Illinois District Court Accepts Narrow Product Market with No Government Payers

The TakeAway

On March 25, 2015, a federal district court in Illinois denied dominant provider OSF Healthcare System's motion for judgment on the pleadings (reviewed under same standard as a motion to dismiss) in an antitrust suit filed against OSF by rival Methodist Health Services Corporation. The upshot of the opinion is that the court allowed Methodist to proceed with a product market definition that includes medical services sold to commercial health insurers, but expressly excludes the same services sold to government payers. This case importantly varies from some recent precedent in which courts declined to accept the same "narrow" market definition. Judicial recognition of the well-known distinctions between these two markets will likely be key for future plaintiffs, as well. Read on for details on the facts and the court's analysis. Access the full opinion here.

Claims

Methodist's complaint alleged 11 claims in connection with OSF's alleged exclusive dealing arrangements with commercial health insurers including Midwest giant Blue Cross/Blue Shield that kept Methodist from contracting those insurers. Methodist's federal law claims include Sherman Act Section 1 exclusive dealing, Section 2 monopolization and attempted monopolization, and state law antitrust, tort and consumer protection claims. The court's denial of this motion means that the case will continue on to discovery.

The Parties and Players

Plaintiff Methodist is an integrated health care delivery system located in Peoria, Illinois that contains an acute care hospital. Defendant OSF operates St. Francis Medical Center, another acute care hospital also located in Peoria. Although both

Methodist and St. Francis provide acute care services, St. Francis offers some essential services, including organ transplant, tertiary pediatric services, NICU and Level I Trauma care that are not offered by Methodist.

In addition to St. Francis and Methodist, there are four other hospitals and several non-hospital-based providers that provide outpatient surgical services in the relevant geographic area. According to the Complaint, because St. Francis is the only local provider of certain essential medical services, most health insurance companies in the area consider it a "must-have" participating provider in their networks.

Geographic Market

The alleged relevant geographic market includes Peoria, Tazewell and Woodford Counties in Illinois. This market definition does not appear to be in dispute.

Product Markets &amp|Shares

Methodist alleged two relevant product markets: (1) the sale of inpatient hospital services to commercial health insurers and (2) the sale of outpatient surgical services to commercial insurers. "Commercial health insurers" includes managed-care organizations, other HMOs or PPOs, and employer self-funded plans. ***These product markets expressly exclude government payers, including Medicare, Medicaid, and TRICARE***.

Methodist excluded government payers from the product market definition because the prices government payers pay for medical services do not significantly constrain those paid by commercial insurers, who negotiate their rates with providers separately and individually. With government payers, there is no negotiation|the payer sets the price.

Methodist claims that St. Francis enjoys a 53% market share for inpatient hospital services and 50% share for outpatient surgical services sold to commercial health insurers.

Anticompetitive Conduct &amp|Harm

Methodist alleges that St. Francis has achieved market power in the relevant

markets through its size and "must-have" status, and, as a result, charges higher prices and demands and receives certain terms in its contracts with commercial health insurers. Specifically, Methodist alleges that St. Francis has threatened the insurers with leaving their networks—and taking its essential services with it—or imposing severe pricing penalties, should the insurers include competing providers in their networks.

Methodist says it (and other providers besides St. Francis) has been foreclosed from 60% of the fully insured commercial insurance market as a result of St. Francis' exclusive deals with BCBS (the largest insurer in the relevant geographic market), Humana, Aetna, and Health Alliance. Methodist explains that inclusion in commercial health insurance markets is crucial to providers because patients almost always seek in-network providers. Methodist says this foreclosure threatens its long-term sustainability. Moreover, it cannot make up for the losses suffered as a result of this foreclosure by treating more Medicare patients because hospitals depend on payments from commercial health insurer to compensate for the relatively low payments from government payers.

In short, Methodist alleges that these contracts are illegal exclusive dealing arrangements undertaken as part of a monopolization scheme, and that Methodist has suffered competitive harm as a result.

The Court's Analysis

The critical issue in this motion is Methodist's exclusion of government payers from its product market definition. The product market definition is essential to both the analysis of the exclusive dealing arrangements under Section 1 of the Sherman Act and the monopolization analysis under Section 2 of the Act.

In its motion, OSF cited Eighth Circuit and Illinois district court precedent to argue that a product market that excluded government payers was implausibly narrow. The Eighth Circuit, in 2009, affirmed a lower court's ruling in *Little Rock Cardiology Clinic PA v. Baptist Health* that a similar product market definition excluding government payers was deficient because patients using private insurance were reasonably interchangeable with those using government insurance. The Southern District of Illinois, in 2013, relying on *Little Rock*, ruled in *Marion Healthcare v.*

Southern Ill. Healthcare that a similar product market definition was implausible, not because of interchangeability, but because such a definition failed to include all potential buyers of the services at issue. Methodist countered that such an interchangeability analysis breaks with Supreme Court precedent in the seminal *Brown Shoe*.

Here, the district court declined to go with Eighth Circuit and proximate district court analysis of the product market issue. The court was persuaded by Methodist's arguments that: (1) access to commercially-insured patients is critical to hospitals' sustainability because government payers pay much less—even ***below cost*** sometimes—for the same services|and (2) government prices do not significantly constrain providers' pricing to commercial healthcare insurers (providers can target insurers exclusively for price increases, whereas government payers, and not providers, set the relevant rates arrangements between those entities). Accordingly, the court ruled that it could not find, as a matter of law, that the sales of inpatient hospital services and outpatient services to commercial insurers were interchangeable with the sales of the same services to government payers.

OSF also argued for dismissal on the grounds that Methodist failed adequately to plead foreclosure from the relevant market. On this point, the court ruled that Methodist's allegations raised open questions of fact. To grant a motion for judgment on the pleadings, the court must find that the moving party has established that no genuine issue of material fact exists, and a judgment as a matter of law is warranted. Here, the court believed a factual issue remained as to the foreclosure issue, and therefore declined to grant OSF's motion on these grounds.

We look forward to following future developments in this case!