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FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

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N.D. OF ALABAMA

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)	Master File No. 2:13-CV-20000-RDP This document relates to Provider Track Cases

PROVIDER PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT REGARDING THE STANDARD OF REVIEW FOR THEIR GROUP BOYCOTT CLAIMS

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Pursuant to Qualified Protecitve Order (Dkt. 550) and the Order Regarding Revised Sealing Procedures (Dkt. 758)

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Exhibit	Document	Citation
1.	Deposition of Jeffrey A. Ingrum, June 21, 2017	Ingrum Tr.
2.	Deposition of Bradley D. Eisemann, May 3, 2017	Eisemann Tr.
3.	Deposition of Christine Stewart, September 20, 2017	Stewart Tr.
4.	Deposition of Michael D. Bruce, June 13, 2017	Bruce Tr.
5.	Deposition of Keith Parrott, December 6, 2017	Parrott Tr.
6.	Deposition of Nina Dusang, August 9, 2017	Dusang Tr.
7.	Deposition of Joseph Swedish, July 28, 2017	Swedish Tr.

INTRODUCTION

In Alabama, the vast majority of commercially insured patients are covered by Blue Cross and Blue Shield of Alabama (BCBS-AL) or one of the other Blues. Healthcare providers, who cannot compete without access to commercially insured patients, have a choice: they can contract with BCBS-AL and access the other Blues' members as well, or they can be excluded from the network of every single Blue plan. The reason for this all-or-nothing choice is the Blues' agreement—a horizontal agreement among potential competitors—not to include a provider in any Blue plan's network unless that provider contracts with the local Blue plan. The horizontal nature of the agreement, the absolute exclusion of providers who do not contract with BCBS-AL, and the Blues' overwhelming share of the commercially insured patients in Alabama combine to make the Blues' agreement a *per se* unlawful group boycott.

STATEMENT OF UNDISPUTED FACTS

The following facts are undisputed, relevant, and material:

1. "[S]ome competition between [Blue] Plans has been a fact of life from the earliest days of the Blues' organization." Doc. No. 2063 at 10.

2. Without exclusive service areas, the Plans are potential competitors. Doc. No. 2063 at 20 (describing sworn testimony by an Anthem representative that it would be "exhilarating" to have "unfettered access" in "50 states"); *id.* at 35 ("There is also evidence in the record that, apart from the Blue Plans' ESAs (which are ostensibly based on the Marks), the Blues would be competitors under the Blue brand in the health insurance market."); Doc. 2565-49 and 50 (Expert Report of Kevin Murphy, Ph.D.) ¶ 60.

3. The Board of Directors of the Blue Cross and Blue Shield Association (Association) comprises a representative of each member plan (Plan), "which person shall be the

duly elected and qualified CEO (even if such CEO is the CEO of more than one Regular Member) or, if none, and if the Chair of the Board consents, the Acting CEO of the Regular Member," as well as the Chief Executive Officer of the Association. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 2 (undisputed by Defendants); Doc. No. 2063 at 37.

4. The governance structure of the Association is set out in the Association's bylaws. The Plans may amend or repeal the bylaws, and adopt new bylaws, by vote. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 2 (undisputed by Defendants); Doc. No. 2063 at 37.

5. The Plans are governing members of the Association. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 2 (undisputed by Defendants); Doc. No. 2063 at 37.

6. The Association owns the Blue Cross and Blue Shield names and marks (the "Blue marks"), and it grants licenses to the Plans to use the Blue marks. The license agreements may be amended by vote of the Plans. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 2–3 (undisputed by Defendants); Doc. No. 2063 at 37.

7. Due to the organizational structure of the Association, an agreement among the Blues relating to competition is a horizontal agreement. Doc. No. 2063 at 37.

8. The license agreements identify a "Service Area" for each Plan. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 3 (undisputed by Defendants); Doc. No. 2063 at 40.

9. The majority of the Plans' service areas are exclusive, meaning that they do not overlap with another Plan's service area. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 3 (undisputed by Defendants); Doc. No. 2063 at 9. The State of

Alabama is such an exclusive service area. Doc. 1350-7 (BCBSA03879017, 018-020) (Association Map Book).

10. Under the license agreements, the Association's rules, or both, a Plan generally may not develop a provider network or contract with a healthcare provider outside its service area for services to be provided under the Blue marks. Provider Plaintiffs' Motion for Partial Summary Judgment, Doc. No. 1350, at 3–4 (undisputed by Defendants); Doc. No. 2063 at 10. Therefore, the only way for a healthcare provider to join a Blue-branded network of a Plan located outside the service area in which the provider is located is to contract with the local Plan and access the other Plan's members through the BlueCard program. There are exceptions to these rules not relevant to this motion.[1]

11. In Alabama, more than 80% of commercial patients are covered by the Blues. Doc. 2454-6, (Expert Report of Deborah Haas-Wilson, Ph.D. (April 15, 2019)) ¶ 275. Across all Core-Based Statistical Areas (CBSAs) and counties not part of a CBSA in Alabama, the Blues' share ranges from 62% to 94%. *Id.* More than 400,000 Alabamians are covered by Blues other than BCBS-AL. Doc. No. 2063 at 13–14.

12. BCBS-AL offers contracts to healthcare professionals on a "take it or leave it" basis, with the same terms and reimbursement rates for a given service statewide, regardless of the professional's skill or experience. Ex. 1 (Deposition of Jeffrey A. Ingrum, Corporate Representative of BCBS-AL (June 21, 2017)) at 25:14–33:4. Contracts for at least some outpatient

[1] For example, the Blues allow certain types of providers, such as laboratories and sellers of durable medical equipment, to contract with Plans outside their service areas. Doc. No. 2063 at 10. This motion applies to healthcare providers in the putative Provider Plaintiff Classes, which exclude these types of providers. *See* Doc. No. 2604 at 2 (Provider Plaintiffs' Renewed Motion for Class Certification and Supporting Memorandum). The Blues also permit a Plan to contract with providers in an area contiguous to the Plan's service area, but only to serve Plan members living or working in the Plan's service area. Doc. No. 2063 at 10. A Plan may contract with a provider outside its service area for a non-Blue branded network, but this possibility is irrelevant here because no Plan has a significant number of subscribers in Alabama for a non-Blue branded product.

services provided by healthcare facilities are also not open to negotiation. Deposition of Crenshaw Community Hospital Corporate Representative Bradley D. Eisemann, Ex. 2, at 257:20–22 ("I called and asked [BCBS-AL] if [our contract] would be negotiated, and he said no, take it or leave it. We don't negotiate outpatient rates.").

13. Self-pay patients spend only about half as much per year on healthcare services as patients with insurance, and the majority of their care is uncompensated. Doc. 2454-6 (Haas-Wilson Report) ¶ 239. Under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, a hospital that participates in Medicare must stabilize any patient who presents at the emergency department with an emergency medical condition (or transfer the patient if the patient requests or if stabilization is beyond the capabilities of the hospital), regardless of the patient's ability to pay. Healthcare providers generally do not collect as much from self-pay patients as they do from commercially insured patients, and they sometimes collect nothing at all. [REDACTED]

[REDACTED] Ex. 4 (Deposition of Michael Bruce, Corporate Representative of Ivy Creek) at 157:24–158:2 (agreeing that "[s]elf-pay means no pay"), 417:6–7 ("Self-pay is – is the worst form of payment), 417:8–9 (Blues' own counsel stating that he advises clients that self-pay is the worst form of payment); Ex. 5 (Deposition of Keith Parrott, Corporate Representative of Tenet Healthcare) at 174:4–10 ("[I]f we automatically did all the elective charity that came in, we would definitely go bankrupt."), 218:25–219:9 (Alabamians without insurance have financial difficulties); [REDACTED]

14. BCBS-AL does not honor assignment of benefits for out-of-network providers, meaning that BCBS-AL will pay the subscriber, not the provider, for the service. Ex. 1 (Deposition of Jeffrey A. Ingrum, Corporate Representative of BCBS-AL (Sept. 25, 2017)) at 14:12–23. When a physician or an ancillary provider treats a BCBS-AL subscriber on an out-of-network basis, BCBS-AL generally pays less than it would to an in-network provider. *Id.* at 17:6–10.

15. At any given time, there is a fixed number of people covered by government programs, and they do not change doctors frequently: in a survey, 96% of Medicare beneficiaries said they had a usual source of care, and only 7% reported looking for a new primary care physician in the previous year. Doc. 2454-6 (Haas-Wilson Report) ¶ 241.

16. Government programs generally pay less for medical services than commercial insurance. Doc. 2454-6 (Haas-Wilson Report) ¶ 242. During litigation over Anthem's proposed merger with Cigna, Anthem admitted that "government programs generally reimburse providers at far lower rates than do commercial health insurers." *United States v. Anthem*, Doc. No. 15, ¶ 67 (D.D.C. Jul 26, 2016).

17. Anthem CEO Joseph Swedish testified in this case that he has characterized commercial payments as subsidizing payments from government payors. Ex. 7 (Deposition of Joseph Swedish) at 242:23–243:7. Healthcare providers have testified in this case that [REDACTED] Ex. 3 (Deposition of Christine Stewart, Corporate Representative of Russellville Hospital Tr.) at 90:25–92:23, 187:16–188:14; Ex. 6 (Deposition of Nina Dusang, Corporate Representative of DCH Healthcare Authority) at 82:24–83:16; Ex. 5 (Deposition of Keith Parrott, Corporate Representative of Tenet Healthcare) at 175:13–177:17.

18. "The very existence of the national health insurers against whom the Blue Plans compete shows that collusion between competitors is not essential to the sale of health insurance." Doc. No. 2063 at 44 n.15.

ARGUMENT

For decades, courts have applied the *per se* rule to group boycotts that arise from horizontal agreements among competitors. *NYNEX Corp. v. Discon, Inc.*, 525 U.S. 128, 134–35 (1998). As far back as 1930, the Supreme Court held that it was unlawful for competitors to boycott a customer who refuses to agree to the competitors' jointly established terms. *Paramount Famous Lasky Corp. v. United States*, 282 U.S. 30 (1930). "The Eleventh Circuit has recognized that certain group boycotts constitute *per se* violations of the Sherman Act." Doc. No. 2063 at 54 (citing *All Care Nursing Serv., Inc. v. High Tech Staffing Servs.*, 135 F.3d 740, 746 (11th Cir. 1998)). "Group boycotts generally are only subjected to a *per se* analysis if (1) the boycott blocks access to a necessary product, facility, or market for competition, or (2) if the boycotting firms possess market power within the relevant market." *Id.* (citing *All Care Nursing*, 135 F.3d at 748; *Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co.*, 472 U.S. 284, 294 (1985)). Here, the Blues have agreed that they will not allow their members to access a healthcare provider on an in-network basis unless that provider has entered into an agreement with the Blue Plan in whose service area the provider is located. Because access to the Blues' patients on an in-network basis is necessary for healthcare providers to compete, the Blues' agreement is a group boycott subject to a *per se* analysis.

I. The Blues Have Entered Into a Horizontal Agreement Not to Do Business with Alabama Healthcare Providers Who Do Not Contract With BCBS-AL.

The Blues, who are competitors or potential competitors, have undisputedly agreed not to give a healthcare provider access to their commercial patients on an in-network basis unless the

provider signs a contract with the local Blue plan—a horizontal agreement. Facts 7, 10. In Alabama, a provider can join the network of all the Blues under the terms and prices imposed by BCBS-AL, or not join any Blue's network at all. This arrangement is fundamentally different from the one in *All Care Nursing*, in which the defendant hospitals merely agreed to "seek first nurses from preferred providers before going to nonpreferred agencies." 135 F.3d at 744. Thus, the hospitals were still allowed to contract individually with the plaintiff nursing services, which were nonpreferred. 135 F.3d at 748. The Blues have no such exception; their boycott is ironclad.[2]

II. The Blues' Boycott Cuts Off Access to a Supply, Facility, or Market Necessary for Healthcare Providers to Compete: Commercial Patients.

"In cases of group boycotts where the per se rule has been applied, 'the boycott often cut[s] off access to a supply, facility, or market *necessary to enable the boycotted firm to compete* ….'" *All Care Nursing*, 135 F.3d at 748 (quoting *Nw. Wholesale Stationers*, 472 U.S. at 294). While group boycotts are often intended to damage the boycotters' rivals, the *per se* rule does not require such an intent. *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990) (holding that a boycott by CJA lawyers intended to increase their compensation was a *per se* violation of the Sherman Act); *Tunica Web Advertising v. Tunica Casino Operators Ass'n, Inc.*, 496 F.3d 403, 413 (5th Cir. 2007) ("Nothing in *Northwest Wholesale Stationers* or the Supreme Court's later cases, however, establishes a bright-line rule limiting the application of the *per se* rule to cases in which the victim is a competitor of at least one of the conspirators, and no such rule is justified under the Court's precedents.").

[2] The Provider Plaintiffs are seeking the right to opt out of the BlueCard system and contract with Blue Plans directly, as the nursing services in *All Care Nursing* were able to do. The Provider Plaintiffs are also seeking improvements to the efficiency of the BlueCard program and a fee for participating that will compensate them for the administrative burdens that BlueCard imposes on them.

In Alabama, in-network access to commercial patients is necessary for healthcare providers to compete. Governmental programs like Medicare and Medicaid tend to pay at lower rates than commercial insurance, and the number of patients is limited. Facts 15–17. Thus, a healthcare provider who loses commercial patients will see not only a drop in volume, but likely also a decrease in average reimbursement per patient. Access on an in-network basis is necessary because commercial healthcare financing provides lower benefit levels for services performed by out-of-network providers (or no out-of-network benefits at all), steering commercial patients away from providers who are not in their plan's network. *See* Fact 14 (BCBS-AL pays less to out-of-network providers than in-network providers). Collecting payment is more difficult as well, because BCBS-AL sends its payment for the service to the patient, whom the provider must then pursue. Fact 14.

The Blues' dominant position among commercial patients in Alabama satisfies either of the alternative requirements for *per se* illegality that this Court identified it its opinion on the standard of review. First, the Blues' "boycott blocks access to a necessary product, facility, or market for competition." Doc. No. 2063 at 54 (citing *All Care Nursing*, 135 F.3d at 748; *Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co.*, 472 U.S. 284, 294 (1985)). The Supreme Court illustrated this requirement in *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963), in which the New York Stock Exchange cut off private wire communications between the plaintiff's securities firms and Exchange members. Although the plaintiff's firms could still do business with non-Exchange members, *id.* at 343, and one of those firms was able to continue operating at a reduced scale, *id.* at 345, the Court held that "[i]t is plain" that the Exchange's actions "constitute a per se violation of s 1 of the Sherman Act" as long as no other statute permitted it, *id.* at 347. The Court noted that "[w]ithout membership in the network of simultaneous communication, the over-the-counter dealer loses a significant volume of trading with other

members of the network which would come to him as a result of his easy accessibility." *Id.* at 348. Healthcare providers are harmed as well when they are cut off from commercial patients. As explained above, a healthcare provider without in-network access to commercial patients cannot compete effectively because he or she "loses a significant amount of trading" with commercial patients "which would come to him [or her] as a result of his [or her] easy accessibility." Just as the New York Stock Exchange controlled access to the most important securities firms, in Alabama the Blues collectively control in-network access to the vast majority of commercial patients. Fact 11. Such a provider will have a smaller pool of patients to pursue, at lower average rates. Without the group boycott, a provider who does not want to accept BCBS-AL's offered rates might pursue relationships with the other Blues, who cover more than 400,000 commercial patients in the state. *Id.* With the group boycott, that is not an option; no other Blue may offer a contract to an Alabama provider who does not contract with BCBS-AL. Without access to commercial patients, it is difficult or impossible for healthcare providers to break even. Fact 17. And even if it might be possible for a provider to stay in business at a reduced scale without commercial patients, that is not the test for *per se* illegality, as *Silver* demonstrates. If the provider cannot compete effectively, that is enough.

The Blues' boycott also satisfies the alternative ground for *per se* treatment: the Blues "possess market power within the relevant market." Doc. No. 2063 at 54 (citing *All Care Nursing*, 135 F.3d at 748; *Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co.*, 472 U.S. 284, 294 (1985)). When determining the standard of review for a group boycott, it is not always necessary to perform a full product market definition if there is "direct evidence of anticompetitive effects." *Toys "R" Us, Inc. v. FTC*, 221 F.3d 928, 937 (7th Cir. 2000) (citing *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 460–61 (1986)). Here, BCBS-AL offers contracts to most providers on a

"take it or leave it" basis, with the same reimbursement rate for a given service statewide, regardless of the provider's skill or experience. Fact 12. The ability to dictate prices without even the possibility of negotiation is a hallmark of market power. *See Bd. of Regents of Univ. of Okla. v. Nat'l Collegiate Athletic Ass'n*, 546 F. Supp. 1276, 1292 (W.D. Okla. 1982) ("The networks were offered a take-it-or-leave-it proposition. A truly free market would not have yielded the identical prices and packages which result from the contracts."), *aff'd in relevant part*, 707 F.2d 1147 (10th Cir. 1983).

Even if a more thorough market definition were required, the Blues' market power in Alabama would be obvious. When this Court denied the Blues' motion to dismiss, it held that it is plausible to allege a market for the purchase of healthcare services that is limited to commercial patients, as opposed to participants in government programs like Medicare, or patients who pay out of pocket. Doc. No. 1306 at 13. The Court noted the Providers' allegations that the substitutability between commercial payors and non-commercial payors is low, "owing to such factors as the small fraction of people who pay out of pocket for health care service and the limited number of Medicare and Medicaid patients," as well as lower reimbursement by government programs. *Id.* at 13–14. The court also cited two opinions in which product markets that excluded government payors were held to be plausible. *Id.* at 14 (citing *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 2015 WL 1399229 (C.D. Ill. Mar. 25, 2015); *Steward Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I.*, 997 F. Supp. 2d 142 (D.R.I. 2014)). Therefore, the Court held, the Providers' alleged markets were plausible. *Id.* at 14–15.

The Providers have now developed a thorough record supporting each of the allegations they made in their complaint. Dr. Haas-Wilson's report explains that self-pay patients spend only about half as much per year on healthcare services as patients with insurance, and that the majority

of their care is "uncompensated." Fact 13. She explains that at any given time, there is a fixed number of people covered by government programs, and that they do not change doctors frequently: in a survey, 96% of Medicare beneficiaries said they had a usual source of care, and only 7% reported looking for a new primary care physician in the previous year. Fact 15. She showed that government programs generally pay less for medical services than commercial insurance. Fact 16. She then used this information to show that a hypothetical monopsonist could profitably decrease reimbursements to healthcare providers below competitive levels because the providers would not have a financial incentive to switch to patients covered by government programs. Doc. 2454-6 (Haas-Wilson Report) ¶ 243.[3]

Dr. Haas-Wilson's conclusion that commercial payors and other payors are not interchangeable is also consistent with the evidence in this case. Commercial payors pay more than government payors, Facts 16–17, and providers would struggle to break even if they had to rely exclusively on government payments, Fact 17. Self-pay patients generally lack the ability to pay for their care, which is sometimes written off as charity. Fact 13.

Dr. Haas-Wilson's conclusion is also consistent with the position taken by the DOJ in its challenge to Anthem's merger with Cigna. After an extensive trial, the DOJ (which co-wrote the Horizontal Merger Guidelines), argued that commercial payors are not interchangeable with other payors for the same reasons Dr. Haas-Wilson cites: the low number of uninsured patients and their typical inability to pay, low reimbursement rates for government programs relative to commercial insurance, and the fixed population of government-insured patients. *United States v. Anthem*, No.

[3] The Blues have argued that the relevant product market is actually a two-sided market for healthcare transactions. The Providers have explained why the Blues are wrong in their summary judgment motion on the standard of review in light of *Amex*, but for purposes of this motion it makes no difference whether the market is one for commercial patients, or for healthcare transactions, because providers interact with commercial patients in the context of providing healthcare.

1:16-cv-1493, Doc. No. 483 at 33–37 (D.D.C. Jan. 17, 2017). The DOJ also noted that providers cannot lower their prices to attract more government-insured patients because those prices are non-negotiable. *Id.* at 36. And Anthem itself admitted that "government programs generally reimburse providers at far lower rates than do commercial health insurers." *United States v. Anthem*, Doc. No. 15, ¶ 67 (D.D.C. Jul 26, 2016). Additionally, in a challenge to the proposed merger of Aetna and Humana, the DOJ proved that Medicare Advantage (which is offered by commercial insurers) and Original Medicare (which is administered by the government) are separate product markets. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 22–42 (D.D.C. 2017).

This Court's opinion on the motion to dismiss, Dr. Haas-Wilson's analysis, the opinions of other courts, the DOJ's position in *United States v. Anthem*, and Anthem's own admissions are consistent with the facts on the ground in Alabama: healthcare providers are not in a position to forgo commercial patients. The Blues collectively control in-network access to the vast majority of commercial patients across the state—in big cities, small counties, and everywhere in between. Statewide, the Blues' commercial enrollees make up more than 80% of the total commercial enrollees. Fact 11. Across all Core-Based Statistical Areas (CBSAs) and counties not part of a CBSA in Alabama, the Blues' share ranges from 62% to 94%. *Id.* In the Eleventh Circuit, a monopoly can exist with a market share of more than 50%, *McWane, Inc. v. FTC*, 783 F.3d 814, 830 (2015) (citing cases), and the threshold for market power is lower than the threshold for monopoly, *Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 481 (1992) ("Monopoly power under § 2 requires, of course, something greater than market power under § 1."). Therefore, the Blues' overwhelming market share in every corner of Alabama easily satisfies the more lenient test for market power. *See Toys "R" Us*, 221 F.3d at 936–37 (finding an effect on the market when the boycotting firms accounted for 40% of that market); *McWane*, 783 F.3d at 837 ("Traditionally

a foreclosure percentage of at least 40% has been a threshold for liability in exclusive dealing cases."). While the Providers and the Blues have disagreed about how to define the relevant geographic markets in this case, for present purposes that dispute is academic because the Blues possess market power in the market for commercial patients no matter how Alabama is sliced and diced. In short, because the Blues have more than four times as many commercial patients in Alabama than all their competitors combined, they "possess market power within the relevant market."

III. There Are No Plausible Procompetitive Benefits of the Type That Would Save the Blues' Group Boycott from *Per Se* Treatment.

As the Court noted in its previous order on the standard of review, it may be necessary "to consider plausible procompetitive benefits of the type of boycott alleged in this action before determining whether the group boycott is subject to *per se* review." Doc. No. 2063 at 55 n.21 (citing *Levine v. Cent. Fla. Med. Affiliates*, 72 F.3d 1538, 1550–51 (11th Cir. 1996); *Diaz v. Farley*, 215 F.3d 1175, 1183-84 (10th Cir. 2000)). If so, the Blues bear the burden of persuasion on this issue. *City of Vernon v. S. Cal. Edison Co.*, 955 F.2d 1361, 1370 (9th Cir. 1992); *see Diaz*, 215 F.3d at 1183–84 (considering a procompetitive justification proffered by the defendant).

Because the Blues bear the burden of persuasion, the Providers will wait to see how the Blues justify their group boycott as procompetitive; at this point, the Providers are not required to anticipate and respond to all potential procompetitive benefits. But if the Blues' justifications for their other practices are any guide, they will not carry their burden. For example, this Court has already held that the Blues' use of exclusive service areas is unnecessary to offer a new product because other insurers provide nationwide coverage without exclusive service areas. Fact 18. Nor is a group boycott necessary to achieve the efficiencies of integration that the Blues have claimed that the BlueCard program allows. *See* Doc. No. 2063 at 53–54. Even if there are procompetitive

justifications for BlueCard, it does not follow that the Blues may agree to exclude from their networks any Alabama provider who does not contract with BCBS-AL. *See Thompson v. Metro. Multi-List, Inc.*, 934 F.2d 1566, 1581–82 (11th Cir. 1991) (holding, on a rule of reason analysis, that requiring membership in the National Association of Realtors was not reasonably necessary to induce brokers to join a multiple listing service, and that if the defendant had market power, the district court "must find that the Realtor membership requirements are an illegal group boycott").

CONCLUSION

Through a horizontal agreement whose existence is undisputed, the Blues have decided that healthcare providers in Alabama can contract with all of the Blues on terms set by BCBS-AL, or with none of them. The providers have no choice but to accept, because they cannot compete without access to commercial patients on an in-network basis, and the Blues collectively insure more than 80% of the commercial patients in the state. These circumstances meet the requirements for *per se* treatment of the Blues' group boycott.

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Respectfully submitted,

/s/ Edith M. Kallas
Edith M. Kallas – ***Co-Lead Counsel***
WHATLEY KALLAS, LLP
152 West 57th Street
41st Floor
New York, NY 10019
Tel: (212) 447-7060
Fax: (800) 922-4851
Email: ekallas@whatleykallas.com

/s/ Joe R. Whatley, Jr.
Joe R. Whatley, Jr. – ***Co-Lead Counsel***
W. Tucker Brown
WHATLEY KALLAS, LLP
2001 Park Place North
1000 Park Place Tower
Birmingham, AL 35203
Tel: (205) 488-1200
Fax: (800) 922-4851
Email: jwhatley@whatleykallas.com
tbrown@whatleykallas.com

Patrick J. Sheehan
WHATLEY KALLAS, LLP
101 Federal Street, 19th Floor
Boston, MA 02110
Tel: (617) 573-5118
Fax: (617) 371-2950
Email: psheehan@whatleykallas.com

Deborah J. Winegard
WHATLEY KALLAS, LLP
1068 Virginia Avenue, NE
Atlanta, GA 30306
Tel: (404) 607-8222
Fax: (404) 607-8451
Email: dwinegard@whatleykallas.com

Henry C. Quillen
WHATLEY KALLAS, LLP
159 Middle Street, Suite 2C
Portsmouth, NH 03801
Tel: (603) 294-1591
Fax: (800) 922-4851
Email: hquillen@whatleykallas.com

E. Kirk Wood, Jr. – ***Local Facilitating Counsel***
WOOD LAW FIRM LLC
P. O. Box 382434
Birmingham, AL 35238
Tel: (205) 612-0243
Fax: (205) 705-1223
Email: ekirkwood1@bellsouth.net

Charles Clinton Hunter
HAYES HUNTER PC
4265 San Felipe, Suite 1000
Houston, TX 77027
Tel: (281) 768-4731
Fax: (713) 583-7047
Email: chunter@hayeshunterlaw.com

Aaron S. Podhurst – ***Plaintiffs' Steering Committee***
Peter Prieto – ***Chair, Expert Committee***
PODHURST ORSECK, P.A.
One S.E. 3rd Avenue
Suite 2300
Miami, FL 33131
Tel: (305) 358-2800
Fax: (305) 358-2382
Email: apodhurst@podhurst.com
pprieto@podhurst.com

Dennis Pantazis – ***Plaintiffs' Steering Committee***
Brian Clark – ***Discovery Committee***
WIGGINS CHILDS PANTAZIS FISHER GOLDFARB
The Kress Building
301 Nineteenth Street North
Birmingham, AL 35203
Tel: (205) 314-0500
Fax: (205) 254-1500
Email: dgp@wcqp.com
bclark@wcqp.com

U.W. Clemon – ***Plaintiffs' Steering Committee***
U. W. Clemon, LLC
5202 Mountain Ridge Parkway
Birmingham, AL 35222
Tel: (205) 837-2898
Email: uwclemon1@gmail.com

Dennis C. Reich – ***Chair, Damages Committee***
REICH & BINSTOCK, LLP
4265 San Felipe, Suite 1000
Houston, TX 77027
Tel: (713) 622-7271
Fax: (713) 623-8724
Email: dreich@rbfirm.net

J. Mark White – ***Litigation Committee***
Augusta S. Dowd – ***Chair, Litigation Committee***
Linda G. Flippo – ***Discovery Committee***
WHITE ARNOLD & DOWD, P.C.
The Massey Building
2025 Third Avenue North, Suite 500
Birmingham, AL 35203
Tel: (205) 323-1888
Fax: (205) 323-8907
Email: mwhite@whitearnolddowd.com
adowd@whitearnolddowd.com
lflippo@whitearnolddowd.com

Nicholas B. Roth – ***Chair, Discovery Committee***
Julia Smeds Roth – ***Discovery Committee***
EYSTER KEY TUBB ROTH MIDDLETON & ADAMS, LLP
402 East Moulton Street, SE
Decatur, AL 35602
Tel: (256) 353-6761
Fax: (256) 353-6767
Email: nbroth@eysterkey.com
jroth@eysterkey.com

Van Bunch – ***Chair, Class Certification Committee***
BONNETT FAIRBOURN FRIEDMAN & BALINT, P.C.
2325 E. Camelback Road, Suite 300
Phoenix, AZ 85016
Tel: (602) 274-1100
Fax: (602) 274-1199
Email: vbunch@bffb.com

David A. Balto – ***Expert Committee***
THE LAW OFFICES OF DAVID A. BALTO
1350 I Street, N.W., Suite 850
Washington, DC 20005
Tel: (202) 789-5424
Fax: (202) 589-1819
Email: david.balto@dcantitrustlaw.com

Robert J. Axelrod – ***Chair, Written Submissions Committee***
AXELROD LLP
800 Third Avenue, Suite 2800
New York, NY 10022
Tel: (646) 448-5263
Fax: (212) 840-8560
Email: rjaxelrod@axelrodllp.com

Joey K. James – ***Litigation Committee***
BUNCH & JAMES
P. O. Box 878
Florence, AL 35631
Tel: (256) 764-0095
Fax: (256) 767-5705
Email: joey@bunchandjames.com

W. Daniel Miles, III – ***Written Submissions Committee***
BEASLEY ALLEN CROW METHVIN PORTIS & MILES, P.C.
218 Commerce Street
Montgomery, AL 36104
Tel: (800) 898-2034
Fax: (334) 954-7555
Email: dee.miles@beasleyallen.com

Richard S. Frankowski – ***Discovery Committee***
THE FRANKOWSKI FIRM, LLC
231 22nd Street South, Suite 203
Birmingham, AL 35233
Tel: (205) 390-0399
Fax: (205) 390-1001
Email: richard@frankowskifirm.com

Michael C. Dodge – ***Expert Committee***
GLAST PHILLIPS & MURRAY, P.C.
14801 Quorum Drive, Suite 500
Dallas, TX 75254
Tel: (972) 419-7172
Email: mdodge@gpm-law.com

John C. Davis – ***Written Submissions Committee***
LAW OFFICE OF JOHN C. DAVIS
623 Beard Street
Tallahassee, FL 32303
Tel: (850) 222-4770
Email: john@johndavislaw.net

Michael E. Gurley, Jr. – ***Discovery Committee***
Attorney at Law
24108 Portobello Road
Birmingham, AL 35242
Tel: (205) 908-6512
Email: mgurleyjr@yahoo.com

Mark K. Gray – ***Discovery Committee***
GRAY & WHITE
713 E. Market Street, Suite 200
Louisville, KY 40202
Tel: (502) 805-1800
Fax: (502) 618-4059
Email: mgray@grayandwhitelaw.com

Lynn W. Jinks, III – ***Expert Committee***
Christina D. Crow – ***Discovery Committee***
JINKS CROW & DICKSON, P.C.
219 North Prairie Street
Union Springs, AL 36089
Tel: (334) 738-4225
Fax: (334) 738-4229
Email: ljinks@jinkslaw.com
ccrow@jinkslaw.com

Stephen M. Hansen – ***Class Certification Committee***
LAW OFFICE OF STEPHEN M. HANSEN
1821 Dock Street
Tacoma, WA 98402
Tel: (253) 302-5955
Fax: (253) 301-1147
Email: steve@stephenmhansenlaw.com

Myron C. Penn – ***Discovery Committee***
PENN & SEABORN, LLC
53 Highway 110
Post Office Box 5335
Union Springs, AL 36089
Tel: (334) 738-4486
Fax: (334) 738-4432
Email: myronpenn28@hotmail.com

Harley S. Tropin – ***Damages Committee***
Javier A. Lopez – ***Discovery Committee***
KOZYAK TROPIN &
THROCKMORTON, P.A.
2525 Ponce De Leon Boulevard, 9th Floor
Miami, FL 33134
Tel: (305) 372-1800
Fax: (305) 372-3508
Email: hst@kttlaw.com
jal@kttlaw.com

J. Preston Strom, Jr. – ***Litigation Committee***
STROM LAW FIRM, LLC
2110 N. Beltline Boulevard, Suite A
Columbia, SC 29204-3905
Tel: (803) 252-4800
Fax: (803) 252-4801
Email: petestrom@stromlaw.com

C. Wes Pittman – ***Settlement Committee***
THE PITTMAN FIRM, P.A.
432 McKenzie Avenue
Panama City, FL 32401
Tel: (850) 784-9000
Fax: (850) 763-6787
Email: wes@pittmanfirm.com

Thomas V. Bender – ***Discovery Committee***
Dirk L. Hubbard
HORN AYLWARD & BANDY, LLC
2600 Grand Blvd., Suite 1100
Kansas City, MO 64108
Tel: (816) 421-0700
Email: tbender@hab-law.com
dhubbard@hab-law.com

Robert B. Roden – ***Litigation Committee***
SHELBY RODEN, LLC
2956 Rhodes Circle
Birmingham, AL 35205
Tel: (205) 933-8383
Fax: (205) 933-8386
Email: rroden@shelbyroden.com

Gregory S. Cusimano – ***Litigation Committee***
CUSIMANO, ROBERTS & MILLS, LLC
153 South 9th Street
Gadsden, AL 35901
Phone: (256) 543-0400
Fax: (256) 543-0488
Email: greg@alalawyers.net

Gary E. Mason – ***Class Certification Committee***
WHITFIELD BRYSON & MASON, LLP
1625 Massachusetts Ave. NW, Suite 605
Washington, DC 20036
Tel: (202) 429-2290
Fax: (202) 640-1160
Email: gmason@wbmllp.com

Brian E. Wojtalewicz
WOJTALEWICZ LAW FIRM, LTD.
139 N. Miles Street
Appleton, MN 56208
Tel: (320) 289-2363
Fax: (320) 289-2369
Email: brian@wojtalewiczlawfirm.com

Michael L. Murphy – ***Discovery Committee***
BAILEY GLASSER LLP
910 17th Street, NW, Suite 800
Washington, DC 20006
Tel: (202) 463-2101
Fax: (202) 463-2103
Email: mmurphy@baileyglasser.com

Archie C. Lamb, Jr.
ARCHIE LAMB & ASSOCIATES, LLC
301 19th Street North, Suite 585
The Kress Bldg.
Birmingham, AL 35203-3145
(205) 458-1210
Email: alamb@archielamb.com

Lance Michael Sears
SEARS & SWANSON, P.C.
First Bank Building
2 North Cascade Avenue, Suite 1250
Colorado Springs, CO 80903
Tel: (719) 471-1984
Fax: (719) 577-4356
Email: lance@searsassociates.com

Paul Lundberg
LUNDBERG LAW, PLC
600 4TH Street, Suite 906
Sioux City, IA 51101
Tel: (712) 234-3030
Fax: (712) 234-3034
Email: paul@lundberglawfirm.com

Jessica Dillon
Ray R. Brown
Molly Brown
DILLON & FINDLEY, P.C.
1049 W. 5th Avenue, Suite 200
Anchorage, AK 99501
Tel: (907) 277-5400
Fax: (907) 277-9896
Email: Jessica@dillonfindley.com
Ray@dillonfindley.com
Molly@dillonfindley.com

Cynthia C. Moser
HEIDMAN LAW FIRM
1128 Historic 4th Street
P. O. Box 3086
Sioux City, IA 51101
Tel: (712) 255-8838
Fax (712) 258-6714
Email: Cynthia.Moser@heidmanlaw.com

Gwen Simons
Simons & Associates Law, P.A.
P.O. Box 1238
Scarborough, ME 04070-1238
Tel: (207) 205-2045
Fax: (207) 883-7225
Email: gwen@simonsassociateslaw.com