v. Grinnell Corp.*, 384 U.S. 563, 576 (1966) (acquisitions undertaken in order to obtain monopoly power can violate Section 2).

Anticompetitive conduct in violation of Section 2 of the Sherman Act is conduct that "not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 n.32 (1985) (citation omitted). Under Section 1 of the Sherman Act, it is sufficient for a plaintiff to allege either "actual detrimental effects" on price, output or quality or market power plus "the potential for genuine adverse effects on competition." *Fed. Trade Comm'n v. Indiana Fed'n of Dentists*, 476 U.S. 447, 460 (1986); *Fleischman v. Albany Med. Ctr.*, 728 F. Supp. 2d 130, 162-164 (N.D.N.Y. 2010) (same). *See* Am. Cplt. ¶¶ 159-165, 200-214.

Courts recognize harm to competition where a low price competitor is eliminated, since that reduces pricing pressure on the other competitors in the market. *See U.S. v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 79 (D.D.C. 2011); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 146 (D.D.C. 2004). The same logic applies to injury to, and, a resulting diminished market role, by a low price competitor such as Saint Francis. Harm to higher quality competitors can also be anticompetitive. *See e.g., Virgin Atl. Airways, Ltd. v. British Airways PLC*, 257 F.3d 256, 264-265 (2d Cir. 2001).

Moreover, threats of the sort alleged here have frequently been found to be exclusionary. *United States v. Microsoft Corp.*, 253 F.3d 34, 77-78 (D.C. Cir. 2001) (pressure not to support competitor); *United States v. Dentsply Int'l, Inc.*, 399 F.3d 181, 189-90 (3d Cir. 2005) (threats to eliminate access to its products).

HHC's interference with health plans' adoption of innovative networks also reduced incentives for lower priced, higher quality care. Am. Cplt. ¶ 53(E), 96-115. A competitive market "is harmed when conduct obstructs the achievement of competition's basic goals, lower prices, better products, and more efficient production methods[.]" *Data General Corp. v. Grunman Sys. Support Corp*., 36 F.3d 1147, 1182 (1st Cir. 1994), *abrogated on other grounds by Reed Elsevier, Inc. v. Muchnick*, 559 U.S. 154 (2010). *See also Todd v. Exxon Corp.*, 275 F.3d 191, 214 (2d Cir. 2001) (finding antitrust injury where the defendants' conduct "reduced competitive incentives").

Defendants' assertions that their actions are procompetitive are irrelevant here. The Amended Complaint states the opposite, and its allegations must be assumed true for purposes of this Motion. *Anderson News*, 680 F.3d at 168. Moreover, whether there are efficiency benefits from an action is an affirmative defense—the plaintiff need not plead or prove the opposite. *See BRFHH Shreveport, LLC v. Willis Knighton Med. Ctr*., 176 F. Supp. 3d 606, 623 (W.D. La. 2016) (citing *Microsoft*, 253 F.3d at 59); *Kaiser Aluminum & Chem. Sales, Inc. v. Avondale Shipyards, Inc.*, 677 F.2d 1045, 1050 (5th Cir.1982)); *see also Tasty Baking Co. v. Ralston Purina, Inc.*, 653 F. Supp. 1250, 1255 (E.D. Pa. 1987) ("Defendants counter by characterizing Tasty's possible injuries as due to defendants' increased operating efficiencies and better service to customers. This creates a factual dispute, but does not demonstrate any inadequacy of plaintiffs' pleading.").

Moreover, "[n]o court … has found efficiencies sufficient to rescue an otherwise illegal merger." *F.T.C. v. ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011) (citing *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 371 (1963)).

2. Saint Francis's Actual Injury

The second step in the antitrust injury analysis requires the Court to identify Saint Francis's "actual injury" or the "ways in which the plaintiff claims it is in a 'worse position' as a consequence of the defendant's conduct." *IQ Dental Supply, Inc.*, 924 F.3d at 62. A company "is entitled to conduct business in a market that is not infected with an anticompetitive distortion." *Id.* at 64. Indeed, "this is the type of injury the antitrust laws were designed to prevent." *Id.*

Saint Francis is certainly worse off as a result of HHC's conduct. HHC's acquisitions have deprived Saint Francis of 95% of the patients of those physicians who had previously practiced at Saint Francis. Am. Cplt. ¶ 5. 86. HHC's actions have also imposed significant costs on Saint Francis. *Id.* ¶¶ 91-93. As HHC's actions have increased its market shares, Saint Francis' shares have decreased commensurately, costing it tens of millions of dollars. *Id.* ¶¶ 166-168.

3. Hartford HealthCare's Anticompetitive Conduct Caused Saint Francis's Injury

a. HHC's Actions That Harm Saint Francis Have Also Caused Anticompetitive Consequences

Saint Francis must also allege that HHC's "anticompetitive behavior caused its actual injury." *IQ Dental Supply, Inc.*, 924 F.3d at 64–65. Here, harm to Saint Francis is completely intertwined with the anticompetitive effects of HHC's actions. HHC has gained market share by taking patients away from Saint Francis and the other hospitals in Hartford County through its anticompetitive conduct. Am. Cplt. ¶¶ 6, 57-61, 84, 167-168, 174. And, because of this increase in share and control of more patients through its control of referrals, HHC is able to successfully charge higher prices and provide poorer quality. *Id.* ¶¶ 2, 6-7, 174. As other hospitals become

weaker and less attractive (e.g. because fewer doctors practice there), insurers have less bargaining leverage because the alternatives to HHC which are available to them are less acceptable to patients. *Saint Alphonsus*, 2014 WL 407446 at *10**.** Additionally, HHC's interference with the use of cutting edge medical equipment and innovative health plans directly harms consumers as well as Saint Francis by increasing costs and reducing quality. *Id.* ¶¶ 116-124.

The fact that Saint Francis is a competitor of HHC certainly does not disqualify it from claiming antitrust injury. "[A] rival clearly has standing to challenge the conduct of rival(s) that is illegal precisely because it tends to exclude rivals from the market, thus leading to reduced output and higher prices." Phillip Areeda & Herbert Hovenkamp, Antitrust Law: An Analysis of Antitrust Principles and Their Application § 348a. While the antitrust laws are often said to protect competition, not individual competitors, "[t]he oft-quoted chestnut distinguishing between protecting competition and protecting competitors has been misconstrued with some regularity by antitrust defendants . . . Injury to competition necessarily entails injury to at least some competitors." *Hasbrouck v. Texaco, Inc.*, 842 F.2d 1034, 1040 (9th Cir. 1987), *aff'd sub nom. Texaco, Inc. v. Hasbrouck*, 496 U.S. 543 (1990). "Competition does not exist in a vacuum; it consists of rivalry among competitors. Clearly, injury to competitors may be probative of harm to competition . . ." *Id.*; *see also W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 101 (3rd Cir. 2010) ("When the plaintiff's injury is linked to the injury inflicted upon the market . . . the compensation of the injured party promotes the designated purpose of the antitrust law—the preservation of competition."); *Yankees Ent. & Sports Network*, 224 F. Supp. 2d at 669–70 ("[A]

rival has clear standing to challenge the conduct of rival(s) that is illegal precisely because it tends to exclude competitors from the market.").[1]

The impact on Saint Francis from HHC's growing physician shares is apparent. For example, the greater percentage of cardiologists that HHC controls, the greater the portion of the cardiology services hospital market that will become unavailable to Saint Francis and other competitors because more cardiologists will be "locked in" to HHC. Am. Cplt. ¶ 162. At the same time, the increase in HHC's shares enhances its bargaining power and leads to higher prices. *Id.* ¶¶ 173-176. *See ProMedica Health Systems v. FTC*, 749 F.3d 559, 570 (6th Cir. 2014) (finding that "the higher a provider's market share, the higher its prices").

The link between injury to a competitor and competition is especially strong here because Saint Francis is the only significant competitor to HHC's hospitals in Hartford County and the lowest price competitor. Am. Cplt. ¶¶ 22-24. In *Kissing Camels Surgery Ctr., LLC v. Centura Health Corp*., 2015 WL 5081608, at *6-7 (D. Colo. Aug. 28, 2015), the court held that the conclusion of plaintiffs' expert witness that "because [the market] is highly concentrated, elimination of any of the Plaintiffs as competitors would have a substantial negative impact on competition" was "sufficient to defeat summary judgment." *Id.* at *7. *See also Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance*, 123 F.3d 301 (5th Cir.1997) (plaintiff's hospital suffered antitrust injury because its "alleged losses and competitive disadvantage" flowed from the allegedly exclusionary conduct of defendant hospital).

Disruption of vertical relationships (like those between hospitals and physicians) is a classic case of antitrust injury. In *Christian Schmidt Brewing Co. v. G. Heileman Brewing Co.,*

[1] "We have little doubt that antitrust injury to a competitor can be found when the market share of the merging firms threatens to be decisive." *R.C. Bigelow, Inc. v. Unilever N.V.*, 867 F.2d 102, 108 (2d Cir. 1989).

Inc., 753 F.2d 1354, 1357 (6th Cir. 1985), two brewers brought an antitrust action under Section 7 challenging the proposed merger of two competitors. The Sixth Circuit affirmed a finding of antitrust injury because "the economic power of the merged corporation would induce distributors to drop the smaller brewers as customers" and that this established the threat of a "predatory and anticompetitive consequence." *Id.* The same analysis applies to the loss of physician referrals.

b. Defendants' Counterarguments Ignore Saint Francis' Allegations

HHC's argument that Saint Francis's injuries are no different from the injury suffered by any hospital when a physician chooses to join any competitor ignores the facts alleged in the Amended Complaint. HHC relies on one district court decision, *SCPH Legacy Corp. v. Palmetto Health*, 2017 WL 1437329 (D.S.C. Feb. 23, 2017) *aff'd*, 724 F. App'x 275 (4th Cir. 2018), involving an acquisition of a single physician practice. The district court concluded that there was no antitrust injury because "Palmetto Health's increased size and market presence did not compound or add to any injury that Providence would have otherwise suffered at the loss of the Moore Clinic . . ." *Id.* at *4.

The facts alleged here could not be more different than those in *SCPH*. Critically, Saint Francis does not claim injury from only a single (possibly fortuitous) acquisition, but instead from a series of acquisitions and other anticompetitive actions. The Amended Complaint alleges that HHC was able to successfully engage in this series of acquisitions as a direct result of its market power, its actions to control referrals and the mass of physicians it had already acquired.

The Amended Complaint explains that HHC's size and campaign of acquisitions (which have substantially increased its market share, *Id.* ¶ 167) have made it progressively easier to engage in more acquisitions:

> As more physician practices have been acquired, and more referrals have been controlled by Hartford HealthCare, the benefits of

> acquisition by Hartford HealthCare have grown because of the greater number of available referrals to physicians whose practices are acquired. At the same time, practicing independently of Hartford HealthCare has become more difficult, because these referrals are unavailable to physicians who do not practice at Hartford HealthCare.

Id. ¶ 87; *see also id.* ¶ 89.

Similarly, HHC's control of referrals through threats, penalties and incentives have made it more successful in its acquisition efforts:

> Since Hartford HealthCare's employed physicians and physicians and ICP overwhelmingly restrict their referrals to physicians practicing at Hartford HealthCare facilities, this creates a strong incentive for independent physicians to practice at those facilities in order to obtain those referrals.

Id. ¶ 88.

HHC's success is a direct result of its market power. For example, the recruitment of physicians by ICP

> can only work because ICP and HHC are able to impose contracts on managed care plans that do not require the most cost effective care, [this] means that physicians can participate in the ICP network without the need to take the normal risks inherent in a competitive health care market. Thus, Hartford HealthCare effectively attracted the physicians by promising them that they could enjoy some of the fruits of Hartford HealthCare's market power and anticompetitive conduct.

Id. ¶ 74. Similarly, HHC's ability to pay more than fair market value for physicians, provide physicians with medical director positions for which there was no work, and offer physicians positions that involved whatever roles they wished, as long as they did not work at Saint Francis, Am. Cplt. ¶¶ 70-71, 79, were only possible because of its market power. Thus, the Amended Complaint explains, these activities reflected a willingness to acquire physician practices under terms that made no sense except because they allowed HHC to earn monopoly profits by increasing

its market dominance and maintaining or increasing its high prices. *Id*. For this reason, as well, the acquisitions could not have occurred without HHC's market power.

This illustrates why HHC's ability to attract and acquire physician practices does not reflect "competition on the merits," but is a reflection of the anticompetitive nature of HHC's actions. When HHC is able to use its market power to refuse to undertake measures such as risk contracts, or to charge higher rates, it can share the benefits of that market power with the physicians it acquires, or demand less from physicians. Am. Cplt. ¶¶ 70-71, 79. Thus, the fact that HHC can harm consumers by demanding higher rates is precisely why it can attract physicians. "If the merger is anticompetitive, the acquiring firm's purchase price may have reflected a premium for anticipated monopoly or oligopoly gains…" Areeda ¶ 990, *supra*.

Of course, no merger or acquisition has ever been found lawful because the seller was willing to sell. That is always the case, and can itself show that the transaction is anticompetitive. If physicians are offered more because patients are forced to pay more, as the Complaint alleges, that is not procompetitive by any stretch of the imagination.

Similarly, only HHC had the motive to undertake such an extensive series of acquisitions, because only HHC had the ability to use these acquisitions to increase its already existing market power and therefore benefit from the acquisitions by the ability to charge higher prices and avoid the need to provide the highest quality in the marketplace. *Id*. ¶¶ 6, 89, 114.

HHC's interference with innovative networks also has increased its ability to engage in physician acquisitions:

> Hartford HealthCare's suppression of tiered networks has also accentuated its ability to acquire more physician practices and to control more referrals. If tiered networks were more widely adopted, then Hartford HealthCare would face the risk of losing more patients if it entered into uncompetitive arrangements with physicians at unusually high rates of compensation, which increased its overall

> costs. The absence of tiered networks allows Hartford HealthCare to pay very high prices to acquired physician practices without concern regarding the effects of those costs on its own rates and competitiveness.

Id. ¶ 113.

The Amended Complaint's allegations, if proven, would establish beyond doubt that the acquisitions which harmed Saint Francis result directly from HHC's market power, and the full range of HHC's anticompetitive activity. An isolated transaction would not violate the antitrust laws. The violation comes from the undue (because repeated) accumulation of power, the effect of which "may be to substantially lessen competition.." 15 U.S.C. § 18.

Similarly, HHC's threats, including the threat to cut off hospital cases to specialists who did not direct virtually all their referrals to HHC, *id.* ¶ 80, were effective only because of HHC's size. A small hospital could only threaten a small loss of cases.[2]

The Amended Complaint also alleges, contrary to Defendants' argument, that no other hospital in the market was in a position to make the series of acquisitions engaged in by HHC. ¶¶ 27-33, 37-38 ("Manchester Memorial does not have the resources to substantially invest in an expansion of its capabilities … UConn is facing a financial crisis, and is not in a position to vigorously compete … Bristol Hospital is marginally profitable and does not have the resources to compete significantly by … hiring additional physicians…"). Only HHC had the ability to undertake this pattern of acquisitions.

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[2] Defendants claim that these allegations are conclusory. But the Amended Complaint includes very specific allegations of conditioning the availability of cardiology cases on strict adherence to referral patterns by independent cardiologists; threats to particular doctors that if they left HHC their professional reputations would be ruined; and threats to "crush" doctors who did not join HHC. Am. Cplt. ¶¶ 62, 80-82. Moreover, factual details behind the claim –i.e. "who, where when or how" – are not required by *Twombly*. *Wiggins v. ING U.S., Inc.*, No. 3:14-CV-01089 (JCH), 2015 WL 8779559, at *3 (D. Conn. Dec. 15, 2015); *Arista Recs., LLC v. Doe 3*, 604 F.3d 110, 119-20 (2d Cir. 2010).

All of these facts should be considered together. "In cases such as this [involving multiple instances of anticompetitive conduct], plaintiffs should be given the full benefit of their proof, without tightly compartmentalizing the various factual components and wiping the slate clean after scrutiny of each." *Continental Ore Co. v. Union Carbide Corp.*, 370 U.S. 690, 699 (1962).

In any event, defendants' interpretation of *SCPH* should be rejected. The Sixth Circuit in *In re Cardizem CD Litig.*, 332 F.3d 896, 912 (6th Cir. 2003), rejected defendant's argument (paralleling Defendants' argument) that "a plaintiff must allege that the only way the defendant could have caused the plaintiff's injury was by engaging in the antitrust violation." The Sixth Circuit explained that "the defendants' position, if adopted, risks undermining a basic premise of antitrust law that, as the district court observed, in many instances, an otherwise legal action – e.g. setting a price – becomes illegal if it is pursuant to an agreement with a competitor. Under the defendants' view, such an action would never cause antitrust injury because a defendant could have unilaterally and legally set the same price." *Id.* at n.19.

The *Cardizem* analysis applies here. Defendants' approach would eliminate the ability to bring private actions under the antitrust laws whenever the actions that injured a private party could have in theory occurred some other way. Since this is virtually always true, such an approach would eviscerate the intent of Congress to allow "private attorneys general" to enforce the antitrust laws for the benefit of the public. *See Blue Shield of Virginia v. McCready*, 457 U.S. 465, 472 (1982) ("Congress sought to create a private enforcement mechanism that would deter violators and deprive them of the fruits of their illegal actions").

Defendants' argument is inconsistent with a host of landmark antitrust decisions. For example, under Defendants' theory, the Supreme Court's decision in *Aspen*, 472 U.S. 585 was wrongly decided. In *Aspen*, the plaintiff complained about the defendant's refusal to continue to

sell joint ski lift tickets involving both firms' ski slopes. The Supreme Court found that behavior anticompetitive. *Id.* at 610-11. Under Defendants' rationale, the plaintiff would not have suffered antitrust injury, since in theory such refusal to share could occur whether or not the defendant was a monopolist. But the correct analysis is that the plaintiff would not have been harmed if the defendant were not a monopolist, and the defendant would not have been motivated to act if it did not stand to gain by enhancing its monopoly power. Similarly here, the Amended Complaint's allegations establish that Saint Francis would not have suffered the large loss of cases it has suffered unless HHC had not increased its market power through its monopolistic pattern of acquisitions, and efforts to control referrals. Nor would HHC have been motivated to aggressively seek acquisitions but for the higher prices they could yield.

The other cases cited by Defendants are equally irrelevant. In *Port Dock & Stone Corp. v. Oldcastle Ne., Inc.*, 507 F.3d 117, 123 (2d Cir. 2007), the court noted that "the complaint pleads no facts that would show that Tilcon's vertical expansion was for an anticompetitive purpose rather than for the purpose of improving efficiency." Of course, here, there are substantial allegations of anticompetitive purpose and effect. Additionally, the injury, "the manufacturer's decision to terminate [a dealer] relationship" was "something the manufacturer could just as well done without having monopoly power." *Id.* at 123. As explained above, the actions taken here were motivated by the prospect of enhanced monopoly power.[3]

Similarly, in *Brunswick*, 429 U.S. at 487, unlike this case, the plaintiff's injury bore "no relationship to the size of either the acquiring company or its competitors." Indeed in *Brunswick*,

[3] In *Arnett Physician Grp., P.C. v. Greater LaFayette Health Servs.*, Inc., 382 F. Supp. 2d 1092, 1096 (N.D. Ind. 2005), the court rejected the plaintiffs' claims on the merits, concluding that "none of the individual actions alleged by Plaintiffs is unlawful[.]" No such challenge is being made here.

the plaintiff complained about an acquisition because of the fear that it would make the defendant more efficient. Here, Saint Francis has alleged the opposite.

4. Saint Francis is an Efficient Enforcer of the Antitrust Laws

Defendants attempt to argue that Saint Francis' injury is too remote for it to possess standing. However, they make this argument (1) only as to the tiered network issue and (2) without seriously addressing any of the other "efficient enforcer" factors applicable to the standing analysis: (1) "the directness or indirectness of the asserted injury," (2) "the existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement," (3) "the speculativeness of the alleged injury," and (4) "the difficulty of identifying damages and apportioning them among direct and indirect victims so as to avoid duplicative recoveries." *IQ Dental Supply, Inc.*, 924 F.3d at 65 (internal quotations marks and citations omitted). All four factors weigh in Saint Francis's favor.

(a) Directness of the injury. The direct nature of Saint Francis' injury is amply supported by its allegations. Saint Francis has alleged that HHC "directly pressured" physicians to stop working with Saint Francis. *Id.* ¶¶ 80-83. HHC executives have stated repeatedly that their plan was to "crush" or "bury" Saint Francis. *Id.* ¶ 7. HHC also acquired the practices of physicians who had previously admitted patients at Saint Francis. *Id.* ¶¶ 5, 54, 57-58, 63-65, 69, 86. And HHC seeks to "bury" Saint Francis. *Id.* ¶ 7. As in *Crimpers Promotions Inc. v. Home Box Off., Inc.*, 724 F.2d 290, 297 (2d Cir. 1983), injury to Saint Francis "was the precisely intended consequence" of HHC's anticompetitive conduct. Because Saint Francis was a "target, these are direct injuries." *IQ Dental Supply, Inc.*, 924 F.3d at 68; *see also Westchester Rad. v. Empire Blue Cross*, 659 F. Supp. 132, 137 (S.D.N.Y. 1987) ("Because the [plaintiffs] allegedly are the targets of Empire's conduct, they are the logical plaintiffs to bring this action.").

The Supreme Court's decision in *Blue Shield of Virginia v. McCready*, 457 U.S. 465 (1982) is also instructive. "The harm to McCready and her class was clearly foreseeable; indeed, it was a necessary step in effecting the ends of the alleged illegal conspiracy. Where the injury alleged is so integral an aspect of the conspiracy alleged, there can be no question but that the loss was precisely the type of loss that the claimed violations . . . would be likely to cause. " *Id.* at 479 (quotations and citations omitted). As in *McCready*, it was clearly foreseeable that HHC's anticompetitive conduct would harm Saint Francis, and it was a "necessary step" for HHC to maintain and increase its market dominance, since Saint Francis was HHC's closest (and only significant) competitor. Am. Cplt. ¶¶ 7, 22-23.

Defendants' argument ignores all these facts. Even as to the "tiered network" allegations which are the sole focus of their argument, Defendants ignore the specific allegations that the success of tiered networks and the State of Connecticut programs would have allowed Saint Francis to attract more patients because of its low cost, high quality care. *Id.* ¶¶ 108-109, 112.

Moreover, an argument as to only one issue in the Complaint cannot be a basis for denial of standing. There is no such thing as a piecemeal or partial antitrust standing which allows a party to sue but carves up its claims. In *Associated Gen. Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 542 (1983), the Supreme Court explained that the efficient enforcer doctrine is intended to identify a "class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement . . . to perform the office of a private attorney general." Saint Francis is undoubtedly such a person here.

The fact that other parties may also have suffered directly (and even if Defendants argued their injury was more direct) is irrelevant. *See In re DDAVP Direct Purchaser Antitrust Litig.*, 585

F.3d 677, 688–89 (2d Cir. 2009); *In re Interest Rate Swaps Antitrust Litigation*, 261 F. Supp. 3d 430, 493 (S.D.N.Y. 2017).

(b) Sufficiently motivated plaintiff. "The second factor simply looks for a class of persons naturally motivated to enforce the antitrust laws." *DDAVP*, 585 F.3d at 689. As HHC's largest competitor in the respective markets, and an entity that has lost tens of millions of dollars due to HHC's anticompetitive conduct. *Id.* ¶¶ 7, 22-23, 168. Saint Francis certainly has a very strong motive to enforce the law. *See also Id.* ¶¶ 5, 186 (alleging a loss of 95% of acquired practices' patients as a result of HHC's acquisitions). Defendants do not argue to the contrary.

(c) Speculative damages and duplicative recovery. Defendants do not argue that Saint Francis' damages are speculative or would result in duplicative recovery. Moreover, the Supreme Court has held that the "potential difficulty in ascertaining and apportioning damages is not . . . an independent basis for denying standing where it is adequately alleged that a defendant's conduct has proximately injured an interest of the plaintiff's that the statute protects." *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 135 (2014). Thus, each of the standing criteria is satisfied here.

B. Saint Francis Has Plausibly Alleged an Antitrust Violation Stemming from Hartford HealthCare's Acquisition of Physician Practices

HHC mischaracterizes Saint Francis's allegations as mere "recruitment and direct employment of physicians." Defendants' Memorandum at 20. But Saint Francis has alleged that HHC did not just hire physicians, but also acquired their practices and patients, Am. Cplt. ¶ 56 and controlled their referrals. For example, after the practices of specialty physicians who admitted patients at Saint Francis were acquired by HHC, the patient volume seen by these physicians at Saint Francis was reduced by more than 95%. *Id.* ¶¶ 5, 86. Moreover, when HHC acquires a physician's practice, it often acquires the physician's facilities and equipment. *Id.* ¶ 61. HHC has

also acquired entire physician groups, not just merely individual doctors. *Id.* ¶¶ 63-64, as well as ambulatory surgery centers. *Id.* ¶¶ 196-197.

These allegations are more than sufficient to establish an antitrust claim for unlawful acquisitions given the broad scope of Section 7 of the Clayton Act. Section 7 liability covers "a *broad spectrum* of transactions whereby the acquiring person may accomplish the acquisition by means of purchase, assignment, lease, license, *or otherwise*." *FTC v. Phoebe Putney Health Sys. Inc.*, 793 F. Supp. 2d 1356, 1364 (M.D. Ga 6/27/11), *aff'd* 663 F. 3d 1369 (11th Cir. 2011), *rev'd on other grounds* 133 S. Ct. 1003 (2013) (emphasis added). For example, in *Nelson v. Pac. Sw. Airlines*, 399 F. Supp. 1025, 1028 (S.D. Cal. 1975), the court found that any "arrangement under which a single corporation achieved control of the decision making processes" of the entities could violate the Clayton Act. *See also*, *U.S. v. Columbia Pictures Corp.*, 189 F. Supp. 153, 182 (S.D.N.Y 1960) ("[The Clayton Act] imposes no specific method of acquisition. It is primarily concerned with the end result of a transfer of a sufficient part of the bundle of legal rights and privileges from the transferring person to give the transfer economic significance and the proscribed adverse 'effect.'"); *United States v. Waste Management, Inc.*, 591 F. Supp. 859, 866 (N.D. Ill. 1984) (§ 7 forbids "not only direct acquisitions but also indirect acquisitions . . . [t]he economic significance of the relationship, rather than its size or form, is the relevant inquiry."); *S. Concrete Co. v. U.S. Steel Corp.*, 394 F. Supp. 362, 374 (N.D. Ga. 1975) (the "words 'acquire' and 'assets' . . . are generic, imprecise terms encompassing a broad spectrum of transactions whereby the acquiring party may accomplish the acquisition by means of purchase, assignment, lease, license or otherwise."). The standards under Section 1 and 2 of the Sherman Act, as noted above, are less demanding. Section 1 only requires an anticompetitive agreement or understanding.

Fleischman, supra at 156-157. It need not involve an acquisition. Section 2 broadly prohibits exclusionary conduct. *Aspen Skiing, supra*.

As described above, the Federal Trade Commission frequently enforces Section 7 of the Clayton Act against hospitals acquiring physicians' practices. https://www.ftc.gov/about-ftc/bureaus-offices/bureau-competition/inside-bureau-competition (explaining that the FTC's "Mergers IV Division" investigates transactions involving hospitals and physicians). The, employment status of the physicians has no impact on the analysis in these cases. *Renown,* 2012 WL 6188550 at *10 ("acquisitions of . . . practices and employment of the associated physicians" violated Section 7); *Saint Alphonsus*, 778 F.3d at 782, n.3 (the fact that the PSA was "the functional equivalent of an employment agreement" did not affect the relief granted).

If Defendants were correct, and acquisitions of physician practices were the mere hiring of talent, not governed by the antitrust laws, then all these courts are wrong, and the Federal Trade Commission's significant initiative to prevent anticompetitive acquisitions of physician practices is completely misguided. Indeed, under Defendants' view, HHC could lawfully acquire *every physician practice in a market*, as long as that did not fit Defendants' definition of "predatory" conduct. But that is certainly not the law.

This case, just like previous cases brought involving physician acquisitions, is not about "talent". The Amended Complaint does not allege that Saint Francis lost valuable physician employees who helped it better run the internal operations of the hospital. This case is not about physicians as employees, but about physicians' practices as independent economic actors, setting prices, treating patients and (critically) deciding where those patients will be hospitalized. Thus, the role of a physician in these markets is in significant part like that of the distributor or retailer who chooses which manufacturers' products are sold to its customers. *See Saint Alphonsus*, 2014

WL 407446 at *9-13. When those distributors or retailers are controlled by a particular manufacturer, competition is foreclosed by other manufacturers. *See Brown Shoe,* 370 U.S. at 329. The same effects (among other things) result from acquisition of physician practices. Am. Cplt. ¶ 7 (HHC's actions were undertaken in part to "foreclose the opportunities to compete for patients by other hospitals in Hartford County").

The fact that Saint Francis lost 95% of the patients of doctors who had practice there after HHC's acquisitions establishes that this is about more than employment. Of course, the gain and loss of patients equates to a gain and loss of market share. That is what the antitrust laws address.

This is also why there is substantial economic literature finding that acquisition of physician practices by hospitals with market power results in higher prices. *Id.* ¶ 186. Indeed, one of the studies cited in the Amended Complaint refers to these acquisitions as "vertical integration." *Id.* ¶ 186C. Thus, the economic analysis also recognizes that physician acquisitions are the equivalent of vertical mergers, not the mere hiring of talent, because they affect decisions as to where patients are hospitalized.

A review of the cases relied upon by Defendants further illustrates why their theory is inapplicable here. None address the facts of this case. *Int'l Dist. Ctrs., Inc. v. Walsh Trucking Co.*, 812 F.2d 786, 794 (2d Cir. 1987) concerns an effort to "hire away [plaintiff's] 'key' executives to undermine its credibility[.]" *Universal Analytics, Inc. v. MacNeal-Schwendler Corp.*, 914 F.2d 1256 (9th Cir. 1990), concerned the "hiring of five of UAI's six key technical employees." *Id.* at *1257. *Midwest Radio Co. v. Forum Pub. Co.*, 942 F.2d 1294, 1296 (8th Cir. 1991) concerned "the raid of key personnel[.]" In *Bio-Medical Applications Mgmt. Co. v. Dallas Nephrology Assoc.*, 1995 WL 215302, at *6 (E.D. Tex. Feb. 6, 1995), the claim was that the defendant "raided BMA employees".

But Saint Francis's allegations never refer to raiding employees. Saint Francis never even alleges that any of the physicians whose practices were acquired by HHC were employed by Saint Francis (many were not). The allegation is that HHC engaged in the "acquisition of numerous physician practices, including physicians who *were practicing* at Saint Francis, Bristol and Manchester Memorial..." Am. Cplt. ¶¶ 53A, 57-60. (Emphasis added). Of course, virtually all specialist physicians, whether or not employed by a hospital, will practice at one or more hospitals, i.e. they admit their patients needing hospital care to a hospital. Indeed, the Amended Complaint specifically refers in many instances to the impact of HHC's conduct on independent physicians. *Id.* ¶¶ 53A, 53B, 59, 66, 75, 79-81, 83, 87. Changes in physicians' hospital admitting patterns affects competition whether the physicians are employed or independent.

Significantly, none of Defendants' cases addressed employee raiding claims with regard to physicians. In *Bio-Medical* the claims with regard to physicians were *not* treated as employee raiding. 1995 WL 215302, at *5.

In the one district court case relied on by Defendants whose facts bear some resemblance to the allegations here, *BRFHH Shreveport, LLC v. Willis Knighton Med. Ctr.*, 176 F. Supp. 3d 606, 625 (W.D. La. 2016), the court partly adopted the "hiring talent" analysis, but excepted acquisitions of "a previously independent cardiology group", or employment of physicians whose assets were acquired. As described above, both exceptions apply here.

Finally, even if Saint Francis's claims were misinterpreted as requiring predatory hiring, the allegations here establish such a claim. Saint Francis has specifically alleged that "[i]n many cases, Harford HealthCare has acquired physician practices solely in order to deny those physicians and their practices to Saint Francis." *Id.* ¶ 71. Physicians were offered highly compensated medical director positions but with few or no duties. *Id.* ¶ 70. As a result, HHC has

an unusual number of part time medical director positions, created not because of medical need, but because of their referrals. *Id.* ¶ 70.

C. Saint Francis Adequately Pleaded that Services Provided to Commercially Insured and Medicare Advantage Patients Comprise the Appropriate Product Markets

HHC's assertion that the relevant product markets cannot be limited to services provided to commercially insured or Medicare Advantage patients also flies in the face of well-established antitrust healthcare law. All or virtually all of the more recent (21st century) heath care antitrust cases involving acquisitions have focused on services provided to privately insured patients as separate product markets. That is because it is those patients who are affected by the critical antitrust question—can a provider, by gaining market power, demand higher prices? This is not a concern for Medicare or Medicaid patients, since the government sets the rates. *See FTC v. ProMedica*, No. 3:11-cv-47, 2011 WL 1219281, at *5 (N.D. Ohio Mar. 29. 2011) ("For patients covered by Medicare or Medicaid, the government sets the reimbursement rates for hospital services."); *see also FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075 (N.D. Ill. 2012); *Saint Alphonsus*, 2014 WL 407446, at *6, *aff'd* 778 F.3d 775, *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 20 (D.D.C. 2017) (Medicare Advantage and Medicare are separate markets).

These cases focus their analysis on "two stage competition", involving competition for commercial insurers, not Medicare or Medicaid. *See, e.g.*, *Sanford Health*, 2017 WL 10810016, at *10 ("The plaintiffs' proposed market definition includes only commercial insurers, to the exclusion of government payers—Medicare and Medicaid. There is no evidence that contracting with government payers involves the two-stage competition described above."); *Saint Alphonsus*, 778 F.3d at 784 n. 10 (the two stage model is the accepted model); *FTC v. Advocate Health Care Network*, 841 F. 3d 460, 465, 468 (7th Cir. 2016) ("most hospital care is bought in two stages . . . insurers and hospitals negotiate . . . and hospitals compete to attract patients[.]"); *FTC v. Penn*

State Hershey Med. Ctr., 838 F.3d 327, 338, 342 (3d Cir. 2016) (noting that two-stage model is recognized by the FTC and several courts). Unless all these cases were wrongly decided, Defendants' argument is completely misguided.

These markets are also justified as submarkets. As the Supreme Court explained in *Brown Shoe*, 370 U.S. at 325:

> [W]ithin [a] broad market, well defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes. The boundaries of such a submarket may be determined by examining such practical indicia as industry or public recognition of the submarket as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors. [Footnote 43] Because § 7 of the Clayton Act prohibits any merger which may substantially lessen competition "in *any* line of commerce" (emphasis supplied), it is necessary to examine the effects of a merger in each such economically significant submarket to determine if there is a reasonable probability that the merger will substantially lessen competition. If such a probability is found to exist, the merger is proscribed.

These criteria are clearly met here. Commercial insurance and Medicare Advantage involve separate economic entities from government payment, Am. Cplt. ¶ 141, serve distinct customers, *Id.* ¶¶ 141-142, distinct prices, *Id.* ¶ 143, peculiar characteristics and uses, *Id.* ¶ 142 (distinct benefits) and industry recognition (*Id*. ¶ 92).

Defendants' reliance on *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591 (8th Cir. 2009) (a case decided before the bulk of the decisions defining commercially insured markets described above) and its out-of-circuit progeny does not salvage their argument. The court in *Little Rock* assessed the issue as under "exclusive-dealing … whether there are alternative [Medicare or Medicaid] patients available to the cardiologists." *Id*. at 597. But the physician acquisitions are not exclusive dealing. Moreover, the Amended Complaint makes clear that government payment is not an alternative on which hospitals can rely. "Medicare and Medicaid

cases produce little, if any margin over cost, and therefore the loss of commercially insured cases is especially harmful to the financial health and ability to compete of a hospital such as Saint Francis." Am. Cplt. ¶ 92. The Amended Complaint also specifically alleges that hospitals could not induce their commercially insured patients to sign up for government programs (available only to the elderly and the poor) for which other patients are not eligible. *Id*. ¶ 141.

Defendants try to argue that this is not enough, and that it is necessary to allege that commercially insured patients are critical to Saint Francis's long-term survival. But, the facts alleged say effectively just that. If a reliance on Medicare and Medicaid cases produces little or no margin, and the loss of commercially insured patients threatens the "ability to compete" of Saint Francis, *Id*. ¶ 92, that certainly plausibly alleges a threat to long-term survival. In any event, the "survival" test makes no sense in light of the basic principles of market definition, which address "reasonable interchangeability". *Todd*, 275 F.3d at 201; *US Airways, Inc. v. Sabre Holdings Corp.*, 938 F.3d 43, 64 (2d Cir. 2019). A lower paying Medicare patient is certainly not interchangeable with a commercially insured patient. Moreover, a "survivability" test makes sense only if a competitor need be driven from a market for anticompetitive effects to occur. That is certainly not true; anticompetitive effects can arise from higher prices, poorer quality or greater concentration. *See* discussion *supra* at 17-26.

Defendants' argument is based on the false assumption that Saint Francis' case is solely about exclusive dealing and foreclosure. But exclusive dealing is alleged only in connection with medical equipment and the Mako robot. Foreclosure is one form of injury here, but Saint Francis and other hospitals have also been injured because HHC has caused their costs to increase and through HHC's interference with innovative health care plans by commercial insurers. Am. Cplt. ¶¶ 91-93, 96-115.

Moreover, the approach undertaken in *Little Rock Cardiology* and these other exclusive dealing cases ignore the fact that market definition is an exercise undertaken to determine an area within which market power could be exercised and prices could be increased to the detriment of consumers. "The goal in defining the relevant market is to identify the market participants and competitive pressures that restrain an individual firm's ability to raise prices or restrict output." *Geneva Pharms. Tech. Corp. v. Barr Lab'ys Inc.*, 386 F.3d 485, 496 (2d Cir. 2004). *Gelboim*, 823 F.3d 759, 772–73 (2d Cir. 2016) ("when consumers . . . must pay prices that no longer reflect ordinary market conditions, they suffer injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful") (quotations and citations omitted). A focus on commercially insured patients, and Medicare Advantage patients, each of whom might suffer from high prices, is therefore critical.

HHC's actions would deprive large numbers of commercially insured patients of access to competing hospitals such as Saint Francis, would increase HHC's dominance in dealing with managed care plans, and therefore give HHC the ability to raise prices to managed care plans. The ability to accomplish those anticompetitive harms are exactly what are measured by shares of the markets involving commercially insured and Medicare Advantage patients, defined here. Defendants' proposed analysis focuses only on individual *competitors*, the foreclosed parties, while the antitrust laws ultimately focus on *competition*, i.e. consumers. *Brunswick Corp.*, 429 U.S. at 488.

Indeed, it is well established that relevant markets can be defined with regard to "targeted customers". "If a hypothetical monopolist could profitably target a subset of customers for price increases, the Agencies may identify relevant markets defined around those targeted customers[.]" Horizontal Merger Guidelines p. 12; *see United States v. Am. Cyanamid Co.*, 719 F.2d 558, 567

(2d Cir. 1983) (relying on Merger Guidelines to analyze acquisition). District courts in this circuit have defined relevant markets with regard to a particular group of customers. *Grumman Corp. v. LTV Corp.*, 527 F. Supp. 86, 90 (E.D.N.Y. 1981) (market defined as government as purchaser). This approach justifies markets linked to commercially insured patients, since (as noted above) firms can charge higher prices to commercially insured patients than they can charge for Medicare.

For these reasons, many courts have rejected Defendants' argument. *See e.g. In re Blue Cross Blue Shield Antitrust Litig.*, 2017 WL 2797267, at *9 (N.D. Ala. June 28, 2017). *Methodist Health Services Corp. v. OSF Healthcare System*, 2015 WL 1399229, at *7 (C.D. Ill. Mar. 25, 2015); *Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of Rhode Island*, 997 F. Supp. 2d 142, 161 (D.R.I. 2014). Defendants' argument was rejected in *Methodist* because, among other reasons, "Methodist also has alleged that government reimbursement rates do not significantly constrain healthcare providers' pricing to commercial health insurers . . . and that providers can target a price increase for inpatient hospital and/or outpatient surgical services solely at commercial health insurers[.]" 2015 WL 1399229, at *7. The same reasoning was applied in *Steward*:

> Medicare and Medicaid purchase hospital services, but they can only do so for the limited number of individuals that qualify for those programs. The remainder of the market consists of private insurers purchasing hospital services for their subscribers. Viewing the product market from the perspective of an aggrieved private purchase of hospital services, then, it is appropriate to exclude Medicare and Medicaid purchases because the private purchaser was never competing to purchase those services in the first place.

997 F. Supp. 2d at 162. Of course, this reasoning applies directly here.

The only case cited by Defendants from this circuit on this issue, *Pro Music Rights, LLC v. Apple, Inc.*, 2020 WL 7406062 (D. Conn. Dec. 16, 2020), undercuts their position. The relevant markets alleged in that case were rejected because they were "purely conclusory" and did not

"address interchangeability and cross elasticity of demand at all." *Id.* at *10. While that court did address the relevant market issue from the point of view of sellers, that is because that was a "monopsony" case involving a claim of buyer power where sellers were the victims of the anticompetitive conduct. *Id.* By the logic of *Pro Rights Music*, the market here must be defined with respect to buyers, the victims in a case involving the market power of a seller, HHC. Thus, *Pro Rights* strongly supports Saint Francis's position here. *See also Chapman v. New York State*, 546 F.3d 230, 237 (2d Cir. 2008) (relevant market defined by "interchangeability of use"). Of course, as Defendants admit, patients who have private insurance do not see Medicare or Medicaid as interchangeable alternatives. [4]

D. Saint Francis Has Alleged a Plausible Factual Foundation for Its Claims Regarding Innovative Health Care Plans.

Defendants begin their argument relating to HHC's interference with tiered and other innovative networks by another mischaracterization of the Amended Complaint. They state that the claim "boils down to a gripe that Hartford HealthCare did not help Saint Francis make its services more attractive to payors and patients…" Defendants' Memorandum at 31. Of course, what the Amended Complaint alleges is that HHC interfered with the efforts by customers (in particular the State of Connecticut) to develop innovative networks which would encourage members to utilize lower cost higher quality care. Am. Cplt. ¶¶ 97-104, 114.

This mischaracterization is not gratuitous, but is central to Defendants' misguided argument. That is because Defendants next argue that these actions cannot constitute a violation

[4] In any event, "courts hesitate to grant motions to dismiss for failure to plead a relevant product market." *Todd*, 275 F.3d at 199–200, 203 (because such a "fact-specific question cannot be resolved on the pleadings").

If this Court were (we believe incorrectly) to find that the relevant market here needs to involve government payment, Plaintiff respectfully request leave to amend its Complaint to revise the market definition to include such patients.

of the antitrust laws, relying on *Verizon Commc'ns, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 408 (2004). But *Trinko* addressed "a refusal to cooperate with rivals". *Id.*[5] "Vertical" refusals to deal, refusals to contract with persons who are on different market levels, e.g. purchasers of services, are not governed by the *Trinko* standard:

> Vertical refusals, which involve the terms of dealing with the rivals' customers and suppliers, have a different history and involved considerations different from those governing denials of access to rivals, sometimes called "horizontal" refusals to deal . . . Cases involving these types of "vertical" arrangements are far less controversial than horizontal denial of access ceases like Aspen and Trinko. . .

Susan A. Creighton and Jonathan M. Jacobson, Twenty-Five Years of Access Denials, Antitrust, Vol. 27, Issue No. 1 (2012) at 2-3. The refusals to deal here are vertical because the refusal is to contract with purchasers of health care services, the State of Connecticut, as well as managed care plans. Am. Cplt. ¶¶ 98-99, 110.

Additionally, the *Trinko* standard does not apply to conditional refusals to deal, i.e. threats of refusals to deal conditioned on particular behavior. HHC's threatening letters to physicians to keep them from participating in the state's program constitute just such a threat. *Id.* ¶ 102. In *Dentsply*, decided after *Trinko*, the Third Circuit held that the defendant manufacturer's practice of supplying replacement teeth only to those dealers who carried its products exclusively was illegal. *Dentsply*, 399 F.3d at 191. *See also U.S. v. Microsoft*, 253 F.3d 34, 77-78 (D.C. Cir. 2001) (threat to supplier if it would not stop aiding Sun Microsystems held "exclusionary, in violation of § 2 of the Sherman Act"). This distinction was also explained in *Datagate, Inc. v. Hewlett-*

[5] Defendants' Memorandum acknowledges this, referring to the *Trinko* rule as "no duty to aid competitors". Defendants' Memorandum at 31.

Packard Co., 60 F.3d 1421, 1427 (9th Cir. 1995), analyzing a footnote from *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451 (1992):

> [T]he defendant may sell the tying product to anybody or nobody at all. What is may not do is condition the sale of the tying product upon the purchase of the tied product, thereby expanding its market power into the market power for the tied product.

In *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), the monopoly newspaper refused to allow ads to be placed by advertisers who also patronized the Journal's only rivals—local radio stations. In holding that this conduct violated Section 2, the Supreme Court acknowledged the "general right" to "refuse to accept advertisements from whoever it pleases." *Id*. at 155. But it found that was not dispositive, because the monopolist newspaper was using its "monopoly to destroy threatened competition" of its rivals, the radio stations. *Id.* at 154. *See also Potters Med. Ctr. v. City Hosp. Ass'n*, 800 F.2d 568, 580 (6th Cir. 1986) (Pressuring physicians to not seek privileges at the plaintiff's hospital deemed exclusionary).

Indeed, the Department of Justice has pursued claims challenging "anti-steering" and "anti-tiering" conduct very similar to those alleged here, and withstood a motion to dismiss. *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720, 732 (W.D.N.C. 2017) (Plaintiffs "alleged facts sufficient to state plausibly that Defendant's steering restrictions were an unreasonable restraint on trade[.]"). The case was ultimately resolved by a consent decree by which the hospital system in question agreed to cause this behavior. *United States v. Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-00311-RJC-DCK, 2019 WL 2767005, *1 (W.D.N.C. Apr. 24, 2019).

Defendants argue that Saint Francis's allegations do not make it plausible that insurers do not offer tiered networks in Hartford *because of* HHC's resistance to such plans. But the Amended Complaint alleges that "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." *Id.* ¶ 110. It is certainly plausible to conclude that these payors followed their contractual requirements. More detail is not necessary at this stage. *Wiggins*, *supra* at *3, *Arista*, 604 F.3d at 119-20. *In re Text Messaging Antitrust Litig.*, 630 F.3d 622, 629 (7th Cir. 2010) (at the complaint stage, "plaintiffs have conducted no discovery" which "may reveal the smoking gun").

Defendants' argument makes no sense at all with regard to HHC's interference with state programs. Am. Cplt. ¶¶ 99, 102. Saint Francis does not claim that these actions cause the state to forego such programs. It alleges that because of HHC's dominant market position, its actions kept many patients from participating in these networks, because they could not do so while accessing HHC or its physicians where desired. *Id.* ¶¶ 108, 114-115. The allegations of causation here are clear and specific.

Finally, contrary to Defendants' assertions, Saint Francis has adequately alleged that it was harmed by HHC's suppression of tiered networks. The Amended Complaint alleges that in the absence of HHC's behavior Saint Francis would have attracted substantially more patients, because these tiered and innovative networks would have given more patients an incentive to utilize Saint Francis's lower cost, higher quality services. The health care literature establishes that tiered networks cause a diversion of significant numbers of patients to lower cost providers like Saint Francis. Am. Cplt. ¶ 112.

Again, Defendants rely on a mischaracterization for their argument. They cite to the fact that SoNE has successfully offered tiered networks to some employers. *Id.* ¶ 110. But they ignore the fact that the Amended Complaint points out that it has been unable to do so with the major payors. *Id.* That is the subject of the claim.

E. Saint Francis Has Alleged a Plausible Factual Foundation for Its Claim Regarding Exclusive Dealing for Medical Equipment.

Defendants' arguments concerning HHC's demands for exclusivity with regard to medical equipment are equally misplaced. Their claims that exclusive deals are legal so long as there is competition to obtain the contract misconstrues Saint Francis's allegations. Saint Francis has not alleged that HHC provided a more competitive price to obtain an exclusive deal for Mako Robots; instead, HHC *demanded* exclusivity *because of its market power.* Am. Cplt. ¶¶ 118-119. This kind of threat has frequently been found illegal. *See e.g. United States*, 399 F.3d at 187; *Grinnell Corp.*, 384 U.S. at 570; *LePage's*, 324 F.3d at 157.

Contrary to HHC's allegations, Saint Francis has adequately pleaded that it was injured, because the Mako robot provided HHC with a significant competitive advantage, which enabled HHC to attract orthopedic surgeons. Am. Cplt. ¶ 121. This caused a loss of significant orthopedic surgery business at Saint Francis, which has the highest rated orthopedic surgery practice in Hartford County through its Connecticut Joint Replacement Institute ("CJRI"). *Id.* ¶ 122.

Defendants try to argue that HHC's behavior with regard to the Mako robot cannot be unlawful unless that behavior alone foreclosed Saint Francis from a substantial portion of the relevant market. But Defendants cannot slice Saint Francis's claims into small pieces and assume that each piece by itself must establish anticompetitive effect. *See Continental Ore, 370* U.S. at 699. As the Amended Complaint describes, all these actions complemented one another in their anticompetitive effects. *Id.* ¶¶ 6, 121-122.

F. Saint Francis Has Adequately Alleged State Law Violations.

Contrary to Defendants' argument, Saint Francis has adequately pleaded claims under the Connecticut Antitrust Act and Connecticut Unfair Trade Practices Act for the same reasons it has adequately pleaded federal antitrust claims. *See Roncari Dev. Co. v. GMG Enterprises, Inc.*, 45 Conn. Supp. 408, 433, 718 A.2d 1025, 1037 (Super. Ct. 1997).

Defendants also misconstrue Saint Francis's allegations relating to tortious interference. Under Connecticut law, a plaintiff establishes tortious interference with business relationships by pleading "some improper motive or improper means." *Am. Diamond Exch., Inc. v. Alpert*, 101 Conn. App. 83, 90, 920 A.2d 357, 363 (2007). The relevant factors included the nature of Defendants' conduct, their motive, the interests of the parties, the public interest, and relations between the parties. *Blake v. Levy*, 191 Conn. 257, 263, 464 n. 4 A.2d 52, 55 (1983). Here, Saint Francis alleges that Defendants' conduct was anticompetitive, caused harm to the public (*e.g.*, consumers, insurers, other healthcare providers), and suppressed competition from their largest competitor, Saint Francis. Defendants made it clear that their improper motive was to "crush" and "bury" Saint Francis. Am. Cplt. ¶ 7.

Furthermore, following the standard cited by Defendants, Saint Francis need only allege "intimidation" to show that Defendants' conduct was tortious. *See Kopperl v. Bain*, 23 F. Supp. 3d 97, 110 (D. Conn. 2014) ("This element may be satisfied by proof that the defendant was guilty of fraud, misrepresentation, intimidation or molestation or that the defendant acted maliciously.") Saint Francis has extensively alleged that Defendants engaged in a pattern of intimidation. *Id.* ¶¶ 3C, 7, 53B, 62, 75-86. Contrary to Defendants' argument, these factual allegations are more than specific enough to satisfy *Twombly*. *See Wiggins*, *supra* at *3, *Arista*, 604 F.3d at 119-120.

V. CONCLUSION

For all the reasons stated herein, Defendants' motion should be denied in its entirety.

Date: March 25, 2022

Respectfully submitted,

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CERTIFICATION OF SERVICE

I hereby certify that on March 25, 2022, a copy of the foregoing Memorandum of Law in Opposition to Defendants' Motion to Dismiss Plaintiff's Amended Complaint was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF system.

/s/ *William S. Fish, Jr.*
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