UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

TEAM SCHIERL COMPANIES and HEARTLAND FARMS, INC., on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

ASPIRUS, INC., and ASPIRUS NETWORK, INC.,

Defendants.

Civil Action No. 3:22-cv-00580-jdp

Honorable James D. Peterson

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

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INTRODUCTION

Plaintiffs—two family businesses who provide health care to their employees through self-funded insurance plans—bring this action against Defendant Aspirus, Inc. ("Aspirus"), a hospital system, and Defendant Aspirus Network, Inc. ("ANI"), its subsidiary clinical network, based on a host of anticompetitive conduct that has significantly driven up health care prices throughout North-Central Wisconsin. Defendants dominate health care in the North-Central Wisconsin region—together, they control 65% of inpatient care and 75% of outpatient care in their service areas. ¶ 11.[1] Defendants have used this market power to impose anticompetitive contracting terms on every insurance plan with whom they contract. Defendants have also created and led a horizontal price-fixing conspiracy, setting the prices that their nominal competitors—independent physicians serving the same markets—charge to insurers. Through this course of conduct, Defendants amplify their already substantial market power by making it impossible for an insurance company to create a health care network that does not include all of Defendants' affiliates and services. The result is that Defendants are effectively insulated from price and quality competition, which has led directly to Plaintiffs and similarly situated insurers paying artificially inflated prices for health care.

Indeed, Wisconsin has high health care costs overall compared to national averages, but Defendants' prices are even higher than the Wisconsin average, and they are increasing faster than prices charged by other Wisconsin health care providers. ¶¶ 43-48. Defendants' anticompetitive conduct is the cause of these inflated prices. Plaintiffs bring this action under Sections 1 and 2 of the Sherman Act to seek damages for the overcharges Defendants' conduct has enabled, and to enjoin them from continuing their anticompetitive conduct.

[1] All "¶" references are to the Class Action Complaint, ECF No. 1 ("Complaint").

The market for health care services is different from other markets because those who choose the services (*i.e.*, patients) typically do not pay the full cost, and those who do pay (*i.e.*, health plans), do not choose the services consumed. ¶ 2. This disconnect means that the primary source of competition in the health care market is in negotiations between health care providers and payers, like Plaintiffs here, who negotiate over prices for bundles of services to be offered to their members as in-network services. ¶¶ 29-32. In a functioning market, providers who do not offer competitive prices during these negotiations will be excluded from the payer's network, which incentivizes providers to keep their prices competitive. *Id.* Thus, for purposes of antitrust analysis, payers "are the most relevant buyers," *FTC v. Advocate Health Care*, 841 F.3d 460, 475 (7th Cir. 2016), and competition for inclusion in insurance plan networks is the way price competition works.[2]

Defendants' anticompetitive scheme is designed to suppress—and has successfully suppressed—this competition. As explained in greater detail below, Defendants have used their monopoly power and contractual restraints to block payers from assembling insurance networks that could compete with Aspirus, thereby suppressing price competition at the payer network level. Defendants have done so through a multifaceted scheme that includes exclusive dealing, price fixing, and tying. The principal components of the scheme are: (1) Defendants coerce independent physicians—their nominal competitors—into joining the ANI clinical network by, among other things, threatening to withhold referrals; (2) Defendants force these independent physicians to

[2] *See St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys.*, 778 F.3d 775, 784 n.10 (9th Cir. 2015) ("This two-stage model of health care competition is the accepted model. In the first stage, providers compete for inclusion in insurance plans. In the second stage, providers seek to attract patients enrolled in the plans. Because patients are largely insensitive to price, the second stage takes place primarily over non-price dimensions. Thus, antitrust analysis focuses on the first stage." (internal citations and quotation marks omitted)). *See also* Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 Antitrust L.J. 671, 674-75 (2000).

charge prices dictated by ANI; (3) Defendants impose *de facto* exclusive contracts on these independent physicians that prevent them from separately joining payer networks that would compete with Defendants; and (4) Defendants use a tying scheme that requires health plans wanting to include *any* Aspirus provider in their networks to include *all* Aspirus facilities and ANI Providers in their networks. ¶¶ 13, 70-88. Defendants' scheme prevents payers from assembling insurance networks that could compete with Aspirus and drive down prices. Plaintiffs and members of the Class have been and continue to be injured by paying the supracompetitive prices that result from Defendants' scheme.

FACTUAL BACKGROUND AND SUMMARY OF ARGUMENT

Plaintiffs Team Schierl Companies and Heartland Farms are family businesses that operate self-funded insurance plans for employees and their families. ¶¶ 20-21. Plaintiffs paid Defendants for health care and are suing on behalf of themselves and a class of similarly situated self-funded and commercial health insurance plans ("payers") who did the same (the "Class"). ¶ 4.

Plaintiffs allege that that Defendants illegally maintained and enhanced monopoly power in two health care services markets: (1) the market for inpatient general acute care ("GAC Market"), which consists of a broad group of medical and surgical diagnostic and treatment services that include overnight hospital stays ("GAC Services"); and (2) the market for outpatient care ("Outpatient Market"), encompassing all the medical services that are not GAC services (collectively, the "Relevant Markets"). ¶¶ 10-19, 36-54. Plaintiffs allege that Defendants restrained trade and maintained and enhanced their monopoly power in these markets in North-Central Wisconsin (the "Relevant Geographic Market"). ¶¶ 55-58.

Aspirus dominates health care services in the Relevant Markets with a greater than 65% share in the GAC Market. ¶¶ 11-12, 59. Moreover, that market-share data understates Aspirus's market power because Aspirus's GAC facilities are so prevalent in North-Central Wisconsin—and

its flagship facility, Aspirus Hospital Wausau ("AHW") is such a critical GAC facility—that no payer could assemble a commercially viable network that excludes Aspirus's facilities altogether. ¶¶ 6, 11-12. Aspirus also dominates the Outpatient Market, with more than a 75% market share. ¶¶ 11-12, 59. That, too, understates Defendants' market power because payers offering health plans in North-Central Wisconsin cannot offer a commercially viable plan that altogether excludes Aspirus's Outpatient Market providers, including those affiliated with Defendant ANI's provider network. ¶ 11-12. Defendants do not dispute that the Complaint plausibly alleges that they have monopoly power in the Relevant Markets.

Defendants used the series of anticompetitive restraints alleged here (together, the "Scheme") to maintain and enhance this monopoly power. First, Aspirus used its monopoly power to coerce the vast majority of independent outpatient providers in the Relevant Geographic Market into joining ANI and becoming "ANI Providers." ¶¶ 13(a), 74-76, 79. Aspirus coerces these providers by conditioning access to referrals from Defendants' dominant slate of GAC and outpatient providers on membership in ANI. Because Defendants' pipeline of referrals is critical to independent health care providers in North-Central Wisconsin, providers have little choice but to join ANI and maintain access to that pipeline. ¶¶ 7, 13(a), 74-76, 79. Defendants also condition access to ANI's favorable (and artificially inflated) payer reimbursement rates on membership in ANI, and outpatient providers risk losing admitting privileges at Aspirus's GAC facilities if they leave ANI. *Id.* Loss of access to Aspirus's referral network, favorable reimbursement rates, and admitting privileges would be financially catastrophic for an Outpatient Services provider in North-Central Wisconsin. *Id.*[3]

[3] ANI engages in what is known as "referral trapping" by requiring ANI Providers to refer patients exclusively, or nearly exclusively, within the network of ANI Providers. ¶¶ 13(c), 34.

Second, Aspirus uses ANI to fix the price for services in the Outpatient Market. ¶¶ 13(e), 85-88. As a condition of joining ANI, providers must allow ANI to negotiate on its behalf with payers. ¶¶ 17, 87. In those negotiations, ANI establishes uniform pricing for ANI Providers. *Id.* As a result, payers are not only prevented from assembling networks of providers that can compete with Aspirus, but the prices charged by ANI Providers are fixed by ANI—even for those ANI Providers that are purportedly independent practitioners. *Id*. Moreover, because some payers attempted to mitigate the artificial price inflation imposed by Defendants' Scheme through a system called reference-based pricing ("RBP"), ¶¶ 13(f), 17, 88, Aspirus shut that avenue for payers off by colluding with its competitors—including Marshfield Clinic and purportedly independent ANI Providers—by assuring them that Defendants would not accept RBP and advising these competitors to follow suit. *Id*.

Third, the ANI contracts that providers are coerced into signing are *de facto* exclusive-dealing contracts. The contracts not only require ANI Providers to charge prices fixed by ANI, but also foreclose ANI Providers from separately contracting with other payers to create networks that would compete against Aspirus and drive down Aspirus's prices. ¶¶ 13(b), 17, 74-80.

Fourth, Aspirus illegally ties GAC and Outpatient Services together by forcing payers into all-or-nothing contracting. ¶¶ 13(d), 81-84. If a payer wants to include any Aspirus GAC facility in its network, Defendants require the payer to also include all Aspirus GAC facilities and the entire ANI network, at prices higher than those facilities could otherwise obtain. *Id*. Likewise, if a payer wants to include any Outpatient facility or provider in its network, Defendants require them

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Because of the size and dominance of ANI, this requirement increases the coercion for independent providers to join ANI because a provider knows that leaving ANI means leaving behind a vast referral network. This referral trapping also prevents rivals from expanding in the GAC and Outpatient Markets, further bolstering Aspirus's monopoly power. *Id.*

to include all of Defendants' other GAC and Outpatient facilities and providers. *Id.* And because Defendants have market power in both markets, ¶¶ 59-65, payers in either case have no choice but to accept the entire package—to take the "all" rather than the "nothing"—and include all Aspirus and ANI facilities in their networks. ¶¶ 59-65, 83. By tying the GAC and Outpatient markets together, Defendants prevent health plans from creating a network of predominantly non-Aspirus facilities that would compete vigorously with Aspirus. *Id*.

As a result of this Scheme, Defendants prevented the competition at the payer level that is critical to lowering prices and increasing patient choice and access to care. *E.g.*, ¶¶ 3, 16-19, 69-70, 90-91.

These allegations are sufficient to state claims under Sections 1 and 2 of the Sherman Act. Courts have repeatedly recognized similar conduct by dominant health care systems to impede price competition in health care markets as anticompetitive. One such case, brought by a class of health plans just like this one, recently settled for $575 million after the plaintiffs defeated summary judgment.[4] Similarly, in *United States v. Charlotte-Mecklenburg Hosp. Auth.*, No. 3:16-cv-311-RJC, 2019 WL 2767005 (W.D.N.C. Apr. 24, 2019) ("*Atrium II*"), the U.S. Department of Justice's Antitrust Division resolved an antitrust case against a North Carolina hospital system with a consent decree enjoining the use of contractual provisions that harmed competition at the payer

[4] *See UFCW & Emp'rs Benefit Tr. v. Sutter Health*, No. CGC-14-538451, 2021 WL 5027181 (Cal. Super. Aug. 27, 2021) ("*UFCW III*") (approving $575 million class settlement); *UFCW & Emp'rs Benefit Tr. v. Sutter Health*, 2016 WL 3459451, at *3-4 (Apr. 1, 2016) ("*UFCW I*") (overruling demurrer where plaintiffs had alleged analogous "all-or-nothing, anti-incentive, and price secrecy terms foreclose price competition by rival providers"); *UFCW & Emp'rs Benefit Tr. v. Sutter Health*, 2019 WL 3856011, at *2 (June 13, 2019) ("*UFCW II*") (upholding on summary judgment the plaintiffs' claims that "Sutter [hospital system] use[d] its market power to compel 'Network Vendors' to agree to all-or-nothing, anti-incentive, and price secrecy terms, thereby unlawfully restraining trade and restricting the ability of its competitors to compete in the relevant markets").

level. And in *Davis v. HCA Healthcare, Inc.*, 2022 NCBC 52 (N.C. Super. Sept. 19, 2022), insured patients recently defeated a motion to dismiss their restraint of trade claim alleging an anticompetitive scheme with some of the same core elements Plaintiffs allege here. The *Davis* court relied upon three additional directly relevant hospital cases holding that contractual restraints imposed on payers by dominant hospitals to inhibit competition stated claims under federal and state antitrust laws.[5] Notably, Defendants cite none of these cases, in which the schemes at issue were less comprehensive and pernicious than the Scheme alleged here.

Defendants' Motion to Dismiss ("Motion" or "Mot.") should be denied for the following reasons: First, in arguing that Plaintiffs fail to state a claim for price fixing under Section 1 of the Sherman Act, Defendants incorrect analyze Plaintiffs' price-fixing allegations separately instead of as part of an overarching anticompetitive scheme. Mot. at 23-26. This is wrong because in antitrust cases, "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." *Cont'l Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 699 (1962). Defendants also argue that ANI's price fixing cannot be subject to a *per se* rule of illegality because they have found no case deeming a clinical network's price fixing to be *per se* illegal. Mot. at 25-26. That gets things backwards: Price fixing is presumptively subject to *per se* condemnation, which means

[5] *See Sidibe v. Sutter Health*, No. 12-cv-4854, 2021 WL 879875 (N.D. Cal. Mar. 9, 2021) ("*Sidibe II*") (denying summary judgment in case alleging similar all-or-nothing tying of inpatient and outpatient facilities and anti-steering provisions in provider contracts with health networks as violating Section 1 of the Sherman Act); *Dicesare v. Charlotte-Mecklenburg Hosp. Auth*., No. 16 CVS 16404, 2017 WL 1359599 (N.C. Super. Apr. 11, 2017) (denying motion for judgment on the pleadings in analogous anti-steering and anti-tiering provisions as violating the state analogs to both Sections 1 and 2); *United States v. Charlotte-Mecklenburg Hosp. Auth.*, 248 F. Supp. 3d 720 (W.D.N.C. 2017) ("*Atrium I*") (denying motion to dismiss U.S. DOJ's complaint challenging dominant hospital system's use of contractual provisions to inhibit insurers from engaging in price and quality competition under Section 1).

that Defendants bear the burden of proof on any exemption from that *per se* rule—and they offer no reason why their scheme should be exempt. And even if Defendants are correct that no court has yet addressed this specific type of scheme, that is no defense: "Anticompetitive conduct can come in too many different forms, and is too dependent upon context, for any court or commentator ever to have enumerated all the varieties." *Caribbean Broad. Sys. v. Cable & Wireless P.L.C.*, 148 F.3d 1080, 1087 (D.C. Cir. 1998).

Second, Defendants argue that Plaintiffs fail to allege anticompetitive tying because Plaintiffs do not specify which product is the "tying" product and which product is the "tied" product. Mot. at 20. The Complaint makes clear that Defendants have monopoly power in both Relevant Markets and use this power to impose a two-way tie through their all-or-nothing contracting practices. When a payer wants to include an Aspirus GAC facility in its network, Defendants' all-or-nothing requirement forces that payer to include not just the facility it wants, but *all* of ANI's facilities and Outpatient providers. In that case, the GAC Services are the tying product, and Outpatient Services are the tied product. Similarly, when a payer wants to include *any* ANI Outpatient provider in its network, it must include *all* of Aspirus's GAC Services. In that case, the Outpatient Services are the tying product and the GAC Services are the tied product.

Third, Defendants argue that Plaintiffs' exclusive-dealing claim fails because the Complaint does not allege that the ANI contracts are exclusive or that they substantially foreclose competition. Mot. at 16-20. This is wrong. Plaintiffs allege that Defendants coerce providers into signing contracts to join ANI and that those ANI contracts prevent supposedly independent providers from contracting with payers separately from ANI. Because ANI includes at least 75% of the Outpatient Market, these contracts plainly substantially foreclose competition.

Fourth, Defendants argue that Plaintiffs lack antitrust standing. Mot. at 10-15. That argument is easily rejected: Plaintiffs are direct purchasers of health care from Defendants, ¶ 4, and direct purchasers are the consummate antitrust plaintiffs. Indeed, the Supreme Court has "established a bright-line rule where direct purchasers … may sue antitrust violators from whom they purchased a good or service." *Apple Inc. v. Pepper*, 139 S.Ct. 1514, 1522 (2019). That bright-line rule controls here.

Fifth, Defendants incorrectly argue that Plaintiffs fail to allege monopolization under Section 2. Mot. at 26-29. Plaintiffs allege an overarching Scheme to monopolize the Relevant Markets, which includes tying, exclusive dealing, and price fixing. This conduct and its effects must be considered as a whole, and not simply in its component parts, each of which is anticompetitive. Defendants fail to address the overarching Scheme. In whole or in parts, Defendants' conduct has enabled Defendants to maintain and enhance their market power in the Relevant Markets and, ultimately, to charge inflated prices.

Plaintiffs respectfully request that Defendants' Motion be denied.

LEGAL STANDARD

The Complaint contains sufficient facts "to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* "[T]he plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *In re Text Messaging Antitrust Litig.*, 630 F.3d 622, 629 (7th Cir. 2010) (quoting *Iqbal*, 556 U.S. at 678). Thus, at the pleading stage, "the inquiry is whether, if the allegations are true, it is plausible and not merely possible that

the plaintiff is entitled to relief." *Viamedia, Inc. v. Comcast Corp.*, 951 F.3d 429, 486 (7th Cir. 2020) (internal quotation marks omitted).

ARGUMENT

I. PLAINTIFFS PLAUSIBLY ALLEGE THAT DEFENDANTS ENGAGED IN ILLEGAL PRICE FIXING.

The Complaint details how Defendants organized a price-fixing agreement among competitors in violation of Section 1 of the Sherman Act. "A successful claim under Section 1 … requires proof of three elements: (1) a contract, combination, or conspiracy; (2) a resultant unreasonable restraint of trade in the relevant market; and (3) an accompanying injury." *Denny's Marina, Inc. v. Renfro Prods., Inc.*, 8 F.3d 1217, 1220 (7th Cir. 1993). Where "the restraint ... constitutes a horizontal price-fixing conspiracy, it is *per se* an unreasonable restraint of trade." *Id.*

The Complaint alleges that Defendants entered into a horizontal price-fixing conspiracy. In particular, it alleges that Defendants entered into explicit agreements with their purportedly independent competitors (referred to here as "ANI Providers") to fix prices at a level set by ANI. In these agreements, purportedly independent providers agreed not to charge their own prices, but instead to charge a price dictated by ANI. ¶¶ 7, 13(e), 85-88. ANI and the providers subject to these price-fixing agreements account for approximately 75% of the Outpatient providers in North-Central Wisconsin, and in some areas within Defendants' service area, all or nearly all Outpatient providers. ¶¶ 11, 13(b), 15-16, 35. Pursuant to these agreements, ANI Providers must also seek consent from Defendants before they enter into separate contracts with payers, ¶¶ 13(e), 87, and Defendants will not consent if those providers ask for prices different from those ANI chooses, ¶¶ 11, 13(b), 36, 76, 87; *see infra* Part III. In addition, to ensure that even the small fraction of transactions not covered by payer contracts remain inflated, Defendants made clear to Marshfield Clinic and the purportedly independent ANI Providers that Aspirus would not accept lower prices

through RBP, and Defendants encouraged these competitors to do the same—all to maintain artificially high prices. ¶¶ 13(f), 88.

The purpose and effect of this conduct was to eliminate competition for health care services and, ultimately, to charge artificially high prices for health care services in the Relevant Markets, which Plaintiffs had to pay. ¶¶ 85-91. "This is an illegal horizontal conspiracy to fix prices in the Outpatient Market in that Aspirus's competitors that are ANI providers have agreed with Aspirus not to compete on price, but instead to charge the price Aspirus chooses." ¶ 17. These allegations are more than sufficient to state a plausible price fixing claim under Section 1 of the Sherman Act.

Defendants do not challenge the bulk of Plaintiffs' allegations. Most important, Defendants do not presently dispute that they entered into contracts with payers that set the prices to be charged by a dominant portion of Defendants' purported competitors. *E.g.*, Mot. at 26 ("At most, any alleged pricing restraint is only ancillary to ANI's core purpose of delivering direct access to personalized care."). Nor do Defendants dispute Plaintiffs' allegations that they require (and withhold) consent for competitors to contract for different prices than those Defendants set. *E.g.*, ¶¶ 13(b), 76, 87. Defendants also do not challenge the Complaint's allegations that this horizontal arrangement inhibits payers from assembling networks that could compete against Defendants and lower prices, *e.g.*, ¶¶ 3, 12, 89, and that this led to Plaintiffs paying higher prices, ¶ 4.

Instead, Defendants incorrectly assert that "Plaintiffs allege two distinct theories of *per se* price fixing"—*i.e.*, one involving ANI's price setting among Outpatient Services providers, and a second for Aspirus's efforts to get its competitor Marshfield to reject RBP. Mot. at 23. Defendants then argue that (1) Defendants' use of ANI to set prices is not *per se* illegal because no court has specifically held that physician networks are *per se* illegal under Section 1 of the Sherman Act,

and (2) Plaintiffs' allegations regarding Aspirus's RBP discussions with Marshfield are insufficient to state a price-fixing claim. Mot. at 23-26. Defendants' arguments fail for several reasons.

As a threshold matter, Defendants are wrong that "Plaintiffs allege two distinct theories of *per se* price fixing." Mot. at 23. It is well settled that "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." *Cont'l Ore*, 370 U.S. at 699; *see also LePage's Inc. v. 3M*, 324 F.3d 141, 162 (3d Cir. 2003) ("[T]he courts must look to the monopolist's conduct taken as a whole rather than considering each aspect in isolation."). Yet that is exactly what Defendants ask the Court to do—analyze what they call "two distinct theories" in isolation, and decide whether each, standing alone, sufficiently states a claim. Mot. at 23-25. The Supreme Court long ago foreclosed this piecemeal approach, instructing that "the character and effect of a conspiracy are not to be judged by dismembering it and viewing its separate parts, but only by looking at it as a whole." *Cont'l Ore*, 370 U.S. at 699. The Complaint pleads a single, multifaceted Scheme, and it plausibly alleges that Defendants' collusion with their would-be competitors led to Plaintiffs paying higher prices.

Defendants also argue that this claim should be dismissed because "ANI's negotiation of reimbursement rates with payers for health care services" cannot amount to *per se* price fixing because such activities do not fall within the "limited instances" where courts apply the *per se* rule. Mot. at 25. This argument does not warrant dismissal for several reasons.

First, Defendants mischaracterize Plaintiffs' claims. Plaintiffs do not allege simply that ANI negotiates reimbursement rates with payers. Rather, Plaintiffs allege that ANI negotiates reimbursement rates with payers on behalf of its own competitors and then forecloses those competitors from charging any other price. Defendants coerce purportedly independent ANI

Providers—who would otherwise be ANI's competitors—to join the ANI network, ¶ 13(a); requires those ANI Providers to charge ANI-dictated prices to payers, ¶¶ 13(e), 87; and prevents those ANI Providers from negotiating separate pricing for payers, ¶ 87. In addition, Defendants invited their competitors to follow their lead and reject RBP, all to prevent price erosion. ¶ 88. Plaintiffs allege that the purpose and effect of this conduct is to restrain price competition and artificially inflate prices for health care services. ¶¶ 89-91.

Second, Defendants do not deny that the conduct alleged by Plaintiffs is an agreement with horizontal competitors to fix, maintain, or stabilize prices charged to payers in the Relevant Markets. Such an agreement is *per se* illegal under well-established law. *Denny's Marina*, 8 F.3d at 1221 (holding that "a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price [in the marketplace] is illegal *per se*"); *see also Arizona v. Maricopa Cnty. Med. Soc.*, 457 U.S. 332, 347 (1982) ("We have not wavered in our enforcement of the *per se* rule against price fixing.").

Defendants nevertheless argue that this conduct should not be subject to the *per se* prohibition on price fixing because "provider networks … have not historically been subject to *per se* treatment." Mot. at 25-26. That gets things backwards. As Defendants' own cases make clear, the default rule is that price fixing gets *per se* treatment, as the anticompetitive effect of price fixing "is generally sufficient to justify application of the *per se* rule without inquiry into the special characteristics of a particular industry." *NCAA v. Bd. of Regents*, 468 U.S. 85, 100 n.21 (1984); *Bunker Ramo Corp. v. United Bus. Forms, Inc.*, 713 F.2d 1272, 1284 (7th Cir. 1983) (identifying "price fixing" as one of "the activities that have been accepted as *per se* offenses"); *see* Mot. at 25 (citing these cases). Defendants have not provided any reason to exempt their price-fixing arrangement from that default rule.

Third, Defendants argue that the *per se* rule should not apply because their price fixing is "ancillary to ANI's core purpose of delivering direct access to personalized health care." Mot. at 26. But to prove that their restraint on price competition was "ancillary," Defendants bear the burden of demonstrating that the challenged restraint is "subordinate and collateral" to a separate, legitimate business collaboration among Defendants and ANI members, *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, 792 F.2d 210, 224 (D.C. Cir. 1986), and further, that the restraint is "necessary" to the business collaboration, *Blackburn v. Sweeney*, 53 F.3d 825, 828-29 (7th Cir. 1995); *see also In re Sulfuric Acid Antitrust Litig.*, 743 F. Supp. 2d 827, 871-72 (N.D. Ill. 2010).

Defendants have not made any such showing. Defendants vaguely assert that their price setting agreements are necessary to achieve ANI's "core purpose of delivering direct access to personalized health care," Mot. at 26, but they offer no justification as to why. Absent from Defendants' brief is an explanation as to why *any* agreement with competitors is necessary to effectuate this purported goal, much less an explanation why an agreement with their competitors *not to compete on price* is necessary. And even if Defendants offered some plausible justification, the inevitably fact-intensive question of ancillarity is not typically decided at the pleading stage. *See, e.g.*, *In re Delta Dental Antitrust Litig.*, 2020 WL 5296996, at *5 (N.D. Ill. Sept. 4, 2020); *U.S. v. eBay, Inc.*, 968 F. Supp. 2d 1030, 1040 (N.D. Cal. 2013) ("At this stage in this action, the court simply cannot determine with certainty the nature of the restraint, and by extension, the level of analysis to apply.").

Fourth, even if Defendants were correct that the *per se* rule is inapplicable, dismissal would still be unwarranted because the price-fixing claim is adequately pled under the "rule of reason." *Blackburn*, 53 F.3d at 828 (explaining that if the *per se* rule does not apply because a restraint is ancillary, then the rule of reason would apply). Defendants argue *solely* that their price-setting

scheme cannot be *per se* illegal; they make no claim that it survives a rule of reason analysis. Yet Plaintiffs have pleaded more than enough to state a claim under the "rule of reason," which asks whether "the questioned practice imposes an unreasonable restraint on competition." *State Oil Co. v. Khan*, 522 U.S. 3, 10 (1997). At the pleading stage, a challenged restraint is *prima facie* "unreasonable" if it produces "anticompetitive effects" in the relevant market, which includes supracompetitive prices. *See Bunker Ramo*, 713 F.2d at 1283.

Defendants' failure to argue that Plaintiffs' price-fixing allegations should survive a rule of reason analysis is fatal to their argument that this claim should be dismissed. They do not dispute that their collusion had substantial anticompetitive effects. Nor do they argue that their restraint was procompetitive. With good reason: There is virtually no conceivable procompetitive justification for fixing prices. Regardless, "balancing anticompetitive effects against hypothesized justifications depends on evidence and is not amenable to resolution on the pleadings." *Viamedia*, 951 F.3d at 460; *Atrium I,* 248 F.Supp.3d at 730 ("Resolution of [the] fact-intensive inquiries" regarding reasonableness "requires discovery, and perhaps ultimate decision by a fact-finder.").

In short, Plaintiffs' claim for horizontal price fixing should go forward, on its own and as part of the overarching Scheme.

II. PLAINTIFFS PLAUSIBLY ALLEGE THAT DEFENDANTS ILLEGALLY TIED INPATIENT AND OUTPATIENT HEALTH CARE SERVICES.

Defendants impose anticompetitive tying restraints on health care plans. "Tying is conduct in which a firm will 'sell one product [the tying product] but only on the condition that the buyer also purchases a different (or tied) product.'" *Viamedia.*, 951 F.3d at 468. When forced on payers by a defendant with monopoly power, a tying scheme violates both Section 1 (as an unlawful vertical restraint) and Section 2 (as an abuse of monopoly power) of the Sherman Act. *See, e.g.*,

Multistate Legal Studies, Inc. v. Harcourt Brace Jovanovich Legal and Professional Publications, Inc., 63 F.3d 1540, 1550 (10th Cir. 1995).

The two ways in which Defendants engage in all-or-nothing contracting are straightforward. First, if a payer wants to include any of Defendants' GAC facilities in its network, Defendants require the payer also to include all other GAC and Outpatient facilities and providers. ¶¶ 13(d), 16, 81-84. Defendants thus use their market power in the GAC Market (the "tying" product market) to force payers to purchase Outpatient Services (the "tied" product market). Second, if the payer wants to include any Outpatient facility or provider in its network, it must include all of Defendants' other GAC and Outpatient facilities and providers. *Id.* In that case, the Outpatient Services are the tying product market and GAC Services are the tied product market. In either case, the upshot is that payers cannot pick and choose among Aspirus and ANI facilities and practices; they must take all of them or none of them. ¶¶ 82-83. And because Defendants have market power in both markets, ¶¶ 59-65, payers have no choice but to accept the entire package—to take the "all" rather than the "nothing"—and "includ[e] all Aspirus and ANI facilities in their networks." ¶ 83; *see also* ¶¶ 59-65. Payers thus cannot build a viable network of predominantly non-Aspirus facilities and providers that could compete vigorously with Defendants. ¶ 13(d).

In recent years, multiple courts have deemed all-or-nothing requirements imposed by dominant hospital systems as illegal tying in analogous cases that Defendants fail to address. *See, e.g.*, *Davis*, 2022 NCBC 52; *Sidibe II*, 2021 WL 879875; *UFCW I*, 2016 WL 3459451, at *3-4 (overruling demurrer where plaintiffs had alleged analogous "all-or-nothing, anti-incentive, and price secrecy terms foreclose price competition by rival providers"); *UFCW II*, 2019 WL 3856011, at *2 ("Sutter [hospital system] use[d] its market power to compel 'Network Vendors' to agree to all-or-nothing, anti-incentive, and price secrecy terms").

Defendants contend that the Complaint does not adequately allege tying because it does not designate one specific product as the "tying" product and another as the "tied" product. Mot. at 20-23. That is wrong—the Complaint alleges the two schemes described above. *E.g.*, ¶ 13(d) (describing two schemes), ¶¶ 14, 34 (describing "tying [Asprius's] dominant Outpatient provider network (ANI) to its GAC facilities"); ¶ 83 ("Aspirus can use its market power in the GAC Market … to force payers to accept other GAC facilities [and] the large number of Outpatient providers in ANI"). In any event, there is no such rigid pleading requirement. *See, e.g.*, *Scheiber v. Dolby Labs., Inc.*, 293 F.3d 1014, 1020 (7th Cir. 2002) ("There are multiple products here, and they are tied together in the sense of having been licensed as a package.").

Aspirus's all-or-nothing requirement is no different from the "block booking" requirement the Supreme Court condemned in *United States v. Paramount Pictures, Inc.*, 334 U.S. 131 (1948), *abrogated on other grounds by Illinois Tool Works Inc. v. Independent Ink, Inc.*, 547 U.S. 28, 43 (2006). There, the defendant film producers offered movie theaters "one feature or group of features on condition that the exhibitor will also license another feature or group of features." *Id.* at 156. Just as Aspirus's restraints prevent payers from choosing only the facilities and providers they want to include in their networks, the film producers' restraints prevented theaters "from bidding for single features on their individual merits." *Id.* at 156-57. The Court rejected the notion that a tying claim requires designating one specific product as the "tying" product and some other as the "tied" product; rather, this form of tying can be unlawful "[e]ven where all the films included in the package are of equal quality," as long as market power exists as to all. *Id.* at 158.

Defendants' cases do not impose (or even discuss) the pleading requirement on which they hinge their argument. *See* Mot. at 22-23. The problem with the tying theory in *Ass'n of American Physicians & Surgeons, Inc. v. American Board of Medical Specialties*, 2020 WL 5642941 (N.D.

Ill. Sep. 22, 2020), was not that the complaint failed to designate one product as "tying" and a second one as "tied," but that it failed to allege any second product at all. *See id.* at *5 ("[T]he [plaintiff] describes the 'tying of certification' without clearly identifying to what it is tied."). The decision in *Siva v. American Board of Radiology*, 38 F.4th 569 (7th Cir. 2022), is equally inapplicable—the plaintiff failed to state a tying claim because the allegedly tied product did not compete in the market in which the defendant was allegedly suppressing competition. *See id.* at 578-81 ("He has not plausibly alleged that MOC is a viable competitor in the market for CPD products."). Here, of course, Defendants' outpatient practices compete in the Outpatient Market and Defendants' GAC facilities compete in the GAC Market. ¶ 10.[6]

Defendants are likewise mistaken that the Complaint fails to allege "the contractual mechanism used to effectuate the alleged tying." Mot. at 21. The Complaint alleges that when Aspirus negotiates with a payer for the inclusion of any "Aspirus GAC or Outpatient facilities in its provider network, Aspirus requires the payer also to contract … for the entire ANI network, regardless of how many facilities the payers want to include within a network and regardless of the high prices at those facilities." ¶¶ 81-82; *see also* ¶¶ 27-32. To the extent Defendants are arguing that a Complaint must allege the exact contractual language that effectuates this all-or-nothing arrangement, they are simply wrong. *See, e.g.*, *In re Broiler Chicken Antitrust Litig.*, 290 F. Supp. 3d 772, 804 (N.D. Ill. 2017) ("If private plaintiffs, who do not have access to inside information, are to pursue violations of the law, the pleading standard must take into account the fact that a complaint will ordinarily be limited to allegations pieced together from publicly

[6] Defendants' other citations, Mot. at 23, are similarly off point, because in both there was no tie at all—purchasers were actually free to purchase one product without the other. *See Wholesale All., LLC v. Express Scripts, Inc.*, 366 F. Supp. 3d 1069, 1079-81 (E.D. Mo. 2019); *Adelphia Recovery Tr. v. Bank of Am., N.A.*, 646 F. Supp. 2d 489, 494 (S.D.N.Y. 2009).

available information."); *Darush v. Revision LP*, 2013 WL 8182502, at *4 n.3 (C.D. Cal. July 16, 2013) ("Defendants are asking for more than evidence of an agreement; they are asking for the agreement itself. This exceeds what is required at this stage."); *Davis*, 2022 NCBC 52 at ¶¶ 46-69 (permitting tying claim to proceed even absent allegations about specific contractual language).

Finally, as with Plaintiffs' price-fixing claim, Defendants attempt to characterize Plaintiffs' tying allegations as a standalone claim that must be analyzed without reference to Defendants' other restraints. Mot. at 20-21 & n.5. But the Complaint alleges that Defendants use tying as one component in their overall Scheme, ¶ 1, which the Court must consider "as a whole," *Cont'l Ore*, 370 U.S. at 699. Thus, the Complaint need only allege that Defendants' tying was part of an overall scheme that violates Section 1 of the Sherman Act under the rule of reason, *see generally State Oil Co.*, 522 U.S. at 10, and unlawfully maintains their monopolies under Section 2 of the Sherman Act, *see generally United States v. Grinnell*, 384 U.S. 563, 570-71 (1966). In any event, even if the tying claim were viewed in isolation, the Complaint pleads all of its elements for the reasons discussed above.

III. PLAINTIFFS PLAUSIBLY ALLEGE THAT DEFENDANTS ENGAGED IN ANTICOMPETITIVE EXCLUSIVE DEALING.

In addition to price fixing and all-or-nothing contracting, the Complaint alleges that Defendants coerced purportedly independent Outpatient providers into signing ANI contracts that lock those providers into *de facto* long-term exclusive contracts, and that this foreclosed competition by locking up a majority of providers and preventing insurers from developing health viable health plans that lower costs. ¶¶ 74-80, 89. These allegations are more than enough to state claims under Sections 1 and 2 of the Sherman Act.[7] Defendants arguments to the contrary—that

[7] Defendants address Plaintiffs' exclusive dealing allegations only under Section 1 of the Sherman Act. Mot. at 9-19. But Plaintiffs also allege that Defendants' exclusive dealing violates

Plaintiffs fail to allege "unconditional exclusivity" and "substantial foreclosure of competition"—are foreclosed by the Complaint's well-pled allegations and governing case law.

A. Plaintiffs Sufficiently Allege Exclusivity.

Defendants' contracts lock providers into exclusive deals with ANI by foreclosing them from joining networks that would compete against Aspirus. ¶¶ 8, 13(a), 13(b), 15, 35, 74-80. Defendants argue that Plaintiffs "fail[] to plausibly allege how those contracts require any 'exclusive dealing'" because they do "not point to any specific provision in ANI's provider contracts that demands unconditional exclusivity." Mot. at 17. Defendants' premise is mistaken: "[A]n exclusive dealing claim does not require a contract that imposes an express exclusivity obligation." *ZF Meritor, LLC v. Eaton Corp.*, 696 F.3d 254, 282 n.14 (3d Cir. 2012). The key question is *not* whether the contracts "contain specific agreements not to use the [goods or services] of a competitor," but whether "the *practical effect* of [the contractual] provisions is to prevent such use." *United Shoe Mach. Corp. v. United States*, 258 U.S. 451, 457 (1922) (emphasis added).

Applying that standard, courts regularly hold that contractual provisions satisfy the exclusivity element based on their "practical effect." *Id.* For example, in *United Shoe*, 258 U.S. 451 (1922), the Supreme Court held that the defendants' leases were unlawfully exclusive even though they did not "contain specific agreements not to use the machinery of a competitor." *Id.* at 457. This was so, the Court explained, because they "effectually prevent" the lessee "from acquiring the machinery of a competitor … except at the risk of forfeiting the right to use the machines furnished by the [defendant] which may be absolutely essential to the prosecution and

Section 2. ¶¶ 74-80. Regardless, there is no substantive difference in the analysis under either Section 1 or Section 2. *See Md. and Va. Milk Producers Ass'n v. United States*, 362 U.S. 458, 463 (1960) (because Sections 1 and 2 of the Sherman Act "closely overlap, … the same kind of predatory practices may show violations" of both).

success of his business." *Id.* at 458. Likewise, in *LePage's, Inc. v. 3M*, 324 F.3d 141 (3d Cir. 2003) (en banc), the Third Circuit found unlawful exclusive dealing even though the defendant's "rebates and discounts" did not expressly require exclusivity, because the restraints' "purpose and effect" was to "achieve sole-source supplier status." *Id.* at 157-58; *see also ZF Meritor*, 696 F.3d at 282 ("[A]lthough the [agreements] did not expressly require the [buyers] to meet the market penetration targets, the targets were as effective as mandatory purchase requirements."); *In re Surescripts Antitrust Litig.*, 2022 WL 2208914, at *10 (N.D. Ill. June 21, 2022) ("Surescripts' 'optional low pricing' deals, coupled with the loyalty pricing clawback provision, may be considered *de facto* exclusive deals.").

Here, the Complaint alleges that the "practical effect" of Defendants' restraints is to prevent providers from contracting with Defendants' competitors. *See, e.g.*, ¶¶ 8, 13(a) ("Aspirus uses its monopoly power in the GAC Market to coerce providers into joining ANI by signing contracts that lock those providers into de facto exclusive contracts"). Contrary to Defendants' claim, the Complaint does not merely "say so" in "conclusory fashion," Mot. at 14—rather, it explains exactly how and why these agreements function as *de facto* exclusive deals. First, the Complaint alleges the specific terms of the contracts: Under the heading "limited exclusivity," the contracts "require[] that any ANI Provider seek Aspirus's consent before the ANI Provider can enter into a direct contract with any payer that also contracts with ANI." ¶ 13(b). Next, the Complaint explains that this provision's supposedly "limited" application to payers "that also contract[] with ANI" is no limitation at all, because "essentially every payer offering a plan in North-Central Wisconsin has a contract with ANI." *Id.*; *see also* ¶ 14 ("No health plan operating in North-Central Wisconsin can put together a commercially viable provider network *without* including at least *some* Aspirus Outpatient and GAC facilities and providers."); *see also* ¶¶ 12, 13(d), 34, 71, 83.

The Complaint then explains why the theoretical possibility of "consent" is no more than theoretical. Providers are dissuaded from even trying to obtain consent "through fear of being cut off from Aspirus and its dominant referral network" or "losing admitting privileges, or being granted admitting privileges on disadvantageous terms." ¶¶ 72, 75; *see Omni Healthcare*, 2015 WL 275806 at *2 (M.D. Fla. Jan. 22, 2015) (noting that "referrals … control the course and scope of most patients' healthcare treatment"). Just as in *United Shoe*, providers cannot try to contract with defendants' competitors "except at the risk of forfeiting [benefits] which may be absolutely essential to the prosecution and success of [their] business." 258 U.S. at 458. And even if providers do seek consent, ANI withholds it. ¶¶ 13(b), 76. In short, the Complaint alleges that ANI has unlimited power to withhold consent or to inflict "potentially catastrophic" harm on anyone who seeks consent. ¶ 13(a). That is how ANI's contracts "operate as exclusive dealing arrangements, despite the lack of any express exclusivity requirements." *ZF Meritor*, 696 F.3d at 282.[8] Accepting these alleged facts are accepted as true—as they now must be—the Complaint plausibly alleges that ANI's contracts operate as *de facto* exclusive arrangements.

Defendants object that the Complaint does not identify a specific instance in which ANI "withheld [its] consent to stifle competition" or a specific provider that "ever actually lost these privileges upon exiting a contract with ANI." Mot. at 17. But they do not cite any authority for this supposed requirement, and the cases are to the contrary; the threat of punishment is enough. In

[8] The Complaint further explains that these *de facto* exclusive contracts are effectively perpetual, because "ANI Providers cannot simply abandon these contracts without risking the severe financial repercussions that come with losing access to the ANI referral network, Aspirus admitting privileges, and access to ANI's favorable reimbursement rates." ¶ 79; *see also* ¶ 13(b). In other words, the same threats that coerce providers into joining ANI and then prevent those providers from contracting with payers to create competing networks also prevent those providers from ever *leaving* ANI. ¶ 13(a) ("Loss of referrals, favorable rates, or admitting privileges is potentially catastrophic for an Outpatient Services provider.").

United Shoe, for example, the Supreme Court acknowledged that "in many instances the[] provisions were not enforced," but held that they remained *de facto* exclusive because "[t]he power to enforce them is omnipresent and their restraining influence constantly operates upon competitors and lessees." 258 U.S. at 457-58. Similarly, in *ZF Meritor*, the contracts were *de facto* exclusive even though the defendant had never exercised its right to terminate the contracts when a customer violated its purchasing requirements. 696 F.3d at 282. It was enough that customers "believed that [the defendant] might" terminate the contracts, as "no risk averse business would jeopardize its relationship with the largest manufacturer of transmissions in the market." *Id.* at 283. Likewise, the threat of expulsion from ANI looms large for each of its members. The Complaint thus alleges that the threat of expulsion and loss of referrals renders ANI's contracts *de facto* exclusive-dealing arrangements.[9]

B. Plaintiffs Sufficiently Allege That ANI's Contracts Substantially Foreclose Competition.

The Complaint also satisfies Plaintiffs' burden to plausibly allege that Defendants' exclusive dealing substantially forecloses competition in the Relevant Markets.[10] *See* ¶ 13(b) ("ANI imposes *de facto* exclusive contracts that lock ANI Providers into exclusive deals with ANI

[9] Defendants argue that their ability to "'force' or 'coerce' providers to sign network agreements" does not mean "those agreements are … 'effectively' exclusive arrangements." Mot. at 18. But what makes the agreements exclusive is not (as Defendants suggest) that providers are coerced into signing, but that once they sign they are foreclosed from contracting separately with payers for fear of losing valuable referrals, among other things. *See* ¶¶ 13, 15, 35, 72, 75.

[10] Substantial foreclosure of competition is an element *only* of Plaintiffs' exclusive dealing claim, because—unlike horizontal price fixing or tying—exclusive contracts are unlikely to be anticompetitive if they affect only a small share of the market. *See, e.g.*, *McWane, Inc. v. F.T.C.*, 783 F.3d 814, 835 (11th Cir. 2015) ("The difference between the traditional rule of reason and the rule of reason for exclusive dealing is that in the exclusive dealing context, courts are bound … to consider substantial foreclosure."). For Plaintiffs' other claims, it suffices that the Complaint alleges that Defendants' Scheme adversely affected competition via increased prices, reduced output, and lowered quality. *See, e.g., Ohio v. Am. Express Co.*, 138 S. Ct. 2274, 2284 (2018).

and foreclose the ANI Providers from contracting with payers to create networks that would compete against Aspirus and drive down Aspirus's prices."); *see also* ¶¶ 74-80. Defendants' exclusive dealing forecloses competition in two, interrelated ways.

First, it eliminates price and quality competition between ANI Providers who normally would compete—with each other and with Defendants—to be included in insurance networks, but who instead are prohibited from doing so because they cannot "enter into direct contracts for payer networks" absent Defendants' blessing. *Id.* ¶ 75. This foreclosure is substantial because "at least 75% of Outpatient providers in North-Central Wisconsin are locked into these restrictive contracts." ¶ 79; *id.* ¶ 89 (Defendants control approximately 65% share in the GAC market).[11]

Second, Defendants' scheme forecloses competition by effectively preventing insurance companies from developing "tiered" networks, in which insurers "offer patients incentives (for example, lower copays or deductibles) for visiting a set of higher value providers." ¶ 77. Absent Defendants' restraints, insurers would use such plans to "encourage[] consumers to select providers with lower prices and higher quality," *id.*, but because Defendants prohibit ANI Providers from participating in any tiered network that does not place every ANI and Aspirus affiliate in the same tier, such plans are effectively impossible to build, ¶ 80 (restraint has "barred the vast majority of providers from participating in innovative insurance products that—in other geographies—help prevent supracompetitive pricing"). By effectively eliminating these insurance products, Defendants have removed a key means by which payers would encourage price and

[11] While courts analyzing exclusive dealing claims under Section 1 typically require that 30-40% of the market be foreclosed, *e.g.*, *In re Surescripts*, 2022 WL 2208914, at *16 (N.D. Ill. June 21, 2022), where, as here, the exclusive contracts are part of a monopolization scheme under Section 2, the foreclosure levels can be lower. *See, e.g.*, *U.S. v. Microsoft Corp.*, 253 F.3d 34, 70 ("[A] monopolist's use of exclusive contracts, in certain circumstances, may give rise to a § 2 violation even though the contracts foreclose less than the roughly 40% or 50% share usually required in order to establish a § 1 violation."). Any of those thresholds is satisfied here.

quality competition and deliver savings to consumers. *See Advocate*, 841 F.3d at 475 (describing importance of payer-level competition); *St. Alphonsus*, 778 F.3d at 784 n.3 (same); *see also* Vistnes, 67 Antitrust L.J. at 674-75 (same). Eliminating a key element of competition is substantial foreclosure. *See U.S. v. Dentsply Intern., Inc.*, 399 F.3d 181, 191 (3d Cir. 2005) ("The test is not total foreclosure, but whether the challenged practices bar a substantial number of rivals or severely restrict the market's ambit."); *Microsoft.*, 253 F.3d at 64 (finding exclusive dealing substantially foreclosed competition because, "although Microsoft did not bar its rivals from all means of distribution, it did bar them from the cost-efficient ones").

Defendants argue that "the Complaint contains no well-pleaded factual allegations that any payer, provider, or patient was forced to take, or were prohibited from taking, any action due to ANI's contracts with providers." Mot. at 19. Defendants are wrong. With respect to non-ANI providers, the Complaint specifically alleges that Defendants "use various tactics to coerce these independent providers into joining the ANI network," including threatening them with the loss of valuable referrals and admitting privileges. ¶ 75. For providers in ANI's network, they must "sign contracts that require those members to seek ANI's consent before entering into direct contracts with payers who also have contracts with ANI," ¶ 76, and they are prohibited "from participating in innovative insurance products that promote competition," ¶ 77. And with respect to payers, the exclusive dealing scheme eliminates the ability of the payers to assemble networks that do not include Defendants' providers because insurers cannot contract with any ANI Provider without Defendants' consent. *Id.*[12]

[12] To the extent Defendants suggest that their scheme cannot foreclose competition because no provider or payer was *contractually* "forced to take, or prohibited from taking" an action, Mot. at 18, that argument is foreclosed by the economic realities of the Relevant Markets and decades of case law. "[A]n arrangement is 'proscribed' notwithstanding the absence of 'specific agreements

Defendants also argue that the Complaint does not allege that the exclusive dealing scheme prevented payers from "favor[ing], or direct[ing] patients to, other provider networks over ANI." Mot. at 19. But that misses the point: Defendants' restraints need not contractually restrain payers from *favoring* competing networks. The conduct alleged here is even worse—by locking up ANI providers, the restraints prevent payers from *forming* viable competing networks in the first place. *See, e.g.*, ¶ 13(b) (Defendants' contracts "foreclose the ANI Providers from contracting with payers to create networks that would compete against Aspirus and drive down Aspirus's prices"). And the Complaint alleges this scheme has succeeded at keeping out competing networks. ¶ 73. That is a classic form of foreclosure.[13]

Defendants' final argument is to challenge the Complaint's use of Defendants' market shares (75% of the Outpatient Market, and 65% of the GAC Market) as a measure of substantial foreclosure. According to Defendants, "even accepting these market shares as true, they do not represent the incremental amount of market share that other payers or out-of-network providers were foreclosed from *because of* the alleged exclusive dealing arrangements." Mot. at 20 (citing ¶¶ 35-36) (emphasis in original). It is unclear what exactly Defendants mean here—the Complaint

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not to use the … competitor' so long as its 'practical effect' is to 'prevent a lessee or buyer from using … a competitor.'" *In re Surescripts*, 2022 WL 2208914, at *10 (quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 326-27 (1961)); *McWane, Inc. v. F.T.C.*, 783 F.3d 814, 833-34 (11th Cir. 2015) (rejecting argument that "short-term and voluntary" rebate program designed to exclude new competitor could not harm competition, because "the practical effect of [defendant's] program was to make it economically infeasible for distributors to . switch to [new competitor]").

[13] *See, e.g.*, *Dentsply*, 399 F.3d at 191 (in a Section 2 context, the defendant's restraint substantially foreclosed competition where "[i]t helps keep sales of competing [products] below the critical level necessary for any rival to pose a real threat to [the defendant's] market share"); *LePage's*, 324 F.3d at 159 ("When a monopolist's actions are designed to prevent one or more new or potential competitors from gaining a foothold in the market by exclusionary, i.e. predatory, conduct, its success in that goal is not only injurious to the potential competitor but also to competition in general. It has been recognized…that even the foreclosure of 'one significant competitor' from the market may lead to higher prices and reduced output.") (citation omitted).

alleges that a substantial majority of the physicians in the Relevant Markets, both inpatient and outpatient, are off-limits to payers unless they agree to deal with Defendants. *E.g.*, ¶ 13(b). That unavailability is "*because of*" Defendants' exclusive dealing scheme. *E.g.*, ¶ 35 ("Once providers join ANI, they are locked into contracts that require Aspirus's consent before they can directly contract with health plans… As a result, payers are prevented from working with Aspirus's rival providers to put together a network that can compete with Aspirus."). In any event, contrary to Defendants' suggestion, using the market shares of the entities subject to the exclusive deal is a textbook method of demonstrating substantial foreclosure.[14]

Finally, Defendants incorrectly suggest that the precise measure of foreclosure must be pleaded. "The only question at this stage is whether the allegations raise a reasonable inference that Defendants' exclusive-dealing provisions could foreclose a substantial portion of the market and reduce output.'" *In re Surescripts*, 2022 WL 2208914, at *17 (internal alterations, citation, and quotation marks omitted). Plaintiffs more than sufficiently allege that ANI's contracts are *de facto* exclusive agreements that substantially foreclose the market, enabling Defendants to maintain monopoly power and charge supracompetitive prices.[15]

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[14] *See, e.g.*, *In re Surescripts*, 2022 WL 2208914, at *9 (finding substantial foreclosure plausible where "exclusive dealing arrangements are imposed on nearly 80% of both the doctor and pharmacy side of the e-prescribing market" (internal quotation marks omitted); *In re Dealer Mgmt. Sys. Antitrust Litig.*, 362 F. Supp. 3d 510, 538 (N.D. Ill. 2019) ("Plaintiffs have alleged facts sufficient to establish substantial foreclosure. Specifically, Plaintiffs allege that CDK and Reynolds together control approximately 75 percent of the DMS market, with CDK alone controlling approximately 45 percent."); *see also ZF Meritor*, 696 F.3d at 284 (holding "if the defendant occupies a dominant position in the market, its exclusive dealing arrangements invariably have the power to exclude rivals").

[15] Defendants incorrectly argue that the exclusive-dealing claim should be dismissed with respect to Aspirus specifically because "the Complaint does not allege that Aspirus entered into any contracts with health care providers." Mot. at 15 (emphasis omitted). Even if Aspirus is not a signatory to the exclusive contracts, Aspirus is critical to and benefits from the exclusive-dealing scheme (along with the broader overall scheme). *See* ¶ 13(a). Moreover, by Defendants' own

IV. PLAINTIFFS HAVE ANTITRUST STANDING.

Defendants argue that Plaintiffs do not have antitrust standing. Mot. at 10-15. That argument is easily rejected: Plaintiffs are direct purchasers of health care from Defendants, ¶ 4, and direct purchasers are the consummate antitrust plaintiffs.

There is one "bright-line rule" in the world of antitrust standing: "[D]irect purchasers—that is, those who are the immediate buyers from the alleged antitrust violators—may sue." *Apple Inc. v. Pepper*, 139 S.Ct. 1514, 1521 (2019) (internal quotations omitted); *see also Marion Diagnostic Ctr., LLC v. Becton Dickinson & Co.*, 29 F.4th 337, 347 (7th Cir. 2022) ("[A] direct purchaser from an alleged monopolist or cartel member is the proper party to bring suit."). Here, Plaintiffs are direct purchasers; they allege that they were injured by directly paying Defendants for health care services at prices inflated by Defendants' overarching Scheme. ¶ 18. And the type of injury here—inflated prices—is quintessential antitrust injury.[16]

Defendants nevertheless contend that Plaintiffs lack antitrust standing because they "cannot establish that their claimed injuries were proximately caused by any exclusive arrangements." Mot. at 9. This "proximate cause" test comes from the Supreme Court's decision in *Associated General Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519 (1983) ("*AGC*"), where the Court held that not every person who experiences "ripples of harm"

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admission, Aspirus and its wholly-owned subsidiary ANI are "controlled by a single center of decisionmaking and they control a single aggregation of economic power." Mot. at 28; *see* Mot. at 3 n.1. Because Defendants are a single economic unit for antitrust purposes, their exclusive-dealing scheme is perpetrated by both entities together, making them both proper defendants. *See Omni* Healthcare, 2015 WL 275806, at *5 & n.11.

[16] *See In re Cardizem CD Antitrust Litig.*, 332 F.3d 896, 910-11 (6th Cir. 2003) (holding that "paying higher prices for a product due to a lack of competition" is "the 'type of injury' the antitrust laws were meant to prevent"); *Am. Ad Mgmt., Inc. v. GTE Corp.*, 92 F.3d 781, 791 (9th Cir. 1996) ("[I]t is difficult to image [sic] a more typical example of anti-competitive effect than higher prices.").

from an antitrust violation may sue. *Id.* at 534 (internal quotations omitted). The rule ensures that parties with remote, derivative injuries step aside in favor of other plaintiffs who were more directly harmed.

The problem for Defendants' "proximate cause" argument is that *AGC* did not involve direct purchasers—indeed, it did not involve purchasers at all. Instead, the plaintiff was a union that argued the defendants' anticompetitive conduct caused some business to be diverted from unionized firms to nonunionized firms, which harmed the union's members and may have resulted in the union receiving lower dues. 459 U.S. at 528 (union's theory of harm was that "particular victims of coercion may have diverted particular contracts to nonunion firms and thereby caused certain unionized subcontractors to lose some business"). The Court ruled that the union's injury was derivative of injuries to others who were more directly harmed by the misconduct. *Id.* at 539-40. Key to the Court's reasoning—why *AGC* is inapplicable here—was the fact that "the Union was neither a consumer nor a competitor in the market in which trade was restrained," which made its injuries remote rather than direct. *Id.* at 539. Here, by contrast, Plaintiffs *are* consumers—they purchased health care directly from Defendants, ¶ 4—and since *AGC* the Supreme Court has made clear that in consumer cases, "direct purchasers … may sue antitrust violators from whom they purchased a good or service." *Pepper*, 139 S.Ct. at 1522. Under this "bright-line rule," Plaintiffs have standing *as a matter of law*. *Id.*; *Illinois Brick Co. v. Illinois*, 431 U.S. 720, 746 (1977). That is reason enough to reject Defendants' argument.[17]

[17] Moreover, despite listing six factors from *AGC* that would be relevant if any antitrust-standing inquiry were necessary, Mot. at 11-12, Defendants argue only one of them. That alone requires rejecting the argument, as "no single [*AGC*] factor is conclusive." *Sanner v. Bd. of Trade of City of Chi.*, 62 F.3d 918, 930 (7th Cir. 1995). Defendants claim that "the first *AGC* factor" can be dispositive, Mot. at 12, but the case they cite says nothing of the sort; it says that dismissal is warranted "when antitrust standing is missing," not based on any one factor. *NicSand, Inc. v. 3M*

Defendants tellingly do not propose any other party as a better-positioned plaintiff to recover the overcharges that result from Defendants' Scheme. They suggest that "rival providers" would have antitrust standing. Mot. at 14-15. This argument fails for several reasons. Most importantly, those hypothetical rival providers injured by being excluded from competing by Defendants' exclusive dealing would not be seeking the *overcharges* that Plaintiffs seek to recover here. Instead, they would seek *lost profits*, a legally distinct injury.[18] There is no one better positioned than Plaintiffs to recover the overcharges they paid directly. Second, the fact that competitors might *also* have standing to sue for distinct injuries in no way diminishes Plaintiffs' standing as direct purchasers. *Castro v. Sanofi Pasteur Inc.*, 2012 WL 12516572, at *8 (D.N.J. Aug. 6, 2012) ("That competitors may also sue for the separate harms they suffered does not bar direct purchasers from suing for their injuries."). Third, to the extent rival providers would have standing, that would be because the exclusive dealing contracts block plans from contracting with them—*i.e.*, exactly the theory of exclusive dealing Plaintiffs allege. So these rival providers would have standing only if the Plaintiffs theory of causation is correct.

What Defendants are really arguing, then, is not that Plaintiffs should stand down in favor of some other party who is better positioned to recover the illegal overcharges alleged here, but that *no one* should be able to do so. That proposition "is not supported by *Illinois Brick*—or economics or fairness for that matter." *Loeb Industries, Inc. v. Sumitomo Corp.*, 306 F.3d 469, 484 (7th Cir. 2002).

Co., 507 F.3d 442, 449 (6th Cir. 2007). Defendants' implicit concession—that the other five factors all favor Plaintiffs—is dispositive.

[18] *See Omni Healthcare,* 2015 WL 275806 at *8 (M.D. Fla. Jan. 22, 2015) ("The two injuries are distinct … and thus both are remediable."); *Andrx Pharm., Inc. v. Biovail Corp. Intern.*, 256 F.3d 799, 816-17 (D.C. Cir. 2001) ("Irrespective of consumer injury, an excluded competitor … suffers a distinct injury if it is prevented from selling its product.").

Tellingly, Defendants cite no case holding that a direct purchaser lacked antitrust standing. Instead, Defendants' cases, Mot. at 12-14, involve *AGC*-like scenarios where the plaintiff's alleged injury was downstream or derivative of harm inflicted directly on someone else. In Defendants' principal case, *In re Aluminum Warehousing Antitrust Litigation*, 520 F. Supp. 3d 455 (S.D.N.Y. 2021), Mot. at 13, the plaintiffs did not purchase anything, directly or indirectly, from the defendants. The plaintiffs instead alleged that defendants had manipulated a benchmark price incorporated into their own aluminum sales, and that plaintiffs suffered derivative harm because they and their non-defendant suppliers chose to incorporate that benchmark into their own deals. *See id.* at 465. The plaintiffs lacked standing because their injuries resulted from their own independent decision to use the benchmark price. *See id.* at 497. That fact pattern, and the similar ones in the other cases Defendants cite,[19] do nothing to cast doubt on a direct purchaser's standing.

Defendants next argue that "Plaintiffs lack antitrust standing for their exclusive dealing claim because that claim is purportedly premised on speculation that but for 'ANI's exclusive dealing arrangements,' non-party providers would have independently decided to join other, competing payer networks that hypothetically could have existed." Mot. at 10-11. Defendants are wrong.

[19] *See de Atucha v. Commodity Exch., Inc.*, 608 F. Supp. 510 (S.D.N.Y. 1985) (holder of silver contracts on the London Metals Exchange alleged that traders manipulated American silver markets in which he did not participate); *Supreme Auto Transp. LLC v. Mittal*, 238 F. Supp. 3d 1032 (N.D. Ill. 2017) (plaintiffs bought products containing steel from manufacturers, who purchased steel from distributors, who purchased raw steel at inflated rates from defendants); *Laydon v. Mizuho Bank, Ltd.*, No. 12-CV-3419 GBD, 2014 WL 1280464, at *2-3 (S.D.N.Y. Mar. 28, 2014) (defendants submitted fraudulent information that affected the Yen-LIBOR rate, which in turn affected the Euroyen TIBOR rate, which in turn affected the value of plaintiff's Euroyen TIBOR futures contracts). The other case on which Defendants rely (at 9, 11) held that soybean farmers *were* proper plaintiffs to pursue claims that defendants manipulated soybean futures prices. *See Sanner*, 62 F.3d at 930.

First, Defendants make this argument only with respect to Defendants' exclusive dealing contracts, implicitly conceding that Plaintiffs have standing to challenge the rest of the conduct that comprises the alleged anticompetitive Scheme. Mot. at 10. But it makes no sense that Plaintiffs would have standing to sue based on all but one prong of a series of anticompetitive acts, each working together to cause anticompetitive harm. Thus, to the extent Defendants concede for purposes of their Motion that Plaintiffs' injuries as direct purchasers are cognizable relating to other aspects of the alleged Scheme (price fixing and tying), and as to the Scheme as a whole, it would illogical to carve one portion of the Scheme out and assert Plaintiffs have no standing to sue based on that portion—even where that one restraint operates in conjunction with the others to harm competition and artificially inflate prices.

Second, Defendants' argument suggests that Plaintiffs' claim of injury is somehow implausible because it involves allegations that absent the exclusive-dealing contracts, the independent ANI Providers would have competed with Defendants by, *inter alia*, joining networks of rival health plans that would compete on price against the plans that include Defendants' facilities and providers. Mot. at 11. But that argument is not about whether direct payers like Plaintiffs are the "proper plaintiffs" to recover for harm caused by Defendants' conduct; it is about whether the exclusive dealing conduct contributed *to any competitive harm at all,* which is about the merits rather than standing, and which Plaintiffs have plausibly alleged.

In any event, Defendants' causation argument is itself implausible and misunderstands how exclusive dealing harms competition. Despite hyperbolic references to "daisy-chain[s]" and "innumerable independent decisionmakers," Mot. at 11, 14, Defendants identify only one step between their exclusive contracts and the resulting anticompetitive harm—they claim that "Plaintiffs would not be able to establish their exclusive dealing claim if some number of providers

would have independently decided to join ANI." Mot. at 14. For starters, Plaintiffs do not allege that affiliation with ANI, standing alone, is anticompetitive. Instead, what is anticompetitive is that ANI prohibits ANI providers from separately contracting with payers to join networks that could compete against Aspirus on price and quality. *See* ¶¶ 13(b), 72. ("Providers are dissuaded, through fear of being cut off from Aspirus and its dominant referral network, from entering into direct contracts with health plans or employers to be part of networks that do not include Aspirus."). Far from being farfetched, this is precisely how competition works in health care markets. *See supra* at 2 & n.2 (citing cases and economic research regarding provider competition for inclusion in payer networks). Indeed, Defendants must believe that independent ANI Providers were likely to join other payer networks absent the restraints, or else why require exclusivity at all?

Third, to the extent Defendants argue that Plaintiffs' injury is somehow not caused by the exclusive dealing because the alleged exclusionary contracts are between Defendants and other providers, Mot. at 12-13, that, too, is without merit. Plaintiffs allege an anticompetitive scheme that includes horizontal agreements between ANI and its erstwhile competitors, and further allege that those contracts substantially foreclose competition, enhance Defendants' monopoly power, and lead to artificially inflated prices. A purchaser has antitrust standing if it is harmed by conduct that is directed at excluding competitors. *See Blue Shield of Va. v. McCready*, 457 U.S. 465, 478-79 (1982) (patient who paid higher prices for psychiatric care under health plan injured by defendants' conduct intended to exclude psychologists from health plan for the benefit of psychiatrists and physicians); *Loeb*, 306 F.3d at 482 (purchasers of copper injured by anticompetitive conduct aimed at separate futures market).

At the motion to dismiss stage, the Court must "accept the factual allegations contained in the complaint as true," *Sanner*, 62 F.3d at 925, and Plaintiffs have alleged that Defendants'

exclusive contracts caused anticompetitive harm, *see, e.g.*, ¶ 8 ("Aspirus's exclusive dealing agreements, as part of the illegal anticompetitive scheme alleged herein, however, forecloses such competition that would have driven down prices and increased quality of health care in North-Central Wisconsin."); *see also* ¶¶ 12, 13(b), 15-19, 72-73, 80. Those allegations—combined with Plaintiffs' undisputed status as direct purchasers—means they have standing to recover the overcharges that Defendants' scheme inflicted.[20]

V. PLAINTIFFS PLAUSIBLY ALLEGE THAT DEFENDANTS ENGAGED IN UNLAWFUL MONOPOLIZATION.

Plaintiffs allege that Defendants engaged in a series of anticompetitive acts as part of the Scheme to maintain and enhance their monopoly power in the Relevant Markets. Such allegations state a claim under Section 2 of the Sherman Act, which requires: "(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident." *U.S. v. Grinnell Corp.* 384 U.S. 563, 570-71 (1966); *Viamedia*, 951 F.3d at 451 (7th Cir. 2020).

As to the first element, Defendants do not challenge Plaintiffs' well-pleaded allegations that Defendants have monopoly power in the Relevant Markets. With good reason: Plaintiffs allege direct evidence of monopoly power, including, *inter alia*, Aspirus's ability to (a) coerce providers

[20] *See, e.g.*, *Castro,* 2012 WL 12516572 (direct purchasers had standing to recover overcharges in case alleging analogous anticompetitive scheme involving vertical agreements between monopolist and purchasers alleged to foreclose competition and artificially inflate prices) *Meijer, Inc. v. Abbott Labs.*, 544 F. Supp. 2d 995 (N.D. Cal. 2008) (upholding direct purchasers' overcharge claims flowing from exclusionary agreements between class members and the defendant); *Natchitoches Parish Hosp. Serv. Dist. v. Tyco Int'l, Ltd.*, 262 F.R.D. 58 (D. Mass. 2008) (certifying class where direct purchasers alleged overcharges stemming from foreclosure due to alleged exclusionary agreements between the defendant and distributors); *In re Hypodermic Prods. Antitrust Litig.*, 2007 WL 1959225 (D.N.J. June 29, 2007) (same); *Bradburn Parent/Teacher Store, Inc. v. 3M (Minn. Mining & Mfg. Co.)*, 2000 WL 34003597 (E.D. Pa. July 25, 2003) (same).

to sign exclusive contracts, (b) coerce buyers to accept "all or nothing" arrangements, and (c) charge supracompetitive prices and artificially reduce consumer choice. ¶ 40; *see also Packaging Supplies, Inc. v. Harley-Davidson, Inc.*, 2009 WL 855798, at *6 (N.D. Ill. Mar. 30, 2009) (collecting cases holding that direct evidence of monopoly power includes the ability to control prices or exclude competition). Plaintiffs also allege indirect evidence of monopoly power, including that Aspirus controls at least 65% of the GAC Market and 75% of the Outpatient Market, ¶ 59—market-share levels that courts have regularly held to constitute a monopoly.[21]

With respect to the second element—maintenance or abuse of monopoly power—the Complaint alleges that Defendants' Scheme enhanced their monopoly power by "'harm[ing] the competitive *process* and thereby harm[ing] consumers.'" *Viamedia*, 951 F.3d at 452-53 (quoting *Microsoft*, 253 F.3d at 58) (emphasis in original). "Conduct that can harm competition may fit into more than one of these court-devised categories. After all, the means of illicit exclusion, like the means of legitimate competition, are myriad." *Viamedia*, 951 F.3d at 453 (internal quotation marks omitted). Plaintiffs allege a Scheme that was not competition on the merits, but rather, consisted of a series of acts that individually and collectively harmed competition by exploiting market power and impeding price and quality competition. As discussed above, Plaintiffs allege, in detail, how Defendants' multi-pronged Scheme—which involved horizontal price fixing, all-or-nothing tying contracts, and exclusive dealing—harmed competition by foreclosing the ability of rival health care providers to contract with payers (like Plaintiffs and insurers), and thus preventing

[21] *See, e.g.*, *Dentsply*, 399 F.3d 181, 187 (3d Cir. 2005) ("A less than predominant share of the market combined with other relevant factors may suffice to demonstrate monopoly power."); *Hayden Publishing Co. v. Cox Broadcasting Corp*., 730 F.2d 64, 69 n.7 (2d Cir. 1984) ("[A] party may have monopoly power in a particular market, even though its market share is less than 50%."); *Arista Networks Inc. v. Cisco Systems Inc.*, 2018 WL 11230167, at *18 (N.D. Cal. May 21, 2018) (holding "at least 50% market share" raised triable question of monopoly power under Section 2).

those payers from assembling networks of providers that can compete against Defendants on price and quality. *See supra* Parts I-III. All of this conduct enabled Defendants to maintain their monopoly power and charge artificially inflated prices. *See supra* at 3-9; ¶¶ 9, 91.

Defendants argue that Plaintiffs' "monopolization claim should be dismissed because Plaintiffs have not included plausible allegations that any Defendant achieved monopoly power through anticompetitive means." Mot. at 27. In so arguing, Defendants barely discuss Plaintiffs' Section 2 claim, merely resting on their arguments under Section 1 of the Sherman Act regarding exclusive dealing, tying, and collusion. This is wrong in two key respects.[22]

First, as discussed above, Plaintiffs allege an overarching Scheme that consists of a variety of conduct that is anticompetitive conduct under both Sections 1 and 2 of the Sherman Act. *See, e.g.*, *Md. & Va. Milk Producers Ass'n v. United States*, 362 U.S. 458, 463 (1960) ("[S]ections [1 & 2] closely overlap, and the same kind of predatory practices may show violations of [both]."); *Microsoft*, 253 F.3d at 84-85 (noting that tying is exclusionary conduct under both Sections 1 and 2); *Dicesare*, 2017 WL 1359599, at *17 (hospital antitrust case observing that the same kinds of practices can constitute violations of both Sections 1 and 2).

Second, Defendants improperly pull apart and analyze separately each piece of the overall Scheme. For purposes of Plaintiffs' Section 2 claim, the question is not whether each individual act or contract violates Section 2; rather, the question is whether the conduct, taken individually or *together*, is anticompetitive. *City of Mishawaka, Ind. v. Am. Elec. Power Co.*, 616 F.2d 976, 986

[22] To the extent Defendants assert that Plaintiffs are required to show that Defendants "achieved" monopoly power through anticompetitive conduct, Mot. at 27, that is not the correct standard. To state a Section 2 claim, Plaintiffs must show that Defendants *acquired or maintained* monopoly power through anticompetitive conduct. *Grinnell*, 384 U.S. at 570-71. As described below, Defendants have maintained—and enhanced—their monopoly power through various types of anticompetitive conduct.

(7th Cir. 1980) ("The [defendant] would have us consider each separate aspect of its conduct separately and in a vacuum. If we did, we might agree with the utility that no one aspect standing alone is illegal. It is the mix of the various ingredients of utility behavior in a monopoly broth that produces the unsavory flavor."); *LePage's Inc.*, 324 F.3d at 162 ("[T]he courts must look to the monopolist's conduct taken as a whole rather than considering each aspect in isolation.").[23]

Each of the elements of the Scheme worked together in a feedback loop that harmed competition and enabled Defendants to artificially inflate prices. As one example, by tying GAC Services to Outpatient Services through all-or-nothing contracting practices, Aspirus was able to maintain its market power in the GAC Market. This dominance enabled Aspirus to coerce providers into signing *de facto* exclusive contracts with ANI, which helped ANI maintain its dominant market position in Outpatient Services. These ANI contracts also trapped referrals within the ANI network, which increased the coercion on ANI Providers to remain in ANI. And because ANI maintained a dominant share of the Outpatient Providers within the ANI umbrella, payers in the Relevant Markets could not avoid the prices that were artificially inflated by ANI's price fixing.

Plaintiffs' allegations regarding Defendants' Scheme are more than sufficient to state a claim under Section 2 of the Sherman Act.

CONCLUSION

Plaintiffs respectfully request that Defendants' Motion be denied.

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[23] *Klein v. Meta Platforms, Inc.*, 2022 WL 17477101, at *2-3 (N.D. Cal. Dec. 6, 2022) (endorsing a "monopoly broth" theory as "enough to go forward" past a motion to dismiss); *In re Intuniv Antitrust Litig.*, 496 F. Supp. 3d 639, 680 (D. Mass. 2020) ("Courts do not require that every single action in an anticompetitive scheme be, on its own, anticompetitive."); *In re Keurig Green Mtn. Single-Serve Coffee Antitrust Litig.*, 383 F. Supp. 3d 187, 230 (E.D.N.Y. 2019) (recognizing that defendant's product design changes, combined with allegations of exclusive dealing, tying agreements, and product disparagement, purportedly coerced customers to purchase defendant's products over comparable products, rather than competing on the merits).

Dated: February 15, 2023

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on February 15, 2023, a true and correct copy of the foregoing was filed with the Court via the CM/ECF system, which will send a Notice of Electronic Filing to all counsel of record.

Dated: February 15, 2023

/s/ Timothy W. Burns
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