IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN

AETNA INC.	)	Civil Action No.
Plaintiff,	)	COMPLAINT
v.	)	JURY TRIAL DEMANDED
BLUE CROSS BLUE SHIELD OF MICHIGAN, a Michigan nonprofit healthcare corporation,	)	
Defendant.	)	

Aetna Inc. ("Aetna"), brings this antitrust action for treble damages and injunctive relief against defendant Blue Cross Blue Shield of Michigan ("Blue Cross") and alleges, based on personal knowledge as to its own acts and otherwise based on information and belief, the following claims for Blue Cross' violations of Section 1 of the Sherman Act, 15 U.S.C. § 1 and Section 2 of the Michigan Antitrust Reform Act, MCL 445.772.

1. Blue Cross, the dominant provider of health insurance and administrative services to managed care plans in Michigan for decades, has implemented a scheme to use ever-increasing premiums from the patients and employers it serves in order to protect its dominant position and thwart competition from Aetna and other competitors. Stated simply, Blue Cross has entered into exclusionary contracts with hospitals under which it agreed to pay hospitals more money if the hospitals increased the rates they demanded to treat patients covered by its competitors' health plans.

2. Beginning in 2005, Aetna made an enormous investment to expand its business operations in Michigan and to challenge Blue Cross' dominance, including a nearly $390 million

acquisition of Michigan-based HMS Healthcare ("HMS"). Through these efforts, Aetna sought to bring competition to the Michigan marketplace, provide the benefits of its superior products and services to Michigan employers and consumers, and lower healthcare costs to Michigan employers and consumers. When Aetna began to make inroads in Michigan and threatened Blue Cross' dominance, Blue Cross responded with an anticompetitive scheme aimed at thwarting competition by increasing the rates that Aetna and other competitors would pay for hospital services.

3. Much of the cost of Blue Cross' scheme has fallen on employers and consumers in Michigan. Blue Cross obtained the funds it used to pay hospitals more by regularly and consistently increasing the premiums its customers must pay. Likewise, Blue Cross pushed its competitors' premiums higher by forcing hospitals to increase the rates they charged to those competitors. And when Aetna began to make inroads by offering superior products and services to Michigan employers and consumers, Blue Cross sought to prevent employers and consumers from obtaining those benefits by increasing Aetna's medical costs and premiums through exclusionary contracts with hospitals across Michigan. Thus, at the very time when Michigan employers and consumers were suffering from the crushing effects of the recession and increasing healthcare costs, Blue Cross increased their pain through its anticompetitive scheme.

4. Aetna seeks to recover the harm it has suffered as a result of Blue Cross' scheme and to ensure there will be effective competition in the future by precluding Blue Cross' further use of its exclusionary contracts. Under some of Blue Cross' exclusionary contracts, hospitals have been required to charge Aetna (and others) substantially more than Blue Cross – as much as 39 percent more. And under other exclusionary contracts, the hospitals have been required to increase Aetna's previously favorable rates until they were at least as high as Blue Cross' rates.

Unlike traditional most-favored-nations clauses, Blue Cross' exclusionary contracts were not designed to secure the lowest price possible from suppliers. Instead, Blue Cross perversely agreed to pay higher rates to those hospitals that entered into exclusionary contracts, and it explicitly threatened to pay lower rates if hospitals declined to enter into such agreements. Blue Cross thus used its exclusionary contracts to ensure that Aetna's attempt to expand in Michigan was thwarted.

5. Blue Cross' exclusionary contracts have stifled competition in the provision of health insurance and administrative services throughout Michigan. Blue Cross' exclusionary contracts have (1) inflated prices paid to hospitals by Blue Cross' competitors, including Aetna, and the customers they serve; (2) reduced or eliminated the ability of Aetna and others to offer attractive services in competition with Blue Cross; (3) decreased the variety and quality of health plans available to Michigan purchasers; (4) increased the prices its own customers must pay; and (5) substantially injured Aetna's business in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, and Section 2 of the Michigan Antitrust Reform Act, MCL 445.772.

I. DEFENDANT, JURISDICTION, VENUE, AND INTERSTATE COMMERCE

6. Defendant Blue Cross is a Michigan nonprofit healthcare corporation headquartered in Detroit, Michigan. Blue Cross is subject to federal taxation but is exempt from state and local taxation under Michigan law. Directly and through its subsidiaries, Blue Cross provides health insurance and administrative services, including preferred provider organization ("PPO") health insurance products and health maintenance organization ("HMO") health insurance products.

7. Plaintiff Aetna provides health insurance and administrative services in competition with Blue Cross. Aetna operates in many states within the United States, offering over 35 million people access to health plans including PPO and HMO products. Aetna brings

this action pursuant to Section 4 and Section 16 of the Clayton Act, 15 U.S.C. § 15, based on injuries Aetna has suffered as a result of Blue Cross' violations of Section 1 of the Sherman Act, 15 U.S.C. § 1, and pursuant to Section 2 of the Michigan Antitrust Reform Act, MCL 445.772.

8. This Court has subject matter jurisdiction over Aetna's Clayton Act claim and jurisdiction over the defendant pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1331, and/or 28 U.S.C. § 1337(a), and this Court has supplemental jurisdiction over Aetna's claim under MCL 445.772 pursuant to 28 U.S.C. § 1367 and principles of pendent jurisdiction.

9. Blue Cross and Aetna are engaged in interstate commerce and in activities substantially affecting interstate commerce, and the conduct alleged herein substantially affects interstate commerce. Among other things, increased prices for hospital services caused by Blue Cross' exclusionary contracts are, in some cases, paid by health insurers and self-insured employers across state lines. By increasing the costs of Blue Cross' competitors, the exclusionary contracts have impacted the products and prices Blue Cross' competitors can offer to potential customers in Michigan as well as other states. Moreover, both Aetna and Blue Cross provide health insurance and administrative services to Michigan residents when they travel across state lines, purchase health care in interstate commerce when Michigan residents require health care out of state, and receive payments from customers located outside Michigan.

10. Blue Cross maintains its principal place of business and transacts business in this District, and is subject to the personal jurisdiction of this Court. Venue is proper in this District under Section 12 of the Clayton Act, 15 U.S.C. § 22. Blue Cross developed its exclusionary policy in substantial part in this District, and entered into exclusionary contracts with hospitals in this District and elsewhere. In this District and elsewhere, Blue Cross' conduct has harmed

Aetna, raised hospital and insurance prices, and threatens to further increase prices and harm consumers.

II. HEALTH INSURANCE AND ADMINISTRATIVE SERVICES IN MICHIGAN

11. In Michigan, as throughout the United States, individuals who are not eligible for Medicare or Medicaid (which are available only to the disabled, elderly, or indigent), typically obtain health insurance and administrative services through commercial managed care companies, such as Aetna and Blue Cross. As explained in detail below, Aetna and Blue Cross compete to provide: (1) administrative services to health plans underwritten by self-insured employers or other groups; (2) insurance plus administrative services to employer or group health plans, which are referred to as "fully insured" plans; and (3) insurance plus administrative services to individuals ("individual health insurance"). As explained below, in all of these cases, access to the managed care company's provider network is a central component of the administrative services provided by Aetna, Blue Cross, and other competing providers of health insurance and administrative services.

12. Employed individuals are most often members of health plans made available through their employers, which typically pay the greater share of insurance premiums. In 2008, approximately 53% of Michigan residents obtained coverage through employer-provided health plans or other group health plans. Employers provide group health plans on either a "fully insured" or a "self-insured" (sometimes called "self-funded") basis. Under self-insured health plans, the employer bears the financial burden to pay for the medical services received by plan members (though in some cases the employer's exposure may be limited by stop-loss insurance). Self-insurance is the preferred option for many employers, including many large employers.

13. Employers that self-insure usually contract with a managed care company to obtain administrative services including: access to a health care provider network (including

hospitals, physicians, and other health care providers) subject to negotiated fee schedules; utilization management tools and programs (such as case management to assist members in managing their illnesses, programs to provide members with access to effective care for difficult conditions, disease management services for members with chronic conditions, information hotlines with 24-hour access to registered nurses, review of certain services or courses of treatment, prenatal care programs, and other programs designed to promote members' health and reduce their need for less efficient forms of medical services); and other services (such as claims processing and payment, coordinating benefits with other sources of coverage, assisting employers in the setup and design of a plan, and assisting employers in the administration of a plan). These administrative services are provided to self-funded employers by managed care companies through agreements generally referred to as either "administrative services only" ("ASO") arrangements or "Administrative Services Contracts" ("ASCs"). Blue Cross is the largest provider of ASO services in Michigan. Blue Cross processed almost $11 billion in health care claims for self-insured employers in 2009. Approximately half of Blue Cross' health insurance business is self-insurance business. Blue Cross earned more than $750 million in ASO fees in 2009. Aetna competes with Blue Cross to offer ASO services in Michigan to self-insured employers.

14. Employers or other groups that do not find it attractive to self-insure their health plans seek "fully insured" plans, in which the insurer bears the financial risk that claims for medical services will exceed the amount paid in premiums. Fully insured plans thus demand health insurance underwriting in addition to the types of administrative services demanded by self-insured plans (as described in the preceding paragraph), including access to a health care provider network. In Michigan, as in most regions, managed care companies that provide ASO

services to self-insured plans typically also offer fully insured health plans to both groups and individuals. Individuals are unable to self-insure and contract for services on an ASO basis, and thus, like employers and groups that elect fully insured plans, individuals desire both health insurance underwriting and administrative services.[1]

15. Under both fully insured and self-insured plans, a critical aspect of competition between Aetna, Blue Cross, and other managed care companies is their ability to offer plan sponsors and plan members a set of tools to manage health care costs. The challenge posed by escalating healthcare costs is widely recognized, and employers and individuals alike value the critical role played by managed care companies' creative cost-control solutions. At a very high level, the medical costs that are incurred by the members of a group health plan are a product of the plan members' utilization of health care services (that is, the volume and type of medical services that they consume) and the rates paid for those services. The higher the medical costs, the higher the premiums paid by employers and plan members. Conversely, the better an administrative services provider is able to manage medical costs (while still providing plan members with a high quality of medical care), the more attractive its products and services are to employers and individuals. Aetna, Blue Cross, and other providers of insurance and administrative services thus compete aggressively on the basis of their ability to manage medical costs (as well as other dimensions of competition, such as customer service, low administrative costs, and other factors).

16. A key component of this competition is the health care provider network offered by providers of insurance and administrative services. Providers of insurance and administrative services enter into contracts with health care providers (including hospitals, physicians, and other

[1] In 2008, about 7% of Michigan residents obtained individual health insurance directly from insurers, including Blue Cross and Aetna.

types of providers) that establish negotiated rates for the providers' services, which are often substantially less than the providers' list prices. When a plan member receives health care services from a provider in the network, the insurer or self-insured employer pays the health care provider at this favorable "in-network" rate. The plan member, in turn, is generally responsible only for a co-pay, a deductible, or a small portion of the cost specified in the health plan. Network rates are a critical factor in the competition for customers between Aetna, Blue Cross, and other providers of insurance and administrative services, because medical costs are closely tied to the network rates, and premium levels are directly tied to medical costs. Moreover, with respect to HMO and PPO plans, Michigan law mandates that plan members must have access to a network of affiliated providers sufficient to assure that covered services are available without unreasonable delay and in reasonable proximity to the recipients of those services. *See* MCLA 500.3530 (requirement for HMO plans); MCLA 500.53 (requirement for PPO plans).

17. With respect to hospitals, providers of insurance and administrative services generally negotiate a discount to be applied to a standardized hospital fee schedule. The standardized schedule could be set forth as a master list of hospital fees for services (referred to in the industry as a "chargemaster"), a schedule of fees for treatment of particular illnesses (typically based on "diagnosis-related groups" or "DRGs" as defined by Medicare and Medicaid), or on another basis. The hospital costs incurred by a provider of insurance and administrative services are thus directly tied to the discounts it is able to negotiate from the standardized hospital fee schedule. Likewise, the price of services at individual hospitals directly affects the premiums that a provider of insurance and administrative services is able to offer for plan sponsors and plan members that use those hospitals. Furthermore, because hospital costs are a significant portion of the medical costs incurred by a typical health plan, the hospital

discounts that a provider of insurance and administrative services is able to negotiate is an important element of its ability to offer competitive rates and products and to attract customers.

III. BLUE CROSS' EXCLUSIONARY CONTRACTS CONSTRAIN HOSPITALS FROM NEGOTIATING WITH BLUE CROSS' COMPETITORS, AND THESE AGREEMENTS HAVE HARMED AETNA AS WELL AS COMPETITION.

18. Blue Cross elicits two types of exclusionary contracts from Michigan hospitals. The first type requires a hospital to charge Blue Cross' competitors higher prices than Blue Cross pays for the same services. The second type requires a hospital to charge Blue Cross' competitors at least as much as Blue Cross' rates. If a hospital previously charged rates to a competitor of Blue Cross that were lower than Blue Cross' rates, the Blue Cross contract requires the hospital to raise the rate charged to the competitor. Both types of exclusionary contracts inhibit competition:

(A) "MFN-plus." Blue Cross' existing exclusionary contracts include agreements with 22 hospitals that require the hospitals to charge *more* for services to other providers of insurance and administrative services than the hospital would charge to the members of plans insured or administered by Blue Cross, typically by a specified percentage differential. These hospitals include major hospitals and hospital systems, including all of the major hospitals in some communities. These 22 hospitals operate approximately 45% of Michigan's tertiary care hospital beds. (A tertiary care hospital provides a full range of basic and sophisticated diagnostic and treatment services, including many specialized services.)

Moreover, at least two of Blue Cross' exclusionary hospital contracts prohibit the hospitals from giving Blue Cross' competitors better discounts than they currently receive during the life of the Blue Cross contracts. In other words, Blue Cross has ensured that these hospitals can never grant more favorable rates to a Blue Cross competitor regardless of any change in

circumstances (e.g., an innovation that reduces the costs of medical services, an increase in the competitor's scale or efficiency, etc.).

Blue Cross' MFN-plus clauses guarantee that at impacted hospitals Blue Cross' competitors cannot obtain hospital services at prices comparable to the prices Blue Cross pays, which limits their ability to compete with Blue Cross. Blue Cross has sought and, on most occasions, obtained MFN-plus clauses in hospital contracts that also included significant rate increases.

(B) "Equal-to MFNs." Blue Cross has entered into agreements with more than 40 small, community hospitals, which typically are the only hospitals in their communities, under which the hospital is required to charge at least as much for services to other providers of insurance and administrative services as they charge for services provided to members of plans administered by Blue Cross. Predictably, and as Blue Cross intended, these contracts have not led the hospitals to lower the rates charged to Blue Cross plan members – instead, hospitals have increased the prices charged to Blue Cross' competitors, including Aetna. A community hospital that declined to enter into one of these agreements would be paid approximately 16% less by Blue Cross than if it agreed to Blue Cross' exclusionary terms. The effect of these agreements has been for Blue Cross to pay *more* to community hospitals, which Blue Cross refers to as "Peer Group 5" hospitals, raising Blue Cross' own costs and its customers' costs, only on the condition that the hospitals agree to handicap Blue Cross' competitors. Accordingly, although these contracts have been referred to elsewhere as containing "MFN" or "equal-to MFN" clauses, they are unlike traditional most-favored-nation clauses because they are not designed to obtain the best price available for Blue Cross and are instead aimed at excluding competition. Blue Cross has also entered into similar contracts with some larger hospitals, with the same effect.

19. In sum, Blue Cross has sought and obtained exclusionary contracts with many hospitals in exchange for increases in the prices it pays for the hospitals' services. In these instances, Blue Cross has purchased protection from competition by placing constraints on its competitors' ability to negotiate with hospitals, and in doing so has also increased its own costs. Blue Cross has not sought or used these exclusionary contracts to lower its own cost of obtaining hospital services, and its exclusionary contracts cannot be justified on this or any other efficiency rationale. Moreover, even if there were some potential efficiency benefit from Blue Cross' exclusionary contracts, any such benefit would be outweighed by their substantial foreclosure effect on Blue Cross' competitors and their dramatic negative impact on competition and consumers.

IV. BLUE CROSS' MARKET POSITION AND AETNA'S CHALLENGE TO ITS DOMINANCE

20. For years, Blue Cross has been the dominant private provider of insurance and administrative services in Michigan, with revenues in excess of $10 billion in 2009. Blue Cross provides insurance and administrative services for at least 60% of the commercial health plan population, more than nine times as many Michigan residents as its next largest competitor.

21. Blue Cross is also the largest non-governmental purchaser of health care services, including hospital services, in Michigan. Blue Cross-administered plans purchase hospital services from all 131 general acute care hospitals in the state, more than $4 billion in hospital services in 2007. Blue Cross-administered plans purchase hospital services in such large quantities that hospitals have no choice but to accede to Blue Cross' demands, even when Blue Cross seeks to restrain competition in ways that harm its competitors, plan sponsors, and plan members. Indeed, several hospitals have informed Aetna in writing that they had no desire to raise the prices charged to Aetna, but that the hospitals had no choice due to pressure from Blue

Cross. For example, one hospital told Aetna that it was forced to raise Aetna's prices because it had entered into an exclusionary contract with Blue Cross, stating "I hope you understand that we just don't have a choice in this matter. Blue Cross is 30% of our business, we cant [sic] put that in jeopardy."[2] Another hospital was similarly coerced to raise Aetna's prices because it had entered into an exclusionary contract with Blue Cross, stating: "since the payer in question represents upwards of thirty percent of our business . . . and the penalties for non-compliance are extensive to the point where we can not afford to be out of compliance, [we] must insist on this amendment to our payment schedule."

22. Blue Cross' dominance in Michigan was largely unchallenged for many years, until late 2005 when Aetna mounted a serious effort to penetrate the market. In or around 2005, Aetna saw an opportunity to substantially expand its business in Michigan and mount a head-on challenge to Blue Cross' dominance. In particular, there was a demand in Michigan for more managed care choices, and there was a demand for the sort of products and services that Aetna – as a strong national competitor with innovative products and services for obtaining high-quality healthcare for plan members with low utilization rates and low medical costs – was able to provide. As the dominant player in the marketplace, Blue Cross was not providing these innovative products and services, and this void created an opportunity for Aetna.

23. However, Aetna believed it needed to improve its provider network in Michigan to mount a serious challenge to Blue Cross. Aetna thus invested nearly $390 million to acquire HMS Healthcare in order to gain access to HMS's network of Michigan hospitals and doctors, which was operated under the trade name PPOM. In contrast to Aetna's pre-acquisition provider

[2] It is consistent for Blue Cross' plans to account for at least 60% of the Michigan commercial health plan population, but only 30% of a hospital's business, because about 43% of hospital business in Michigan consists of commercial insurance. (60% of 43% is about 26%.) In Michigan, Medicare accounts for about 40% of hospital business, Medicaid accounts for about 13%, and uncompensated care accounts for about 4%.

network, the PPOM network offered complete coverage throughout the state of Michigan, and it offered access to hospitals at advantageous rates that in many cases were significantly lower than the rates providers charged to the pre-acquisition Aetna provider network. Combined with Aetna's superior tools for managing healthcare utilization, the complete coverage and advantageous rates of the PPOM network would allow Aetna to provide lower medical costs and lower premiums, directly challenging Blue Cross.

24. Prior to the acquisition of HMS by Aetna, no competitor had been able to challenge Blue Cross with the combination of (a) a national managed care company's services, strategies, and tools for managing utilization and medical costs, technology for claims processing, high-quality customer service, and national brand recognition, along with (b) a competitive network of rates negotiated with hospitals and providers throughout Michigan (such as the PPOM network), and (c) PPOM's on-the-ground presence in local areas throughout the state. That changed in June 2005, when Aetna announced that it would acquire HMS to gain access to the PPOM network. At the same time, Aetna expanded its sales force in Michigan and engaged in marketing efforts aimed at demonstrating a commitment to the Michigan marketplace and to providing services that would offer a new and refreshing competitive alternative to Blue Cross. Through this approach, Aetna undertook a major entry into the Michigan marketplace, and it aimed at challenging Blue Cross' dominance as no competitor had done before.

25. Aetna's aggressive entry into Michigan initially proved a great success, meeting or exceeding expectations. Aetna more than doubled the number of members covered through fully insured large Michigan accounts (referred to as "Select Accounts") from 4,600 in 2005 to over 10,000 in 2006, and then increased further to 17,600 in 2007. Select Accounts revenues nearly quintupled, from $11.2 million in 2005 to more than $52.8 million in 2007. Aetna's

"small group" membership experienced similar success – Aetna's small group coverage extended to only 1,500 Michigan residents in 2005, but grew to 12,700 in 2006 and then to more than 27,000 in 2007. Revenues likewise grew from $1.7 million in 2005 to more than $58 million in 2007.etna's aggressive entry into Michigan initially proved a great success, meeting or exceeding expectations. Aetna's fully insured large Michigan accounts (referred to as "Select Accounts") and "small group" accounts experienced particularly strong growth from 2005 to 2007. By 2007, Aetna achieved more than $52.8 million in revenue from approximately 17,600 Select Accounts, and more than $58 million in revenue from 27,000 small group customers.

26. But as Aetna began to make competitive inroads in Michigan, win important accounts, and build a reputation for providing a desirable alternative to Blue Cross, Blue Cross acted to strangle its nascent competitor. In particular, Blue Cross used its incumbent power to impose exclusionary contracts on hospitals that limited hospitals' ability to negotiate prices with Aetna, ensuring that Aetna could not negotiate for favorable rates, or even maintain the favorable rates negotiated by PPOM.

27. Soon after Blue Cross sought to enforce its exclusionary contracts, one hospital after another approached Aetna and stated that they would have to raise the rates that PPOM/Aetna had previously negotiated. More than a dozen hospitals and hospital systems across Michigan made such demands to Aetna. For example, Spectrum Health Kelsey Hospital (Lakeview, Michigan) and Harbor Beach Community Hospital (Harbor Beach, Michigan) demanded that Aetna accept rate increases of more than 25% due to the exclusionary provisions imposed by Blue Cross. When Aetna attempted to negotiate these rate increases, it was told by the hospitals that rate increases were non-negotiable because Blue Cross was exerting pressure on the hospitals to enforce its exclusionary contracts and because the hospitals could not afford

to resist the demands of Blue Cross. In numerous other instances, when Aetna attempted to negotiate to reduce its rates with hospitals, Aetna was told that the hospitals could not reduce Aetna's rates because of the coercive provisions in the hospitals' contracts with Blue Cross.

28. Blue Cross currently has agreements containing exclusionary provisions with at least 70 of Michigan's 131 general acute care hospitals. These 70 hospitals operate more than 40% of Michigan's acute care hospital beds. Blue Cross' coercive control over Aetna's ability to negotiate rates with such a significant number of Michigan hospitals has harmed Aetna's ability to compete with Blue Cross. Aetna's prices at hospitals began to rise in 2008 as Blue Cross began to enforce the exclusionary provisions of its contracts, and Aetna's discounts at hospitals deteriorated dramatically by July 2009, the date by which Blue Cross required all Peer Group 5 hospitals to comply fully with its exclusionary terms.

29. With Aetna's hospital rates and premiums artificially inflated as a direct result of Blue Cross' anticompetitive contracts, Aetna's effort to compete with Blue Cross deteriorated. For example, Aetna's Select Accounts membership in Michigan fell from 17,600 in 2007 to 13,000 in 2008, then to 8,600 in 2009, and to 6,200 in 2010. Small group membership fell from 27,000 in 2007 to 24,000 in 2008, then to 16,300 in 2009 and to 8,700 in 2010. In July 2010, Aetna announced that it could no longer offer small group insurance to Michigan consumers, effective February 2011.

30. The harm to Aetna's business in Michigan was a direct – and intended – result of Blue Cross' anticompetitive contracts. Blue Cross' exclusionary contracts constrained Aetna's ability to negotiate with hospitals, inflated its costs, and directly harmed its business. Blue Cross' exclusionary contracts likewise harmed consumers by harming competition in the relevant markets, reducing choice, and forcing consumers to pay higher prices.

V. RELEVANT MARKETS

31. Blue Cross has market power in a market for the sale of insurance and administrative services that includes access to Michigan-based provider networks. Blue Cross, Aetna, and other managed care companies compete to provide these services to self-funded health plans (through an administrative services contract). Blue Cross, Aetna, and other managed care companies also compete to provide these services in connection with fully insured health plans to groups as well as individuals.

32. Both the product component and geographic component of this market definition differentiate the sale of insurance and administrative services that include access to Michigan-based provider networks from any other products or services. With respect to the product component of the market definition, insurance and administrative services (as described in more detail in paragraph 13) that do not include access to a network of providers are not a reasonable substitute for insurance and administrative services that include access to a provider network. Under Michigan law, HMO and PPO plans are required to provide access to a network of contracted facilities that are capable of providing covered services in reasonable proximity to plan members (*see* paragraph 16). Moreover, even aside from these legal requirements, access to a provider network is an essential ingredient of insurance and administrative services from the point of view of most health plans, because providers' non-discounted rates are, in most cases, prohibitively expensive. It is only through access to a network that most plans can affordably cover the health care services procured by their members.

33. With respect to the geographic component of the market definition, access to a provider network outside the state of Michigan is not a reasonable substitute for access to a network within the state of Michigan. For example, Aetna's provider network in Connecticut or Ohio is not a reasonable substitute for a health plan seeking to cover plan members located in

Michigan. Plan members in Michigan cannot practicably travel to other areas to seek health care services from providers in networks in other areas.

34. Moreover, many plans serviced by Aetna, Blue Cross, and other providers of insurance and administrative services require access to a network that covers all local areas throughout the state of Michigan. This is because plan members in one local area (for example, Lansing) cannot practicably travel to another local area (for example, Jackson or Ann Arbor) if their health plan does not provide coverage in their local area. Thus, employers that have employees in local areas spread across the state typically require access to a state-wide network. In addition, employers with employees located in a narrower set of local areas may view a statewide network as essential because such a network provides coverage for employees wherever they travel in the state. For these employers, a provider network that provides affordable coverage only in portions of the state is not a reasonable substitute for a network that includes all local areas throughout the state.

35. Some Michigan residents without access to group health plans purchase individual health insurance from commercial health insurers. Individual health insurance is the only product available to individuals without access to a group plan or government programs that allows them to reduce the financial risk of adverse health conditions and to have access to a provider network that provides health care services at the discounted prices negotiated by commercial health insurers. There are no reasonable alternatives to individual health insurance for individuals who lack access to group health plans or government programs such as Medicare and Medicaid. Purchasing provider services (including hospital services) directly, rather than through a commercial insurer, is typically prohibitively expensive and is not a viable substitute for individual commercial health insurance. Patients without health insurance almost never

purchase hospital services directly from hospitals at prices comparable to prices paid by Blue Cross or other managed care companies. In addition, most individually-insured Michigan residents cannot practicably travel to other areas to seek health care services from providers in networks in other areas. Accordingly, from their point of view, individual health insurance products that lack access to networks of Michigan providers are not a reasonable substitute for individual health insurance products that provide access to networks of Michigan providers. Just as is the case for employers, some Michigan purchasers of individual insurance do not view networks limited to localized areas as substitutes for networks that grant access to providers in all local areas throughout the state.

36. There are, however, some individuals or employers that require access to a provider network only within a localized area. For example, an employer with only one facility may only be interested in procuring access to a network of providers in that local area. An employer in this situation may have a strong preference for access to the network in one area and may not be particularly concerned about the quality or rates of the network elsewhere. In light of the existence of such employers and individuals, there may be submarkets that are limited to local areas within the state of Michigan. Providers of insurance and administrative services that can offer access to localized healthcare provider networks can compete for business within these submarkets. Aetna has competed with Blue Cross in all submarkets that exist within Michigan.

37. If a provider network lacks relationships or cannot negotiate competitive rates with providers in one or more local areas, it is at a severe competitive disadvantage when offering services to health plans that desire a statewide network. For example, the exclusionary contract between Blue Cross and Edward W. Sparrow Hospital ("Sparrow"), in Lansing, affects all health plans desiring access to a network covering the Lansing Metropolitan Statistical Area

("MSA"), including health plans that desire statewide coverage and health plans that desire only local coverage in the Lansing area. Such health plans cannot practicably turn to providers of insurance and administrative services that do not offer network access to hospitals in the Lansing MSA. (MSAs and Micropolitan Statistical Areas are geographic areas defined by the U.S. Office of Management and Budget. An MSA contains a core urban area of 50,000 or more population, while a Micropolitan Statistical Area contains an urban core of at least 10,000 – but less than 50,000 – population.)

38. Blue Cross' unlawful contracts negatively impacted competition and harmed Aetna's business and consumers throughout the state of Michigan and in a number of local areas within the state of Michigan. Based on the information currently available to Aetna, the following are the local geographic areas in which Aetna's ability to compete with Blue Cross was hampered by Blue Cross' exclusionary contracts (in addition to harm throughout the state of Michigan).

a. The western and central Upper Peninsula (Alger, Baraga, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Marquette, Ontonagon, and Schoolcraft Counties), where Blue Cross has more than 65% of the commercial health plan population;

b. The Lansing MSA (Ingham, Clinton and Eaton Counties), where Blue Cross has approximately 70% of the commercial health plan population;

c. The Alpena area (Alpena and Alcona Counties), where Blue Cross has more than 80% of the commercial health plan population;

d. The Traverse City Micropolitan Statistical Area (Benzie, Grand Traverse, Kalkaska and Leelanau Counties), where Blue Cross has more than 60% of the commercial health plan population;

e. The "Thumb" area (Huron, Sanilac and Tuscola Counties), where Blue Cross has more than 75% of the commercial health plan population;

f. Each of the Detroit, Flint, Kalamazoo, and Saginaw MSAs, and the Alma and Midland Micropolitan Statistical Areas, in each of which Blue Cross has more than 50% of the commercial health plan population;

g. The Grand Rapids MSA, where Blue Cross has more than 45% of the commercial health plan population; and

h. Each of Allegan, Iosco, Montcalm, Osceola and St. Joseph Counties, in each of which Blue Cross has more than 40% of the commercial health plan population.

39. Blue Cross has an exclusionary contract with at least one significant hospital in each geographic area identified in the preceding paragraph. In the western and central Upper Peninsula, and in the Lansing, Detroit, Flint, Grand Rapids, Kalamazoo and Saginaw MSAs and the Alma and Midland Micropolitan Statistical Areas, Blue Cross has so-called MFN-pluses with at least one significant tertiary care hospital. In the Thumb and in Allegan, Iosco, Montcalm, Osceola and St. Joseph counties, Blue Cross has entered into exclusionary contracts with all of the hospitals, all of which are community hospitals, in the area.

40. The areas identified in paragraphs 38-39 approximate the areas served by the hospitals currently subject to Blue Cross' exclusionary contracts, and approximate the areas in which a supplier of insurance and administrative services requires a provider network, including primary and tertiary care hospitals, in order to compete effectively for health plans that require network coverage in that area. Most employed residents of each of these areas work within the area. Residents of these areas generally tend to use the tertiary care hospitals, if any, within these areas for tertiary care hospital services. Therefore, managed care providers such as Aetna

must include in their networks tertiary care hospitals in these areas in order to compete effectively in the sale of insurance and administrative services to health plans that require coverage in these areas.

41. Blue Cross has market power within the relevant market (and all submarkets that may exist within the relevant market). Blue Cross' market power is indicated in the first place by its market share – Blue Cross provides insurance and administrative services for at least 60% of the commercial health plan population within Michigan (see *supra* paragraph 20 & note 2). Moreover, Blue Cross' market power is reinforced by entry barriers that make it difficult for competing suppliers of managed care services to offer plans in competition with Blue Cross. The entry barriers in Michigan are particularly pronounced, in light of Blue Cross' longstanding dominant position. As noted above, Blue Cross is able to insist that hospitals agree to its demands because hospitals feel that they "just don't have a choice" except to placate Blue Cross, which makes it extraordinarily difficult for other competitors to develop a network that is capable of supporting meaningful competition with Blue Cross. Indeed, Blue Cross' ability to insist on and enforce the exclusionary contracts that Aetna challenges in this suit, even where hospitals indicated they would prefer not to raise prices to Aetna, provides direct evidence that Blue Cross is able to exclude competition from, and increase prices within, the relevant market.

42. Blue Cross' exclusionary contracts apply to hospitals located in most local areas throughout the state of Michigan, and they apply to services procured for both group plans and individual commercial health insurance plans. Likewise, Blue Cross' exclusionary contracts apply to both self-insured and fully insured group plans. And Blue Cross' exclusionary contracts have impaired its competitors' ability to offer attractive services to all health plans and individuals that desire coverage for the affected local areas – including health plans that desire

coverage only for those areas and for health plans that desire statewide coverage. Accordingly, the anticompetitive effects produced by the exclusionary contracts have impacted competition and have harmed Aetna in the sale of insurance and administrative services that include access to Michigan-based provider networks in all product market segments and in geographic areas throughout the state of Michigan.

VI. BLUE CROSS' EXCLUSIONARY CONTRACTS AND THEIR ANTICOMPETITIVE EFFECTS

The Exclusionary Contracts and Their Terms

43. Blue Cross currently has "MFN-plus" or "equal-to MFN" provisions in its contracts with more than half of Michigan's general acute care hospitals. Very few hospitals have refused Blue Cross' demands for an exclusionary contract. Other hospitals' contracts have not been renegotiated in recent years, but Blue Cross is likely to seek exclusionary provisions when its contracts with those hospitals come up for renegotiation.

44. Most of Blue Cross' exclusionary contracts require the hospital to "attest" or "certify" annually to Blue Cross that the hospital is complying with the provisions that set floors under the rates the hospital can charge to Blue Cross's competitors, and they often give Blue Cross the right to audit compliance. Hospitals establish their negotiated rates with managed care companies under different formulas, as discussed in paragraph 17 above. These varying payment methodologies can cause uncertainty for a hospital comparing Blue Cross' effective payment rates with anticipated payment rates from different managed care companies. Therefore, a hospital seeking to avoid a payment reduction by Blue Cross – generally its largest commercial payer – sometimes contracts with Blue Cross' competitors at prices even higher than the exclusionary contract requires, to mitigate the chance that the hospital will accidentally violate

the exclusionary contract and then be penalized after Blue Cross audits the hospital's compliance.

45. On information and belief, Blue Cross' contracts with at least 22 Michigan hospitals contain provisions that require the hospitals to charge higher rates to Blue Cross' competitors than the hospitals charge to Blue Cross (so-called "MFN-plus" clauses). These hospitals are among the most important providers of hospital services in their respective areas. The following hospitals or hospital systems have agreements with Blue Cross containing such clauses:

a. Marquette General Hospital, the largest hospital in the Upper Peninsula and the only Upper Peninsula hospital providing tertiary care, where Blue Cross' contract requires the hospital to charge Blue Cross' competitors at least 23% more than the hospital charges Blue Cross.

b. Sparrow Hospital, the largest hospital in Lansing, where Blue Cross' contract requires the hospital to charge Blue Cross' competitors at least 12.5% more than the hospital charges Blue Cross.

c. Ascension Health, Michigan's largest hospital system, which owns nine general acute care hospitals subject to an MFN-plus clause, including the St. John Providence Health System in the Detroit MSA (five hospitals), Borgess Health in the Kalamazoo MSA, Genesys Regional Medical Center in the Flint MSA, St. Mary's Medical Center in Saginaw, and St. Joseph Health System in Tawas City. Blue Cross' contract with Ascension requires that Ascension's hospitals charge Blue Cross' competitors at least 10% more than the hospitals charge Blue Cross. Blue Cross agreed to pay Ascension higher rates for hospital services in

exchange for Ascension's agreement to charge even higher rates to Blue Cross' competitors, resulting in Blue Cross' paying an additional $2.5 million annually.

d. Both hospitals in Saginaw – Covenant, where Blue Cross' contract requires the hospital to charge most of Blue Cross' competitors at least 39% more than the hospital charges Blue Cross, and St. Mary's, identified in subparagraph c. above.

e. Three Beaumont Hospitals in the Detroit MSA (Royal Oak, Troy and Grosse Pointe), where Blue Cross' exclusionary contract requires the hospital to charge Blue Cross' significant competitors at least 25% more than they charge Blue Cross.

f. Two Mid-Michigan Health Hospitals (Midland and Gratiot), where Blue Cross' exclusionary contract requires the hospitals to charge Blue Cross' competitors at least 14% more than the hospital charges Blue Cross.

g. Metro Health Hospital in Grand Rapids, where Blue Cross' exclusionary contract requires the differential between Blue Cross and other payers to increase over time, to 5% for HMOs and 10% for PPOs.

h. Alpena Regional Medical Center in Alpena, Botsford Hospital in Farmington Hills, Dickinson Memorial Hospital in Iron Mountain, and Munson Medical Center in Traverse City.

46. Blue Cross also entered into a "Participating Hospital Agreement" ("PHA") with each of more than 40 hospitals it classifies as "Peer Group 5" hospitals: small, rural community hospitals, which are often the only hospital in their communities. Under that agreement, Blue Cross committed to pay more to those community hospitals that agreed to charge all other managed care companies rates that would be at least as high as those charged to Blue Cross.

Any community hospital that failed to attest compliance with this provision would be penalized by payments from Blue Cross at least 16% less than if it complied.

Anticompetitive Effects of Blue Cross' Exclusionary Contracts

47. Blue Cross' existing exclusionary contracts, and the additional exclusionary contracts that Blue Cross is likely to seek to include in future agreements with Michigan hospitals, have unreasonably constrained competition, including competition from Aetna, and are likely to continue to constrain competition by:

a. Preventing Aetna and other Blue Cross rivals from negotiating with hospitals to obtain lower prices, thus inflating Blue Cross' rivals' costs and reducing their ability to compete against Blue Cross;

b. Maintaining a significant differential between Blue Cross' hospital costs and its rivals' costs (including Aetna's) at important hospitals, which prevents those rivals (including Aetna) from lowering their hospital costs, lowering their premiums, and becoming more significant competitive threats to Blue Cross;

c. Establishing a price floor below which important hospitals would not be willing to sell hospital services to other managed care companies, including Aetna, and thereby blunting cost competition among managed care companies;

d. Raising the price floor for hospital services to all managed care companies, including Aetna and, as a result increasing the premiums paid by consumers for commercial health insurance; and

e. Limiting the ability of competing managed care companies, including Aetna, to compete with Blue Cross by raising their costs as well as imposing barriers to entry and expansion, discouraging entry, and preserving Blue Cross' dominant market position.

48. As a result of the exclusionary contracts, Blue Cross' competitors often pay substantially higher prices for hospital services than Blue Cross pays. Blue Cross knows that its competitors' higher rates provide Blue Cross with a competitive advantage against other managed care companies. Blue Cross noted in April 2009 that its "medical cost advantage, delivered primarily through its facility [*i.e.*, hospital] discounts, is its largest source of competitive advantage," and earlier stated that its advantages in hospital discounts "have been a major factor in its success in the marketplace."

49. In recent years, Blue Cross became concerned that competition from other managed care companies – including Aetna – was threatening its dominant position. Blue Cross therefore sought to preserve its dominant position by obtaining MFN-plus clauses, with the "expectation . . . that we would not have any slippage in our differential from what we experience today." In other words, rather than seeking lower prices from hospitals, Blue Cross entered into exclusionary contracts that prevent competitors from obtaining hospital services at prices close to Blue Cross' prices and thereby becoming more significant competitive constraints on Blue Cross. Blue Cross' understanding of its strategy was clearly revealed during negotiations in 2008 with one hospital in Grand Rapids, when Blue Cross wrote that "we need to make sure they [the hospital] get a price increase from [our competitor] if we are going to increase their rates."

50. In most cases, Blue Cross compensated hospitals for entering into exclusionary contracts by agreeing to increase its payments to the hospital. Blue Cross has sought and, on most occasions, obtained MFN-plus clauses in contracts that include significant rate increases. Blue Cross also agreed to increase rates to Peer Group 5 hospitals as part of the Peer Group 5 PHA, which included an equal-to MFN. Had a hospital not agreed to this contract, Blue Cross

likely would not have agreed to pay the higher rates sought by the hospital. Thus, the likely effect of the exclusionary contracts has been to raise the prices of hospital services paid by both Blue Cross and its competitors, and to increase the cost of health care coverage to employers and plan members throughout the state of Michigan.

51. Blue Cross' exclusionary contracts have resulted and are likely to continue to result in these anticompetitive effects throughout the relevant market (and in any submarkets that exist) because they effectively create a large financial penalty for hospitals that do not accept them. Blue Cross patients are a significant portion of these hospitals' business, and Blue Cross patients typically are more profitable than Medicare and Medicaid patients, the hospitals' other most significant sources of business. A hospital that would otherwise contract (or had already contracted) with a competing managed care company at lower prices than it charges Blue Cross would have to lower its prices to Blue Cross pursuant to the terms of the exclusionary Blue Cross contract if it sought to offer (or maintain) lower prices in contracts with other managed care companies. The resulting financial penalty discourages a hospital from lowering prices to managed care companies competing with Blue Cross.

52. Moreover, Blue Cross' exclusionary contracts have caused hospitals to raise prices charged to other managed care companies, rather than lower prices to Blue Cross. Absent Blue Cross' exclusionary contracts, hospitals would not have pursued a policy of charging Blue Cross' competitors prices that were no lower than (or higher by a stated percentage than) Blue Cross' discounts. For example, before Blue Cross obtained and enforced its exclusionary contracts, some hospitals had agreed to lower prices with some other managed care companies – including Aetna – than they charged to Blue Cross. Without Blue Cross' exclusionary contracts, some hospitals had an incentive to offer lower prices to other managed care companies seeking

to enter or expand in the hospital's service area and increase competition in the sale of insurance and administrative services.

53. There are no likely procompetitive or efficiency-enhancing effects of the exclusionary contracts that would outweigh the actual and likely anticompetitive effects alleged above. The exclusionary contracts have not led, and likely will not lead, to lower hospital prices for Blue Cross or other managed care companies.

54. If not enjoined, Blue Cross' exclusionary contracts with Michigan hospitals are also likely to have anticompetitive effects in the future. Blue Cross has entered into exclusionary contracts with hospitals that are essential components of a competitive provider network. The exclusionary contracts preserve a pricing differential in favor of Blue Cross that is sufficient to impair competition. Absent an injunction, Blue Cross will seek to enter into and enforce exclusionary contracts with these and other hospitals in Michigan, with the purpose and likely effect unreasonably restraining competition.

VII. VIOLATIONS ALLEGED

Count One – Unlawful Agreement in Violation of Sherman Act § 1

55. Plaintiff Aetna repeats and realleges the allegations of paragraphs 1 through 54 above.

56. Blue Cross has market power in a market for the sale of insurance and administrative services that includes access to Michigan-based provider networks.

57. Each of the exclusionary contracts between Blue Cross and a Michigan hospital is a contract, combination and conspiracy within the meaning of Section 1 of the Sherman Act, 15 U.S.C. § 1.

58. Each of the agreements between Blue Cross and a Michigan hospital that sets a floor under the rates the hospital can charge to Blue Cross's competitors, and all of the agreements in total, have harmed competition in the relevant market by thwarting Aetna's competitive entry and have caused injury to Aetna's business and property, including but not limited to, increased costs, lost sales, lost profits, and diminution in business value, as described above.

59. Each of the challenged agreements has had, or is likely to have, substantial and unreasonable anticompetitive effects in the relevant market, including but not limited to:

a. Depriving consumers of the benefits of competition among providers of insurance and administrative services (including lower prices, innovation, and service improvements) by limiting or preventing Aetna and other providers of insurance and administrative services in competition with Blue Cross from negotiating for and obtaining competitive pricing from critical hospitals;

b. Unreasonably restricting the ability of hospitals to offer to Aetna and other Blue Cross competitors or potential competitors reduced prices for hospital services that the hospitals and Blue Cross' competitors consider to be in their mutual interest;

c. Unreasonably limiting entry or expansion by Aetna and other competitors or potential competitors to Blue Cross in the relevant market;

d. Raising the prices of hospital services to Aetna and other providers of insurance and administrative services in competition with Blue Cross, and to self-insured employers and their employees;

e. Raising the premiums paid by employers, group plan members, and individuals throughout the state of Michigan; and

f. Depriving consumers of hospital services and consumers of insurance and administrative services of the benefits of free and open competition.

60. The procompetitive benefits, if any, associated with Blue Cross' MFN clauses do not outweigh the actual and likely anticompetitive effects of the agreements.

61. Each of the agreements between Blue Cross and a hospital in Michigan containing an MFN clause unreasonably restrains trade in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

Count Two – Violation of MCL 445.772

62. Plaintiff repeats and realleges the allegations of paragraphs 1 through 61 above.

63. Each of the agreements between Blue Cross and a hospital in Michigan containing an MFN clause unreasonably restrains trade in violation of Section 2 of the Michigan Antitrust Reform Act, MCL 445.772.

VIII. RELIEF REQUESTED

WHEREFORE, Plaintiff Aetna requests that this Honorable Court:

a. adjudge and decree that the provider agreements between Blue Cross and hospitals in Michigan containing MFNs violate Section 1 of the Sherman Act, 15 U.S.C. § 1 and Section 2 of the Michigan Antitrust Reform Act, MCL 445.772;

b. award Aetna three times its damages sustained, in an amount to be proven at trial;

c. permanently enjoin Blue Cross, its officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on its behalf, directly or indirectly, from seeking, negotiating for, agreeing to, continuing, maintaining, renewing, using, or enforcing or attempting to enforce any MFNs in any agreement, or any other combination, conspiracy, agreement, understanding, plan, program or other arrangement having the same purpose or effect as an MFN, with any hospital in Michigan;

d. reform the agreements between Blue Cross and hospitals in Michigan to strike the exclusionary clauses as void and unenforceable; and

e. award Aetna its costs in this action, including attorneys' fees, and such other and further relief as may be just and proper.

JURY DEMAND

Aetna demands a trial by jury of all issues so triable.

Respectfully Submitted

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Thomas Cranmer

Dated: December 6, 2011

FOR PLAINTIFF AETNA INC.:

Thomas Cranmer [STATE BAR NO.]
cranmer@millercanfield.com
MILLER CANFIELD
840 W. Long Lake Road, Suite 200
Troy, Michigan 48098
(248) 267-3381

Richard J. Doren (admission pending)
RDoren@gibsondunn.com
GIBSON, DUNN & CRUTCHER LLP
333 South Grand Avenue
Los Angeles, CA 90071-3197
(213) 229-7000

Robert C. Walters (admission pending)
RWalters@gibsondunn.com
Veronica S. Lewis (admission pending)
VLewis@gibsondunn.com
GIBSON, DUNN & CRUTCHER LLP
2100 McKinney Avenue, Suite 1100
Dallas, TX 75201-6912
(214) 698-3100

Joshua Lipton (admission pending)
JLipton@gibsondunn.com
Daniel J. Matheson (admission pending)
DMatheson@gibsondunn.com
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Ave, NW
Washington, DC 20036
(202) 955-8500