NO. 08-3158

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

LITTLE ROCK CARDIOLOGY CLINIC, P.A.; DR. BRUCE E. MURPHY and BRUCE E. MURPHY, M.D.P.A.; DR. SCOTT L. BEAU and SCOTT L. BEAU, M.D.P.A.; DR. DAVID C. BAUMAN and DAVID C. BAUMAN, M.D.P.A.; DR. D. ANDREW HENRY and D. ANDREW HENRY, M.D.P.A.; DR. DAVID M. MEGO and DAVID M. MEGO, M.D.P.A.; DR. PAULO RIBEIRO and PAULO RIBEIRO, M.D.P.A.; DR. WILLIAM A. ROLLEFSON and WILLIAM A. ROLLEFSON, M.D.P.A.

APPELLANTS

v.

BAPTIST HEALTH; ARKANSAS BLUE CROSS AND BLUE SHIELD; USABLE CORPORATION; BAPTIST MEDICAL SYSTEM HMO, INC.; and HMO PARTNERS, INC.

APPELLEES

On Appeal From
The United States District Court for the Eastern District of Arkansas
The Honorable J. Leon Holmes, Chief Judge

BRIEF OF APPELLEES ARKANSAS BLUE CROSS AND BLUE SHIELD, A Mutual Insurance Company; USABLE CORPORATION; and HMO PARTNERS, INC.

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SUMMARY OF THE CASE

This antitrust case challenges USAble Corporation's 1997 decision to terminate its FirstSource® network contracts with plaintiffs. Plaintiffs sued the Health Plan Defendants[1] ten years after their contracts were terminated, claiming that their exclusion from the FirstSource® network was illegal. Chief Judge Holmes dismissed the claims against the Health Plan Defendants as barred by the four-year statute of limitations and laches.

Judge Holmes was correct. The only act of any of the Health Plan Defendants during the limitations period upon which plaintiffs rely is USAble's 2005 decision to admit plaintiffs to a different network, "True Blue," in compliance with the Arkansas Any Willing Provider statute. That was a not new and illegal "overt act" that inflicted new injury on plaintiffs, so it did not restart the statute of limitations under this Circuit's "continuing violation" case law. Judge Holmes' decision should also be affirmed for several independent reasons.

The Health Plan Defendants request twenty minutes oral argument per side.

[1] We refer to Arkansas Blue Cross and Blue Shield and its affiliates, USAble Corporation and HMO Partners, Inc., collectively as "the Health Plan Defendants." We refer to Baptist Health and Baptist Medical System HMO, Inc., collectively as "Baptist Health." Plaintiffs and the district court (JA 591, 593) also referred to these defendants collectively. By following that convention here, we do not suggest that Blue Cross, USAble and HMO Partners are not separate entities with different businesses. They are: Blue Cross sells health insurance; USAble administers self-insured health plans, and HMO Partners operates an HMO. However, these distinctions are largely irrelevant to the issues in this appeal.

CORPORATE DISCLOSURE STATEMENT

Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company, has no parent, and no publicly-held corporation owns 10% or more of its stock. Arkansas Blue Cross and Blue Shield owns 100% of the stock of USAble Corporation. Arkansas Blue Cross and Blue Shield owns 50% of the stock of HMO Partners, Inc., and Baptist Medical System HMO, Inc. owns the other 50% of the stock of HMO Partners, Inc.

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STATEMENT OF THE ISSUES

1. Did Judge Holmes correctly decide that plaintiffs' claims are barred by the four-year statute of limitations, because USAble terminated plaintiffs' FirstSource® network contracts in 1997 and its 2005 decision to admit plaintiffs to a different network was not a new and illegal "overt act" that inflicted "new and accumulating injury" on plaintiffs?

15 U.S.C. § 15b (four-year statute of limitations); *Midwestern Machinery Co. v. Northwest Airlines, Inc.*, 392 F.3d 265, 270-72 (8th Cir. 2004); *Varner v. Peterson Farms*, 371 F.3d 1011, 1019 (8th Cir. 2004); *Concord Boat Corp. v. Brunswick Corp.*, 207 F.3d 1039, 1052 (8th Cir. 2000); *Lomar Wholesale Grocery, Inc. v. Dieter's Gourmet Foods, Inc.*, 824 F.2d 582, 586 (8th Cir. 1987).

2. Alternatively, did Judge Holmes correctly decide that to determine the share of the cardiology services market that is foreclosed by an alleged vertical exclusive dealing contract, the "product market" must include not just cardiology services sold to patients with private insurance, but also identical services sold to patients with Medicare or other government insurance?

Campfield v. State Farm Mutual Auto. Ins. Co., 532 F.3d 1111, 1118-19 (10th Cir. 2008); *B & H Medical, L.L.C. v. ABP Admin., Inc.*, 526 F.3d 257, 263 (6th Cir. 2008); *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of*

Rhode Island, 373 F.3d 57, 67 (1st Cir. 2004); *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, 140 F.3d 494, 514 (3d Cir. 1998).

3. Should the dismissal of Counts 5-7, which allege restraints on the market for health insurance, be affirmed for additional reasons that the parties briefed below: plaintiffs lack standing to sue for restraints on the insurance market, do not allege antitrust injury in that market, and have not plausibly alleged that the relevant geographic market for the sale of health insurance is limited to Little Rock and North Little Rock?

Port Dock & Stone Corp. v. Oldcastle Northeast, Inc., 507 F.3d 117, 122-24 (2d Cir. 2007); *Norris v. Hearst Trust*, 500 F.3d 454, 466-67 (5th Cir. 2007); *South Dakota v. Kansas City Southern Industries, Inc.*, 880 F.2d 40, 46-47 & n.16 (8th Cir. 1989); *Henke Enters, Inc. v. Hy-Vee Food Stores, Inc.*, 749 F.2d 488, 489-90 (8th Cir. 1984).

STATEMENT OF THE CASE

This antitrust case challenges a 1997 decision by USAble Corporation to terminate its contracts with plaintiffs, under which plaintiffs had been members of USAble's "Arkansas FirstSource®" provider network. Complaint ¶¶ 131-136, JA 161-62. The FirstSource® network is a select group of doctors and hospitals that serve people covered by certain health plans. *Id.* ¶ 61, JA 137-38. Since 1997, USAble has "never permitted the plaintiffs back into the FirstSource network." *Id.* ¶ 62, JA 138.

Plaintiffs filed this action in 2006, asserting antitrust claims against Baptist Health (but not the Health Plan Defendants). JA 1. The 2006 complaint alleged that Baptist Health restrained and monopolized a market for cardiologists' services by (1) forming a jointly-owned HMO with Blue Cross in 1993, (2) agreeing with Blue Cross that Baptist Health would be the HMO's exclusive in-network hospital in Little Rock, and (3) agreeing with Blue Cross that USAble would terminate its FirstSource® contracts with plaintiffs. JA 4-6. The district court denied Baptist Health's motion to dismiss that complaint in February 2007, applying the now-outdated "no set of facts" standard of *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). JA 37.

In December 2007, Plaintiffs amended their complaint to add the Health Plan Defendants as defendants. JA 74. All defendants moved to dismiss. JA 89,

93. Chief Judge Holmes dismissed the 2007 complaint, although it was substantially the same as the 2006 complaint, noting that the recent decision in *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007), "overruled [*Conley v. Gibson*] and that's certainly grounds enough for revisiting" the sufficiency of the complaint. Tr. 56, JA 119. Judge Holmes held that the complaint failed to state a claim under the *Twombly* standard, in part because it alleged that the defendants monopolized (and attempted and conspired to monopolize) a market – physicians' services – in which no defendant competes. Judge Holmes explained "you can't possibly prove that Baptist Health monopolized a market in which it does not compete, or attempted to monopolize a market in which it does not compete. And none of the alleged co-conspirators [*i.e.*, the Health Plan Defendants] competed in that market either." Tr. 57, JA 119. Judge Holmes noted that there is a "strong argument" that plaintiffs' conspiracy allegations are implausible under *Twombly*, but he did not dismiss the complaint on that ground because he had already dismissed it on other grounds. *Id.* Finally, Judge Holmes held that the geographic market alleged in the complaint ("central Arkansas") was insufficiently defined, and he rejected plaintiffs' argument that they were entitled to take discovery before alleging what specific market the defendants are accused of monopolizing. Tr. 58, JA 120. Therefore, Judge Holmes dismissed the complaint, but allowed plaintiffs "leave to amend once." Tr. 56, JA 119.

Plaintiffs filed their third and final amended complaint in March 2008. JA 121. Based on new factual detail in the 2008 complaint, the Health Plan Defendants moved to dismiss on a new ground: plaintiffs' claims are barred by the statute of limitations. JA 249. Judge Holmes agreed, and dismissed all claims against the Health Plan Defendants as time-barred. In so holding, Judge Holmes properly distinguished between the claims against Baptist Health (which were filed in 2006) and the claims against the Health Plan Defendants (which were filed in 2007 and 2008). The distinction was important because the complaint challenged Baptist Health's adoption of an "economic credentialing policy" in May 2003 (Complaint ¶ 151, JA 267), which was less than four years before plaintiffs sued Baptist Health, but more than four years before they sued the Health Plan Defendants. Judge Holmes held that Baptist Health's adoption of that policy "can fairly be regarded as an overt act" by Baptist Health within the limitations period applicable to Baptist Health. Opinion at 14, JA 603. But Judge Holmes found no such overt act by the Health Plan Defendants within the limitations period applicable to them. Instead, Judge Holmes held, plaintiffs' central allegation is that

> "[t]hroughout every change in the marketplace, Blue Cross has adhered to the policy adopted in 1997 that, to the extent permitted by law, it would refuse to deal with Little Rock Cardiology Clinic and its doctors. 'In such circumstances, implementation is only a reaffirmation of

> the policy's adoption, and the statute begins to run as soon as the competitor suffers injury.'"

Id. at 13, JA 602, quoting *Midwestern Machinery Co. v. Northwest Airlines, Inc.*, 392 F.3d 265, 270 (8th Cir. 2004). Judge Holmes therefore held that plaintiffs' damage claims against the Health Plan Defendants are time-barred.

Judge Holmes dismissed the claims against Baptist Health in Counts 1-4 on other grounds, which are equally applicable to the Health Plan Defendants: he held that plaintiffs' allegations of the relevant product and geographic markets are "incoherent," and "that this incoherence results not from inadequate draftsmanship or the absence of discovery but from an incurable defect in the legal theory." Opinion at 4, JA 593. Judge Holmes identified three "incurable defects" in plaintiffs' market definitions. First, he held that because hospital services are not substitutes for physician services, they cannot be in the same relevant product market. *Id.* at 17-28, JA 606-17. Second, he held that the relevant market for cardiology services cannot be limited to services sold to people with private health insurance, because plaintiffs' "potential customers are all persons who need cardiologists' services, not just that smaller subgroup who are insured." *Id.* at 31, JA 620. Third, he held that the complaint's factual allegations contradict its conclusion that the relevant geographic market for the sale of cardiology services is limited to Little Rock and North Little Rock, "and the method of defining the

geographic market, as explained in the third amended complaint, is flawed as a matter of law." *Id.* at 32, JA 621.

Finally, Judge Holmes dismissed plaintiffs' claims for injunctive relief as barred by laches. Judge Holmes' decision on laches relates only to counts 5-8 (the other counts having been dismissed on other grounds), but his reasoning applies to all the claims against the Health Plan Defendants:

> "These plaintiffs waited almost eleven years after they were excluded from the network and almost seven years after the defendants allegedly had achieved monopoly power in the private insurance market before seeking relief. The wrongful conduct was not hidden. These plaintiffs knew immediately when they were excluded from the network. . . . [T]hey slept on their rights to equitable relief . . . . [I]n considering all of the equities, the Court has concluded that the balance weighs in favor of dismissing the equitable claims as barred by laches."

Id. at 38-39, JA 627-28. Plaintiffs did not mention this ruling in their opening brief on appeal, so they have waived any claim that Judge Holmes' balancing of the equities was error.[2]

Plaintiffs did not request leave to amend again. Instead, they elected to stand on their complaint, and filed this appeal.

[2] See, *e.g.*, *Ballard v. Heineman*, 548 F.3d 1132, 1136 (8th Cir. 2008) ("Ballard does not raise this argument in his appellate brief, so it is waived"); *Jenkins v. Winter*, 540 F.3d 742, 751 (8th Cir. 2008) ("Claims not raised in an opening brief are deemed waived").

STATEMENT OF THE FACTS

1. Selective Contracting in Little Rock.

This case concerns a common, lawful and procompetitive feature of health care markets: selective contracting by health insurers. The complaint admits that managed care plans generally contract with a limited network of physicians and hospitals, and offer incentives for their insureds to use in-network providers, in exchange for a "significant discount" off those providers' fees:

> "HMOs, PPOs and self-insured plans operate through networks of health care providers, including physicians and hospitals. A network is created by contracts with the health care providers for the terms of payment and participation in the network. Whereas in traditional indemnity plans the payment for health care was based on the usual and customary charge, in a network the terms of payment are based on a contractual 'allowable charge,' which is a significant discount from the provider's actual charge for the service."

Complaint ¶ 56, JA 135.

Plaintiffs do not challenge the legality of selective contracting. Nor could they, because selective contracting is widely acknowledged to be procompetitive and lawful. As the federal antitrust enforcement agencies concluded in their report on competition in health care markets (following the hearings discussed in the complaint, ¶ 85, JA 144):

> "Selective contracting is used to create a restricted network[] of providers. Selective contracting intensifies price competition and allows payors to negotiate volume

> discounts and choose providers based on a range of criteria. The intensity of competition increases with the number of providers and covered lives in the relevant market, and with the restrictiveness of the insurance contracts found in the market (*i.e.,* HMOs, which have more limited panels than PPOs, induce more intense price competition among providers than would PPOs of equivalent size)."

Federal Trade Commission and U.S. Department of Justice, *Improving Health Care: A Dose of Competition,* ch. 1 at 4 (July 2004), available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

The selective contracting at issue in this case began in 1993, when USAble and Baptist Health formed a joint venture to create a new HMO. Complaint ¶ 99, JA 153. That HMO, called Health Advantage, is now jointly owned by Blue Cross, Baptist Health, and a number of physicians who practice at Baptist Health. *Id.* ¶ 69, JA 140. Plaintiffs allege that the joint venture includes an exclusive dealing agreement, under which Baptist Health is the only Little Rock hospital in the FirstSource® network. *Id.* ¶¶ 60-69, JA 137-40.

Other Little Rock health plans also followed a strategy of selective contracting. According to a 1997 market study attached to the complaint, each of the three major hospital systems in Little Rock partnered with an insurer to jointly own and operate an HMO:

> "Many of Little Rock's HMOs are jointly sponsored by insurers and hospitals through shared equity arrangements. These relationships bind together, at least

> in the short run, the fate of some of Little Rock's most important health care organizations. Shared equity arrangements are the foundation of both Health Advantage, a partnership between Baptist and BCBSA, and Healthsource Arkansas Ventures Inc., a joint venture between St. Vincent's Infirmary and the New Hampshire-based HMO company. Moreover, the recently licensed QualChoice network is owned by the University of Arkansas for Medical Sciences, which also owns and operates University Hospital. The principal characteristic that binds these organizations together . . . is a shared financial stake in the success of the products. . . . [H]ealth plans representatives . . . assert that hospitals are willing to offer their best price to the HMOs since they have a strong interest in the products' success in the market and because the contract terms guarantee patient volume."

Complaint exhibit A at 13-14, JA 210-11.

The exclusive or quasi-exclusive relationships between Little Rock hospitals and the three local HMOs were no secret. The complaint states that "[t]he exclusive-dealing arrangement between Baptist Health and BCBS is the most salient feature of the health care market in Little Rock and has been for a decade." *Id.* ¶ 64, JA 138. "This structure of the Little Rock health care market is well known and documented nationally." *Id.* ¶ 65, JA 138. Thus, plaintiffs knew about the alleged exclusive contract in 1997, and plaintiffs' brief disclaims any reliance on equitable tolling to avoid the statute of limitations. Pl. Br. at 34.

2. The Entry and Expansion of Arkansas Heart Hospital.

In March 1997, plaintiffs opened Arkansas Heart Hospital ("AHH"), a specialty cardiac hospital in Little Rock, and began referring their patients to AHH. Complaint ¶ 130, JA 160-61. Plaintiffs are shareholders of AHH, and they perform "95% of the cardiac procedures performed at AHH." *Id.* The majority owner of AHH is MedCath Corporation, based in Charlotte, North Carolina, which owns and operates cardiac specialty hospitals nationwide. Complaint exhibit A at 10, JA 207. MedCath and AHH have chosen not to join this litigation as plaintiffs.

AHH's strategy, as reported in the market studies attached to the complaint, was to attract profitable cardiology patients from the local full-service hospitals. The plaintiff physicians, who were cardiologists practicing at Baptist Health and St. Vincent's, would support AHH by referring their patients to AHH:

> "[A] major development with a potentially significant impact on local institutions was the March 1997 opening of Arkansas Heart Hospital. . . . More than a dozen local cardiologists with ties to both Baptist and St. Vincent's are equity partners in the venture. The Arkansas Heart Hospital poses a significant threat because cardiology programs are reportedly big moneymakers for these institutions, generating as much as one-third of each hospital's total revenues."

Id. According to complaint exhibit A, the investors in AHH did not expect to attract many managed care members, and instead planned to focus on attracting indemnity insureds and Medicare patients:

> "Arkansas Heart Hospital has yet to secure a managed care contract, and its investors anticipated limited success in this regard given the equity position of its two major competitors in two of the area's most highly subscribed HMOs. However, a lack of managed care contracts does not restrict Arkansas Heart Hospital's ability to compete for patients enrolled in traditional health insurance plans, who represent the largest share of Little Rock's commercially insured population. . . .
>
> Arkansas Heart Hospital['s] . . . success will be determined, at least in the short run, by its ability to attract Medicare patients from other area hospitals."

Id. at 10, 18, JA 207, 215.

Plaintiffs and AHH followed this strategy, with considerable success. Because they were not in the FirstSource® network or other managed care networks, they treated "a higher percentage of Medicare and Medicaid patients." Complaint ¶ 193, JA 184. By 1999, AHH had "lured an estimated 10 to 20 percent of cardiac surgical volume away from the two major Little Rock hospital systems. . . . [M]ost of the hospital's volume has come from Medicare fee-for-service patients." Complaint exhibit B at 3, JA 220.

Plaintiffs' market share increased steadily. The 2008 complaint proudly asserts that "***AHH has a dominant market share for cardiovascular surgery***" provided to Medicare patients, with a 45% market share. Complaint ¶ 92, JA 147. Complaint ¶ 92 includes data showing that AHH serves almost 35% of all Medicare cardiology and cardiovascular surgery inpatients in Little Rock:

	Cardiology	Surgery	Total	Share
AHH	1115	2483	3598	34.4%
Baptist LR	1762	1307	3069	29.4%
SVI	1038	956	1994	19.1%
Baptist NLR	902	763	1665	15.9%
SRMC	90	36	126	1.2%
Total	4907	5545	10452	100.0%

Plaintiffs and their hospital also have a substantial market share when ***all cardiology patients*** are counted. Exhibit E to the complaint includes data on cardiology patient discharges, which "include statistics from both Medicare and private insurance." *Id.* ¶ 170, JA 172. These data confirm that AHH treats about 32% of all cardiology inpatients in Little Rock (*id.* ¶ 169, JA 172):

	Discharges	Share
AHH	2920	31.9%
Baptist LR	2697	29.4%
SVI	1924	21.0%
Baptist NLR	1545	16.9%
SRMC	79	0.9%
Total	9165	100.0%

Because the plaintiff physicians perform "95% of the cardiac procedures performed at AHH," *id.* ¶ 130, JA 161, they perform more cardiac procedures than the doctors at any other single hospital in Little Rock. And, because the plaintiff physicians practice at Baptist Health and St. Vincent's in addition to AHH (*id.* ¶¶ 123, 152, JA 159, 167), their market share must be even larger than AHH's share. Thus it is clear from the complaint that plaintiffs and their hospital have done very well in the eleven years since they opened AHH.

Judicially noticeable facts that the complaint cites, but does not quote, reinforce this conclusion. The complaint cites and quotes from public hearings on the Little Rock health care market conducted by the Federal Trade Commission and the Department of Justice in 2003. *Id.* ¶ 85, JA 144. At those hearings, plaintiff Little Rock Cardiology Clinic presented testimony on market shares for "major cardiac DRGs" in the five years following AHH's entry into the market. Dr. James Kane, Senior Member of Little Rock Cardiology Clinic, testified that

> "Our admissions have grown steadily from the time we've opened and we're now about 5,000 a year, that was last year. We've captured a fair amount of the market share, as you can see, and now we're about 40 percent, that was in 2001, this is from medpar data. We may be a little bit higher than that."[3]

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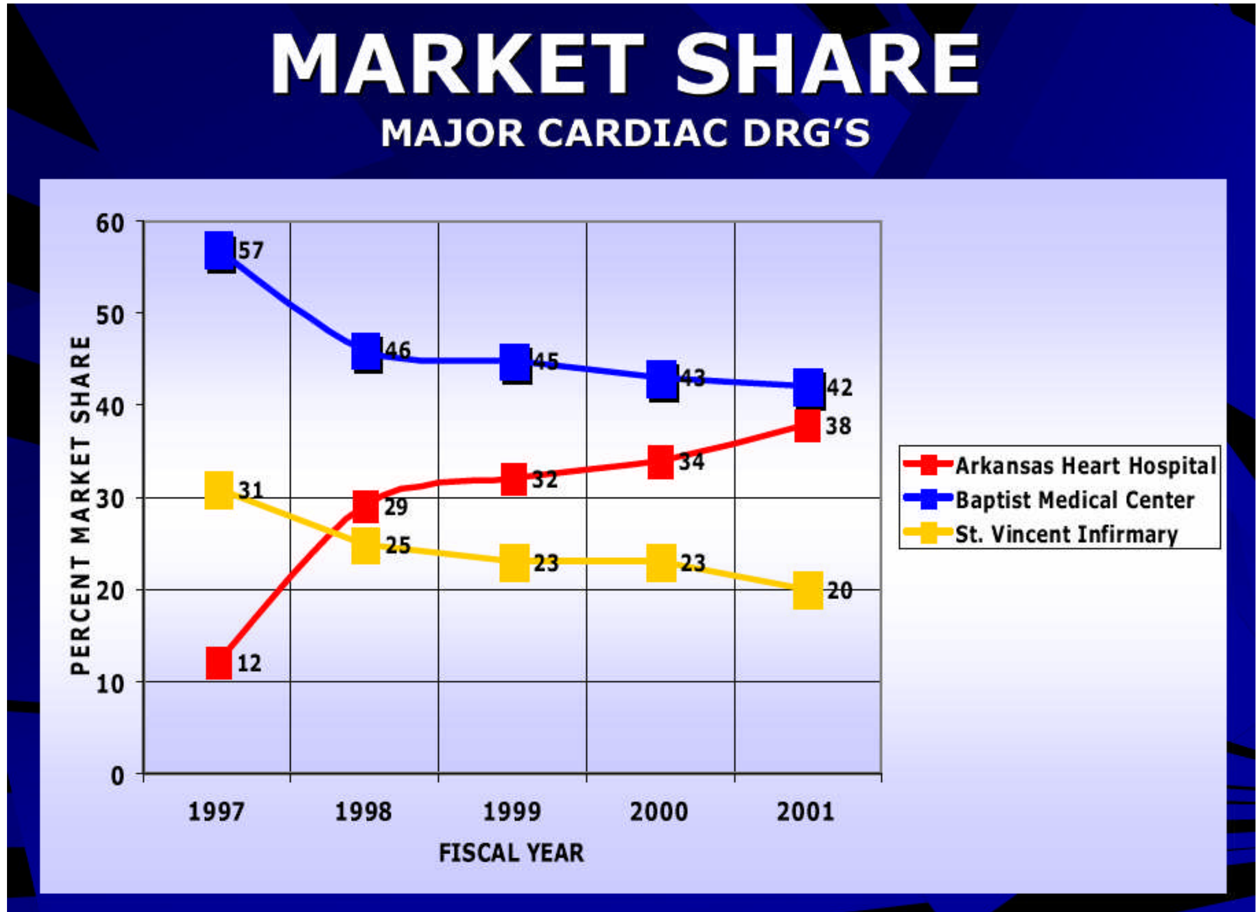
[3] James Kane, M.D., Senior Member of Little Rock Cardiology Clinic, Testimony at FTC & D.O.J. Antitrust Division Healthcare & Competition Policy Hearing, at 49-50 (Apr. 11, 2003), available at http://www.ftc.gov/ogc/healthcarehearings/030411ftctrans.pdf. Dr. Kane's slides used in his testimony, including the slide reproduced below, are available at www.ftc.gov/ogc/healthcarehearings/docs/030410kane.pdf.

The Court may consider this testimony because it is part of the public record, is an admission of the plaintiff, and is cited in the complaint. See, *e.g.*, *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, ___, 127 S. Ct. 2499, 2509 (2007) ("courts must consider the complaint in its entirety, as well as other sources courts ordinarily examine when ruling on Rule 12(b)(6) motions to dismiss, in particular, documents incorporated into the complaint by reference, and matters of which a court may take judicial notice"); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, ___ n.13, 127 S. Ct. 1955, 1972 n.13 (2007) (On a Rule 12(b)(6) motion, "the District Court was entitled to take notice of the full contents of the published articles referenced in the complaint, from which the truncated quotations were drawn").

Dr. Kane referred to the following slide in his testimony:



This testimony confirms that in 2001 (when they now allege that the defendants "were monopolists," Complaint ¶ 82, JA 143), plaintiffs were competing effectively, were steadily taking market share from both Baptist Health and St. Vincent's, and were well on their way to becoming the largest and most successful cardiology practice in Little Rock.

In 2007, citing "growing demand for the hospital's cardiovascular care services," AHH announced a $7.5 million expansion, including a 25% increase in

AHH's bed capacity.[4] Plaintiffs' market success is confirmed by the multi-million dollar profits that plaintiffs have earned from their investment in AHH. JA 372-73, 408 (exhibits to plaintiffs' response to defendants' motions to dismiss, showing that plaintiffs received over $18 million in profit distributions as owners of AHH, including $5.3 million to Dr. Murphy, $5.3 million to Dr. Henry, $1.9 million to Dr. Beau, $1.9 million to Dr. Bauman, and $1.6 million to Dr. Mego).

3. The Termination of Plaintiffs' FirstSource® Contracts.

Plaintiffs' FirstSource® contracts were terminated soon after plaintiffs opened AHH in 1997. Specifically, USAble Corporation terminated its contracts with plaintiffs in June 1997. Complaint ¶ 132, JA 161. HMO Partners terminated its contracts with plaintiffs in September 1997. *Id.* ¶ 135, JA 162.

The complaint clearly alleges that the exclusion of plaintiffs from the FirstSource® network continued unabated from 1997 to the present. See complaint ¶ 61, JA 137 ("they have ***maintained*** FirstSource as an exclusive network"), ¶ 62, JA 138 ("The defendants ***have never permitted*** the plaintiffs back into the FirstSource network"), ¶ 131, JA 161 ("beginning no later than early 1997 and ***continuing*** thereafter"), ¶ 141, JA 165 ("BCBS and HMO Partners ***refused to budge*** from the exclusion"), and ¶ 164, JA 170 ("LRCC and its doctors ***remain*** out

[4] See Press Release, MedCath, *MedCath Corporation Announces Plans to Expand Arkansas Heart Hospital,* (Apr. 5, 2007), available at http://phx.corporate-ir.net/phoenix.zhtml?c=129804&p=irol-newsArticle&ID=982076&highlight=.

of network") (emphasis added). Thus, as Judge Holmes observed, "[i]f ever a refusal to deal was 'irrevocable, immutable, permanent, and final,' this one was. Throughout every change in the marketplace, Blue Cross has adhered to the policy adopted in 1997 that, to the extent permitted by law, it would refuse to deal with Little Rock Cardiology Clinic and its doctors." Opinion at 14, JA 603.

As Judge Holmes noted, plaintiffs do not allege that the termination of their FirstSource® contracts affected competition among cardiologists generally:

> "Nowhere does the third amended complaint allege that the anticompetitive conduct of the defendants has resulted in cardiologists raising their prices for privately insured patients in hospitals or, for that matter, any other patients. Nowhere does the third amended complaint allege that the anticompetitive conduct of the defendants has caused a decline in the number of cardiologists or in the quality of the services offered by cardiologists. . . . [T]he third amended complaint is silent as to the impact on competition among cardiologists, as distinct from the impact on the plaintiffs . . . ."

Id. at 22, JA 611.

Although their exclusion from the FirstSource® network allegedly caused plaintiffs to lose some patients, complaint ¶¶ 132-137, JA 161-62, it did not exclude them from the market. Their hospital grew and thrived for over 10 years without a FirstSource® contract, and now treats more cardiology patients than any other single hospital in Little Rock. *Id.* ¶ 169, JA 172. Plaintiffs estimate that health plans administered by Blue Cross and its affiliates cover 80% of

commercially-insured patients in Little Rock, *id.* ¶ 3, JA 122, and that commercially-insured patients are "roughly half" of the "80% to 85% of the total population who are covered by private insurance or government insurance." *Id.* ¶ 34, JA 129. Therefore, plaintiffs allege that the Health Plan Defendants account for at most 80% of half of 85% of the total population, or 34% of the population. But not all these insureds are in health plans that use the FirstSource® network. Since 2005, FirstSource® has served only self-insured health plans, *id.* ¶ 61, JA 137, which cover "roughly 50% of the privately insureds [sic] in Arkansas," *id.* ¶ 164, JA 170. Thus, plaintiffs allege that FirstSource® covers only about 17% of the population.

4. The "Any Willing Provider" Litigation, and the 2006 Admission of Plaintiffs to the "True Blue" Network.

The question whether physicians have a right to be admitted to the FirstSource® network under the Arkansas "Any Willing Provider" or "AWP" statute,[5] was a subject of litigation for many years. As Judge Holmes observed, "[u]nderstanding the plaintiffs' [statute of limitations] argument, as well as the reason why that argument fails, requires some historical background." Opinion at 10, JA 599.

[5] The AWP statute, Ark. Code. Ann. § 23-99-201 *et seq.,* requires certain health plans to admit to their provider networks all qualified medical service providers that are willing to accept the health plan's contract terms.

In 1997, when USAble terminated its FirstSource® contracts with plaintiffs, the validity of the AWP statute was already the subject of pending litigation. In January 1997, the district court had declared the statute preempted by ERISA and unenforceable insofar as it relates to ERISA plans. *Prudential Ins. Co. v. National Park Medical Ctr*., 964 F. Supp. 1285, 1299 (E.D. Ark. 1997). That decision was appealed to this Court, and HMO Partners argued on appeal that the statute was preempted in its entirety, not just as applied to ERISA plans. *Prudential Ins. Co. v. National Park Medical Ctr.*, 154 F.3d 812 (8th Cir. 1998). In 1998, this Court agreed that the AWP statute "is preempted in its entirety" by ERISA, and permanently enjoined enforcement of the statute. *Id.* at 832. That settled the issue for the next five years.

In 2003, the Supreme Court's decision in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), arguably changed the law of ERISA preemption. Citing *Miller*, plaintiff Little Rock Cardiology Clinic wrote to Blue Cross "requesting to be allowed to participate in that company's network of preferred providers pursuant to" the AWP statute. *Arkansas Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr.*, 2006 U.S. Dist. Lexis 22024, at *7 (E.D. Ark. Mar. 27, 2006). Blue Cross and USAble responded, on August 19, 2003, by filing a lawsuit in federal court seeking a declaration of their rights under the AWP statute. *Id.* at *7-*8. In 2004, the district court dissolved the *Prudential* injunction

in light of *Miller*, and that decision was stayed pending appeal to this Court. *Id.* at *8. The litigation between Blue Cross and Little Rock Cardiology Clinic also was stayed pending this Court's decision in *Prudential*. *Id.* at *9. This Court decided *Prudential* on June 29, 2005, holding that the AWP statute is enforceable, "except with regard to self-funded ERISA plans," as to which it is preempted by ERISA. *Prudential Ins. Co. v. Nat'l Park Med. Ctr., Inc.*, 413 F.3d 897, 914 (8th Cir. 2005).

Under these court rulings, beginning in 2005 plaintiffs had a new legal right to be admitted to provider networks for insured health plans, but not for self-insured ERISA plans. USAble complied with the rulings by creating a new provider network, called "True Blue," and inviting plaintiffs to join that network. Complaint ¶¶ 61-62, JA 137-38. The True Blue network served insured health plans that are subject to the AWP law; the FirstSource® network thereafter served only self-insured ERISA plans that are not subject to that law. *Id.* Plaintiffs agreed that joining the True Blue network gave them everything to which they were entitled under the AWP law, and in 2006 the district court dismissed their claims for equitable relief under the AWP law, finding "no case or controversy." *Arkansas Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr.*, 2006 U.S. Dist. Lexis 22024, *14-*15 (E.D. Ark. Mar. 27, 2006).

The complaint clearly alleges that "the defendants have never permitted the plaintiffs back into the FirstSource network." *Id.* ¶ 62, JA 138. Plaintiffs "remain out of network" for self-insured ERISA plans, just as they have been since 1997. *Id.* ¶ 164, JA 170. As Judge Holmes put it,

> "As to those persons covered by employer self-insured plans, the plaintiffs' situation now is the same as it was in 1997 when they were first excluded from the managed care network as a whole. The action of the defendants in early 2006, allowing the plaintiffs into the network to the extent that the any willing provider statute could be enforced, helped the [plaintiffs]; it did not injure them. The decision continuing their exclusion from the network for employer self-insured programs was merely a reaffirmation of the decision in 1997 to exclude them from the network as to those programs."

Opinion at 12, JA 601.

USAble's 2005 decision to admit plaintiffs to the True Blue network, but to continue to exclude them from the FirstSource® network, is mentioned in only one paragraph of plaintiffs' 247-paragraph complaint. Complaint ¶ 164, JA 170. However, that decision has now become the centerpiece of plaintiffs' antitrust case, because it is the only act of any of the Health Plan Defendants that plaintiffs now argue is evidence of a "continuing violation" of the antitrust laws.

SUMMARY OF THE ARGUMENT

1. Judge Holmes correctly applied this Circuit's "continuing violation" case law to resolve the statute of limitations issue. That case law required plaintiffs to allege an illegal "overt act" by one of the Health Plan Defendants within the four years before plaintiffs sued the Health Plan Defendants. "An overt act has two elements: (1) it must be a new and independent act that is not merely a reaffirmation of a previous act, and (2) it must inflict new and accumulating injury on the plaintiff." *Varner v. Peterson Farms*, 371 F.3d 1011, 1019 (8th Cir. 2004). "[A]cts that 'simply reflect or implement a prior refusal to deal . . . do not restart the statute of limitations.'" *Concord Boat Corp. v. Brunswick Corp.*, 207 F.3d 1039, 1052 (8th Cir. 2000). Because plaintiffs alleged no new illegal act and no new injury, but only a continued refusal to deal, the claims against the Health Plan Defendants were properly dismissed.

2. Alternatively, Judge Holmes correctly determined that plaintiffs failed to allege legally defensible relevant markets. In particular, plaintiffs' attempt to define a cardiology-services market consisting of services sold to patients with private insurance, but not identical services sold to patients with Medicare, is contrary to several recent federal appellate decisions that reject similar attempts to limit the market to customers with insurance. See, *e.g.*, *Campfield v. State Farm Mutual Auto. Inc. Co.*, 532 F.3d 1111, 1118-19 (10th Cir. 2008) ("When there are

numerous sources of inter-changeable demand, the plaintiff cannot circumscribe the market to a few buyers in an effort to manipulate those buyers' market share"). This is an independent basis upon which dismissal of the complaint should be affirmed.

3. The dismissal of Counts 5-7, which allege restraints on and monopolization of the market for health insurance, should be affirmed for independent reasons that the parties briefed below: plaintiffs do not buy or sell health insurance, and do not claim to have been injured by a reduction in competition among health insurers, so they lack standing to sue for alleged restraints on the health insurance market. Counts 5-7 also fail because plaintiffs allege no facts to support their conclusion that the relevant geographic market for the sale of health insurance is limited to Little Rock and North Little Rock.

ARGUMENT

Standard of Review

This Court should review Judge Holmes' legal rulings *de novo*, applying the same legal standards that governed the district court. Those legal standards, as applied to a motion to dismiss an antitrust complaint, are established by *Bell Atlantic Corp. v. Twombly,* 550 U.S. 544, 127 S. Ct. 1955 (2007).

Twombly introduced a new requirement of "plausibility" into federal pleading law, with the goal of ensuring that complex litigation should not proceed to discovery unless the complaint contains "enough fact to raise a reasonable expectation that discovery will reveal evidence of illegal agreement." 127 S. Ct. at 1965. *Twombly* was an antitrust conspiracy case (so it is directly on point here), but the *Twombly* rule is applicable in complex federal litigation generally. The Court's concern was that if implausible complaints are permitted to proceed to discovery, "a plaintiff with 'a largely groundless claim' [will] be allowed to 'take up the time of a number of other people, with the right to do so representing an *in terrorem* increment of the settlement value.'" *Id.* at 1966, quoting *Dura Pharmaceuticals, Inc. v. Broudo*, 544 U.S. 336, 347 (2005) (internal quotation marks and citation omitted). The Court therefore held that "'[s]ome threshold of plausibility must be crossed at the outset before [an] antitrust case should be permitted to go into its inevitably costly and protracted discovery phase.'" *Id.*,

quoting *Asahi Glass Co. v. Pentech Pharmaceuticals, Inc.*, 289 F. Supp. 2d 986, 995 (ND Ill. 2003) (Posner, J., sitting by designation). The Court instructed district judges to "to avoid the potentially enormous expense of discovery in cases with no 'reasonably founded hope that the [discovery] process will reveal relevant evidence' to support a § 1 claim." *Id.* at 1967, quoting *Dura*, 544 U.S. at 347.

The substance of *Twombly* is that "the defendant should not be put to the expense of big-case discovery on the basis of a thread-bare claim." *Limestone Development Corp. v. Village of Lemont*, 520 F.3d 797, 803 (7th Cir. 2008) (Posner, J.). "[H]ow many facts are enough will depend on the type of case," and "[i]f discovery is likely to be more than usually costly, the complaint must include as much factual detail and argument as may be required to show that the plaintiff has a plausible claim." *Id.* at 803-04.

This case illustrates one virtue of the *Twombly* rule: it forces plaintiffs to plead enough facts to fully reveal their theory of the case, so that theory can be fairly evaluated before discovery. By dismissing the 2007 complaint under *Twombly*, Judge Holmes forced plaintiffs to provide more factual detail in the 2008 complaint – enough detail to establish that plaintiffs' claims against the Health Plan Defendants are barred by the statute of limitations and several other incurable defects. Thus, Judge Holmes' application of *Twombly* achieved the Supreme Court's core purpose: to ensure that if "the allegations in a complaint, however

true, could not raise a claim of entitlement to relief, 'this basic deficiency should . . . be exposed at the point of minimum expenditure of time and money by the parties and the court.'" *Twombly*, 127 S. Ct. at 1966, quoting 5 Wright & Miller, *Federal Practice and Procedure* § 1216, at 233-234 (internal quotation marks and citation omitted).

I. The District Court Correctly Applied the Statute of Limitations.

"If the allegations of the complaint 'show that relief is barred by the applicable statute of limitations, the complaint is subject to dismissal for failure to state a claim.'" *Limestone Development,* 520 F.3d at 802, quoting *Jones v. Bock*, 549 U.S. 199, 215 (2007); see Pl. Br. at 35 (admitting that a complaint may be dismissed if it "alleges facts showing that the claim is time barred"). Here, the complaint says that every act that allegedly injured plaintiffs – including USAble's termination of plaintiffs' FirstSource® contracts in 1997, defendants' alleged monopolization of the relevant markets in 2001, and Baptist Health's adoption of its economic credentialing policy in 2003 – occurred before December 17, 2003, and more than four years before plaintiffs first sued the Health Plan Defendants. Therefore, plaintiffs' damage claims against the Health Plan Defendants are barred by the statute of limitations.

Plaintiffs begin their statute of limitations argument with a clear factual mistake: they assert that Baptist's "2003 Economic Credentialing Policy [was]

adopted within the four years preceding the complaint" against the Health Plan Defendants, and accuse Judge Holmes of "manifest error" for not treating this 2003 event as an illegal act of the Health Plan Defendants within the limitations period. Pl. Br. at 34. Plaintiffs argue:

> "The district court correctly concluded that the 2003 Economic Credentialing Policy, adopted within the four years preceding the complaint, stated a continuing violation of the Sherman Act. Add. 14. But as to the other four defendants and co-conspirators in the same unlawful conduct, the district court determined that a continuing violation of the Sherman Act had not occurred. This determination was manifest error."

Id. (footnote omitted). But as Judge Holmes correctly pointed out, the 2003 events occurred less than four years before plaintiffs sued Baptist Health in 2006, but ***more*** than four years before the plaintiffs sued the Health Plan Defendants in 2007:

> "As to [the Health Plan Defendants], the plaintiffs' claims are barred because the third amended complaint alleges no acts occurring within four years of the filing of the second amended complaint on December 17, 2007, other than the unabated inertial consequences of the decision in 1997 not to deal with Little Rock Cardiology Clinic and its physicians."

Opinion at 14, JA 603.[6] Therefore, whether or not the events of 2003 could be characterized as illegal "overt acts," claims based on those events are time-barred as to the Health Plan Defendants.

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[6] Plaintiffs disclaim reliance on "any doctrine of tolling or relation back." Br. at 34. Therefore, claims first asserted in the Second Amended Complaint are barred if

Plaintiffs point to only one event after December 17, 2003 to justify reversal of Judge Holmes' limitations decision. They argue that USAble's 2005 decision not to admit plaintiffs to the FirstSource® network when it admitted them to the "True Blue" network was an illegal "overt act," and therefore that the complaint alleges a "continuing violation" of the antitrust laws in 2005. Pl. Br. at 35-40. This argument fails because, as Judge Holmes correctly concluded, the 2005 events merely continued "the policy adopted in 1997 that, to the extent permitted by law, [Blue Cross] would refuse to deal with Little Rock Cardiology Clinic and its doctors." Opinion at 13, JA 602. The 2005 decision therefore was not a new illegal act, and it did not inflict a new injury on plaintiffs – both of which are essential to state a claim for a "continuing violation" under this Circuit's case law.

This Court has established an exacting standard for plaintiffs who attempt to allege a "continuing violation" of the antitrust laws:

> " '[E]ven when a plaintiff alleges a continuing violation, an overt act by the defendant is required to restart the statute of limitations and the statute runs from the last overt act.' 'For statute of limitations purposes, . . . the focus is on the timing of the causes of injury, *i.e.*, the defendant's overt acts, as opposed to the effects of the overt acts.'

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they are based on events before December 17, 2003, and claims first asserted in the Third Amended Complaint are barred if they are based on events before March 27, 2004. JA 74, 121.

> An overt act has two elements: (1) it must be a new and independent act that is not merely a reaffirmation of a previous act, and (2) it must inflict new and accumulating injury on the plaintiff. Acts that are merely 'unabated inertial consequences' of a single act do not restart the statute of limitations."

Varner v. Peterson Farms, 371 F.3d 1011, 1019 (8th Cir. 2004) (citations and footnotes omitted). "[A]cts that 'simply reflect or implement a prior refusal to deal . . . do not restart the statute of limitations.'" *Concord Boat Corp. v. Brunswick Corp.*, 207 F.3d 1039, 1052 (8th Cir. 2000).

As Judge Holmes specifically found (and plaintiffs did not deny), plaintiffs knew of their injuries and the allegedly wrongful conduct ten years before they sued the Health Plan Defendants. Opinion at 38-39, JA 627-28. Therefore, the policy underlying this Circuit's continuing violation case law favors dismissal of plaintiffs' claims. The

> "distinction between 'new and independent acts [that] inflict new and accumulating injury on the plaintiff' (which restart the statute of limitations), and unabated inertial consequences of previous acts (which do not) allows the statute of limitations to have effect and discourages private parties from sleeping on their rights. . . . [B]ecause private suits under the antitrust laws are allowed to correct public wrongs, it is appropriate to encourage suits as soon as possible to stop (or at least compensate) harm to the public. . . . In practice, where the plaintiff had actual knowledge of the initial violation and suffered sufficient injury, courts generally do not toll the statute of limitations based on a continuing violation theory."

Midwestern Machinery Co. v. Northwest Airlines, Inc., 392 F.3d 265, 271-72 (8th Cir. 2004) (citations omitted); see II Areeda & Hovenkamp, *Antitrust Law* ¶320c3 ("More than almost any other plaintiff, the victim of a direct refusal to deal knows immediately that it has occurred. Particularly when the legal status of the conduct is ambiguous, as it is in nearly all cases involving unilateral refusals to deal, such plaintiffs should have every incentive to bring their suit in a timely fashion, thus minimizing the social damage of any antitrust violation that is subsequently found"); see generally *Ledbetter v. Goodyear Tire Co.*, 550 U.S. 618, 127 S.Ct. 2162, 2167-68, 2170-71, 2177 (2007) ("Statutes of limitations serve a policy of repose"; "tardy lawsuits" may not be justified by the "continuing impact" or "current effect" of prior violations).

Plaintiffs acknowledge that if Judge Holmes was correct that USAble's 2005 decision was merely "a reaffirmation of a previous act," Opinion at 12, JA 601, then their claims are barred by the statute of limitations. Pl. Br. at 35, quoting *Varner*, 371 F.3d at 1019. Plaintiffs therefore attempt to characterize USAble's 2005 decision as a "new action" that "did not exist and could not have been foreseen" before 2005. Pl. Br. at 37-39. This recharacterization ignores plaintiffs'

own descriptions of the same events in their complaint,[7] upon which Judge Holmes relied:

> "According to paragraph 164 of the third amended complaint, after the injunction against enforcement of the any willing provider statute was lifted, in January 2006 the plaintiffs were allowed back into the network with Arkansas Blue Cross and Blue Shield and HMO Partners but not as to 'FirstSource or any network used by employer self-insured plans' so that 'for the roughly 50% of the privately insureds in Arkansas who are covered by employer self-insurance programs,' the plaintiffs 'remain out of network.' This last phrase is key: as to plans that are preempted by ERISA, the plaintiffs 'remain out of network.' Similarly, paragraph 62 alleges that the plaintiffs were excluded from the network in 1997, and 'the defendants have never permitted the plaintiffs back into the FirstSource network.' The action taken by the defendants in early 2006 was not a new and independent act that inflicted new and accumulating injury on the plaintiffs. As to those persons covered by employer self-insured plans, the plaintiffs' situation now is the same as it was in 1997 when they were first excluded from the managed care network as a whole. . . . The decision continuing their exclusion from the network for employer self-insured programs was merely a reaffirmation of the decision in 1997 to exclude them from the network as to those programs."

[7] See complaint ¶ 61, JA 137 ("they have ***maintained*** FirstSource as an exclusive network"), ¶ 62, JA 138 ("The defendants ***have never permitted*** the plaintiffs back into the FirstSource network"), ¶ 131, JA 161 ("beginning no later than early 1997 and ***continuing*** thereafter"), ¶ 141, JA 165 ("BCBS and HMO Partners ***refused to budge*** from the exclusion"), and ¶ 164, JA 170 ("LRCC and its doctors ***remain*** out of network") (emphasis added).

Opinion at 11-12, JA 600-01. Judge Holmes was entitled to accept the complaint's characterization of these events as true for purposes of the motion to dismiss. It is too late now for plaintiffs to change their description of what happened in 2005.

It also is too late for plaintiffs to argue (Pl. Br. at 37) that they could not have foreseen their "damages from the network restructuring," and to claim the benefit of the *Zenith* rule that the statute of limitations "can be tolled under certain circumstances, such as . . . where a plaintiff's damages are only speculative during the limitations period." *Concord Boat*, 207 F.3d at 1051, citing *Zenith Radio Corp. v. Hazeltine Research, Inc.,* 401 U.S. 321, 338-42 (1971). First, the *Zenith* rule is a form of equitable tolling, *Concord Boat*, 207 F.3d at 1051, and plaintiffs have told this Court that they do not rely on "any doctrine of tolling." Pl. Br. at 34. Second, in the district court plaintiffs never asserted any claim to equitable tolling under *Zenith*;[8] because plaintiffs failed to raise the argument below, it is waived.[9]

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[8] Plaintiffs' only reference to tolling in their brief below was a vague statement that after discovery, the "facts might support tolling of the limitations period" in some unspecified way. Brief in Support of Plaintiffs' Response to Motions to Dismiss Third Amended Complaint (District Court Docket No. 154), at 42.

[9] *St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp.*, 539 F.3d 809, 824 (8th Cir. 2008) ("St. Paul waived its choice of law argument by not raising the issue before the district court") (citing *Yankton Sioux Tribe v. United States Dep't of Human Health & Servs.*, 533 F.3d 634, 643 n.6 (8th Cir. 2008) (argument not raised in the district court is waived)).

Third, *Zenith* tolling is inapplicable to plaintiffs' claims here. Plaintiffs have never asserted that they were damaged by their admission to the "True Blue" network, much less that their damages were "speculative or their amount and nature unprovable," as *Zenith* requires. *Zenith*, 401 U.S. at 339. To the contrary, as Judge Holmes observed, admitting plaintiffs to the True Blue network "helped the [plaintiffs]; it did not injure them." Opinion at 12, JA 601. Any injury from USAble's continued refusal to contract with plaintiffs for the FirstSource® network was – as Judge Holmes held – "merely a reaffirmation of the decision in 1997 to exclude them from [that] network." *Id.* The complaint did not allege, and plaintiffs do not assert, that those damages were speculative or unprovable until 2005.

The cases upon which plaintiffs rely for their claim of a "continuing violation" are readily distinguishable from this case, and the differences confirm that Judge Holmes properly applied the statute of limitations. In *DXS, Inc. v. Siemens Medical Systems, Inc.*, 100 F.3d 462 (6th Cir. 1996) (Pl. Br. at 36), Siemens announced in 1986 a policy that it would no longer provide a warranty on equipment installed by third parties such as plaintiff. 100 F.3d at 465. Siemens then "decided not to enforce" that policy in 1987, and continued to warranty equipment installed by third parties. *Id.* In 1998, Siemens told plaintiffs' customers that it would not provide a warranty if plaintiffs installed their

equipment. *Id.* at 469. Plaintiffs sued Siemens for the 1998 statements; Siemens argued that the claim was time-barred because it was merely implementing the 1996 policy. The Sixth Circuit held that if Siemens had in fact implemented the 1996 policy in 1996, the 1998 statements "would probably have represented mere reaffirmations of this policy and inflicted no new and accumulating injury on DXS." *Id.* at 468. However, because Siemens abandoned the 1996 policy in 1997, the 1998 statements were not the result of the 1996 policy; instead, they "were new and independent acts that inflicted new and accumulating injury on DXS, not merely reaffirmations of the" 1996 policy. *Id.* *Siemens* is distinguishable on its facts because unlike Siemens, USAble never abandoned its policy of refusing to contract with plaintiffs for the FirstSource® network; to the contrary, plaintiffs allege that defendants "***refused to budge*** from the exclusion" from 1997 to the present. Complaint ¶ 141, JA 165. On the facts of this case, the law applied in *Siemens* dictates that plaintiffs' claims are time-barred.

Champagne Metals v. Ken-Mac Metals, Inc., 458 F.3d 1073 (10th Cir. 2006) (Pl. Br. at 36), also supports affirmance of Judge Holmes' decision. Champagne alleged that its competitors conspired "to pressure third parties – the mills – not to supply aluminum to Champagne." *Id.* at 1089. That conspiracy was formed more than four years before the suit was filed, but "the subsequent actions (contacting and pressuring the mills when those mills were considering [selling to]

Champagne)" occurred within the limitations period. *Id.* The Tenth Circuit distinguished Champagne's claim from an earlier case, *Kaw Valley*,[10] in which sellers agreed not to sell to the plaintiff; in *Kaw Valley* "the agreeing parties had exclusive control over the input they sought to deny to the plaintiff; a decision not to supply that input required no further action." *Id.* The conspirators in *Champagne*, however, did not simply refuse to sell; they threatened and pressured others to refuse to sell, and the Court held that those "subsequent overt acts" were actionable. *Id.* at 1090. Here, the alleged facts are more like those of *Kaw Valley*. USAble had "exclusive control" over whether to contract with plaintiffs for the FirstSource® network; it decided not to do so in 1997, and "never permitted the plaintiffs back into the FirstSource network" thereafter. Complaint ¶ 62, JA 138. Thus, under the law as stated in *Champagne*, Judge Holmes was correct to dismiss the complaint.[11]

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[10] *Kaw Valley Elec. Coop. v. Kansas Elec. Power Coop., Inc.*, 872 F.2d 931 (10th Cir. 1989).

[11] Plaintiffs argue that "[w]hen the AWP took effect in 2005, Blue Cross had to take new actions to maintain the FirstSource embargo against the plaintiffs." Pl. Br. at 36. Not so. The AWP statute merely required the Health Plan Defendants to permit plaintiffs to serve their insured members; it did not require them to admit plaintiffs to the FirstSource network, which then served only self-insured ERISA plans. USAble's refusal to admit plaintiffs to the FirstSource network in 2005 is nothing more than a continuing refusal to contract, which is not an actionable "overt act." *Concord Boat,* 207 F.3d at 1052 ("acts that 'simply reflect or implement a prior refusal to deal . . . do not restart the statute of limitations'").

Pioneer Co. v. Talon, Inc., 462 F.2d 1106 (8th Cir. 1972), also is distinguishable on the facts, for reasons ably explained by Judge Holmes:

> "The issue [in *Pioneer*] was whether the statute of limitations accrued when Talon gave notice to Pioneer that it would no longer sell products to it or when subsequent orders were refused. *Pioneer*, 462 F.2d at 1107. The Eighth Circuit held that the cause of action accrued when orders were refused, not when notice was given, because even though Talon gave notice that it would refuse future orders, "it terminated nothing of legal significance" because, . . . it had no contract to terminate. *Id.* at 1108."

Opinion at 7, JA 596. Unlike Pioneer, plaintiffs here had formal contracts with USAble and HMO Partners, which were terminated in 1997. Complaint ¶¶ 132, 135, JA 161-62. Thereafter, plaintiffs were not part of the FirstSource® network, and had no right to submit "orders" for reimbursement through that network, and no reason to expect that their "orders" (if any) would be accepted. This Court distinguished *Pioneer* on this ground in *Lomar Wholesale Grocery, Inc. v. Dieter's Gourmet Foods, Inc.*, 824 F.2d 582, 586 (8th Cir. 1987) (emphasis added):

> "In *Pioneer Co. v. Talon, Inc.*, 462 F.2d 1106 (8th Cir. 1972), we held that in the context of a refusal to deal, a supplier's rejection of a specific order placed by a boycotted distributor constitutes an overt act within the meaning of *Zenith Radio*, ***at least where the distributor has no specific distributorship contract which the supplier finally and unequivocably has terminated. The distributor in Pioneer had no such contract***, and even though the supplier had informed the distributor of its 'termination' more than four years before the action was filed, we held that the supplier's subsequent refusals to

> accept specific orders placed within the statutory period 'caused new injury to [the distributor] each time an order was refused.' 462 F.2d at 1109. *Compare David Orgell, Inc. v. Geary's Stores, Inc.*, 640 F.2d 936, 937 (9th Cir. [1981]) (subsequent refusals to deal, even within the statutory period, are not overt acts giving rise to new causes of action where plaintiff's requests are merely 'forlorn inquiries by one all of whose reasonable hopes had been previously dashed')."

Lomar confirms that after USAble and HMO Partners terminated their contracts with plaintiffs in 1997, their refusal to enter into new contracts with plaintiffs is not a new antitrust violation within the limitations period.

Finally, plaintiffs' citation of a law review article[12] for the proposition that a continuing policy is "actionable as long as [the policy] remain[s] in force" (Pl. Br. at 38) is simply contrary to Eighth Circuit law and should be rejected out of hand. The article is a general survey of the law of "continuing violations" as applied to a wide variety of torts and statutory claims. It devotes less than four pages to antitrust claims, and cites only one case (*Hanover Shoe, Inc. v. United Shoe Machine Corp*, 392 U.S. 481 (1968)), for the incorrect propositions upon which plaintiffs rely. The author's conclusion that the statute of limitation never expires as to a continuing refusal to deal conflicts with the settled law of this Circuit. See, *e.g.*, *Concord Boat,* 207 F.3d at 1052 ("acts that 'simply reflect or implement a

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[12] Kyle Graham, *The Continuing Violations Doctrine*, 43 GONZAGA L. REV. 271 (2008).

prior refusal to deal . . . do not restart the statute of limitations'") (citations omitted). Having conceded that this Court's cases require "a new and independent act, not a reaffirmation of a previous act" (Pl. Br. at 35, citing *Varner,* 371 F.3d at 1019), plaintiffs cannot seriously contend that this article accurately states the law.

For these reasons, Judge Holmes' application of the statute of limitations was correct, and should be affirmed. Because the statute of limitations bars all of plaintiffs' damage claims, and because (as noted above) plaintiffs have not challenged the dismissal of their claims for injunctive relief as barred by laches, this is a sufficient basis for affirming the judgment as to the Health Plan Defendants.

II. Alternatively, Plaintiffs' Market Definitions Fail as a Matter of Law.

The judgment should also be affirmed because, as Baptist Health will no doubt demonstrate, the complaint alleges artificially narrow and legally unsupportable definitions of the relevant product and geographic markets for cardiology services. Because the claims against the Health Plan Defendants are based on those same market definitions, Judge Holmes' sound decision dismissing the claims against Baptist Health also supports affirmance of the judgment as to the Health Plan Defendants.

In particular, Judge Holmes properly rejected plaintiffs' assertion that the relevant market for cardiology services is limited to services sold to patients with

private health insurance, and excludes identical services provided by the same doctors in the same hospitals, but paid for by Medicare or Medicaid. Judge Holmes was correct to reject this market definition as a matter of law, and that justifies affirmance of the judgment.

This is not just a technical objection to plaintiffs' pleadings. Plaintiffs' antitrust case depends entirely on their ability to allege relevant markets in which the defendants have large market shares and could exercise market power. Plaintiffs did not dispute in the district court (and have not disputed here) that their antitrust claims fail if services provided to all cardiology patients are included in the relevant cardiology-services market, because plaintiffs are the largest and most successful competitor in that market and FirstSource® does not have a large enough share of patients to support an exclusive dealing claim.[13]

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[13] As discussed above, the complaint admits that FirstSource® covers only about 17% of the population. As a matter of law, 17% foreclosure is far too low to support an exclusive dealing claim. See, *e.g.*, *B & H Med., L.L.C. v. ABP Admin., Inc.*, 526 F.3d 257, 266 (6th Cir. 2008) ("Courts routinely observe that 'foreclosure levels are unlikely to be of concern where they are less than 30 or 40 percent'"), quoting *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of R.I.*, 373 F.3d 57, 68 (1st Cir. 2004); *United States v. Microsoft Corp.*, 1998 U.S. Dist. Lexis 14231 at *61-*62 (D.D.C. Sept. 14, 1998) ("plaintiffs must establish foreclosure on the order of greater than 40% to prevail on their exclusive dealing claims," citing *United States v. Dairymen, Inc.*, 758 F.2d 654 (table), 1985 WL 12976 (6th Cir. 1985) (50% sufficient); *Sewell Plastics, Inc. v. Coca-Cola Co.*, 720 F. Supp. 1196, 1212-14 (W.D.N.C. 1989) (40% insufficient), *aff'd per curiam,* 912 F.2d 463 (9th Cir. 1990); *Oltz v. St. Peter's Community Hosp.*, 656 F. Supp. 760 (D. Mont. 1987) (84% sufficient), *aff'd,* 861 F.2d 1440 (9th Cir. 1988)), aff'd in part and reversed in part on other grounds, 253 F.3d 34, 79 (D.C. Cir. 2001)

As a matter of law, plaintiffs' cardiology-services market definition is improper and must be rejected. Plaintiffs argue that "the government-insurance and private-insurance markets are separate markets because patients cannot substitute one for the other regardless of price differences." Complaint ¶ 32, JA 128-29. Such reasoning would be valid if we were defining a market for the sale of commercial health insurance, because patients normally do not substitute commercial health insurance for Medicare coverage. However, when measuring the extent to which doctors are foreclosed from a cardiology-services market by an allegedly exclusive contract that prevents them from serving some patients, ***the relevant question is what substitute patients are available to the plaintiff physicians***, not what substitute insurance is available to patients. Therefore, all patients must be counted, not just commercially-insured patients. *Campfield v. State Farm Mutual Auto. Ins. Co.*, 532 F.3d 1111, 1118-19 (10th Cir. 2008) ("Although State Farm and its insureds may be a significant consumer of automobile-glass repair and replacement services, Mr. Campfield has not alleged that State Farm insureds are the only consumers available to him. Mr. Campfield

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("Permitting an antitrust action to proceed any time a firm enters into an exclusive deal would both discourage a presumptively legitimate business practice and encourage costly antitrust actions. Because an exclusive deal affecting a small fraction of a market clearly cannot have the requisite harmful effect upon competition, the requirement of a significant degree of foreclosure serves a useful screening function").

might offer his services to other automobile insurance companies or individual car owners who do not have glass coverage. Because these are reasonably interchangeable buyers, the relevant market includes all of these potential consumers of windshield repair and replacement services. When there are numerous sources of inter-changeable demand, the plaintiff cannot circumscribe the market to a few buyers in an effort to manipulate those buyers' market share"); *B & H Med., L.L.C. v. ABP Admin., Inc.*, 526 F.3d 257, 263 (6th Cir. 2008) ("The district court rejected B&H's attempt to define the relevant market as DME/P&O purchases made by individuals covered by a 'large insurance provider network[],' reasoning that the proper market would include 'all purchases or rentals regardless of the source of payment'"; judgment for defendant on exclusive dealing claim affirmed on that basis); *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of Rhode Island*, 373 F.3d 57, 67 (1st Cir. 2004) (Boudin, J.) ("the concern in an ordinary exclusive dealing claim by a shut-out supplier is with the available market *for the supplier*. Here, for Walgreen and Stop & Shop, their potential customers are presumptively *all* retail customers for prescription drugs – not just that smaller sub-group who are insured or reimbursed. To say that some sub-group of customers is foreclosed proves nothing by itself about the impact on pharmacies") (emphasis in original); *Eastern Food Servs., Inc. v. Pontifical Catholic Univ. Servs. Ass'n*, 357 F.3d 1, 6-7 (1st Cir. 2004) (in an exclusive dealing case, "so far as

Eastern's competitive access to customers is concerned, the key question in market definition is what other customers Eastern and its competitors can supply and with what"); *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, 140 F.3d 494, 514 (3d Cir. 1998) (product market could not be limited to defendant's insureds, because "no evidence in the record contradicts the logical assumption that [a pharmacy] considers members of other prescription plans, or uninsured persons, completely interchangeable with U.S. Healthcare members"); Areeda & Hovenkamp, *Antitrust Law* ¶ 570b1 ("The foreclosure effect, if any, depends on the market share involved. The relevant market for this purpose includes the full range of selling opportunities reasonably open to rivals, namely all the product and geographic sales they may readily compete for, using easily convertible plants and marketing organizations") (footnotes omitted). Plaintiffs attempt to distinguish two of these cases on their facts (Pl. Br. at 25-26), while ignoring the rest, and never address the legal principle that the cases establish.

The U.S. antitrust enforcement agencies concluded in a 2004 report (following the hearings cited in the complaint, ¶ 85, JA 144), that Medicare and Medicaid patients must be included in the market when assessing a commercial insurer's market share as a buyer of physicians' services:

> "Defining a buyer-side market involves reversing the standard seller-side formula to ask about the extent to which at-risk suppliers will substitute other outlets for their products or services . . . . [P]urchasers of the input

> need not compete in the output market to be included in the relevant market for the purchase of the input. Thus, it is possible that public payors (*e.g.*, Medicare and Medicaid) and private payors (*e.g.*, health care insurers) do not compete in output markets, but do compete in the market for the purchase of services from health care providers."

Department of Justice and Federal Trade Commission, "Improving Health Care: A Dose of Competition," ch. 3.A (July 2004), available at http://www.usdoj.gov/atr/public/health_care/204694/chapter6.htm#3a.

Under these legal rules, it is clear that Medicare and Medicaid patients are a substitute for commercially-insured patients from the physician's point of view. Indeed, the complaint admits that the plaintiffs have substituted Medicare and Medicaid patients for commercially-insured patients (complaint ¶ 193, JA 184), and suggests that this was their strategy from the beginning (complaint exhibit A, JA 215). Therefore, as a matter of law, cardiology services for Medicare and Medicaid patients are part of the relevant market for purposes of measuring foreclosure.

Judge Holmes' decision rejecting plaintiffs' cardiology-services market definition as a matter of law was therefore correct, and should be affirmed. Because all of plaintiffs' antitrust claims depend on that market definition, the judgment should be affirmed in its entirety.

III. **The Dismissal of Counts 5-7 Should Be Affirmed for Reasons that Judge Holmes Did Not Reach.**

The Health Plan Defendants argued two other, independently sufficient bases for dismissal of Counts 5-7, which allege restraints on and monopolization of the market for health insurance. Judge Holmes did not reach these issues, because he dismissed all claims against the Health Plan Defendants based on the statute of limitations and laches. If this Court does not affirm the judgment for the reasons set forth in Judge Holmes' opinion, the dismissal of Counts 5-7 should be affirmed for these additional reasons.

A. **Plaintiffs lack standing to sue for monopolization of the health insurance market.**

The Third Amended Complaint added three entirely new claims that did not appear in any previous version of the complaint: Counts 5-7 allege conspiracy to monopolize, attempted monopolization, and monopolization ***of the health insurance market***. These new claims allege a *quid pro quo* conspiracy to monopolize two markets. Under that theory,

1. FirstSource's agreement to contract only with Baptist Health excluded plaintiffs from the cardiology-services market and made Baptist a monopolist in that market, and
2. Baptist's agreement to contract only with FirstSource® excluded other insurers from the health insurance market and made Blue Cross a monopolist in that market.

Plaintiffs' claimed damages flow only from the first agreement, not the second. Therefore, Counts 5-7 allege the same damages as Counts 1-4. Plaintiffs' claim for

damages remains exactly the same as it was in the previous complaints, which did not mention any restraint on the insurance market. Because plaintiffs have alleged a violation that did not cause them any injury (and, as discussed below, certainly did not cause them any *antitrust injury*), plaintiffs lack standing to sue and the new counts were properly dismissed.

Plaintiffs are not in the health insurance market, and they do not allege that they either buy or sell health insurance. Nor do they allege that they were injured in any way by a lack of competition in the insurance market. Plaintiffs' claimed injury – the loss of cardiology patients to cardiologists who practice at Baptist Health – is the result of an alleged restraint on competition in the cardiology services market, not the health insurance market. However,

> "[P]laintiffs must prove *antitrust* injury, which is to say injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful. The injury should reflect the anticompetitive effect either of the violation or of anticompetitive acts made possible by the violation. It should, in short, be 'the type of loss that the claimed violations . . . would be likely to cause.'"

Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 489 (1977) (internal quotation marks and citation omitted). In Counts 5-7, what "makes defendants' acts unlawful" is the elimination of competition among insurers. The "type of loss that the claimed violations would be likely to cause" is the exclusion of insurers, overcharging of insurance customers, and possibly forcing down the price of

medical services. Plaintiffs do not allege any such injury. Therefore, plaintiffs lack standing to sue for restraints on competition in the health insurance market. *See, e.g., Port Dock & Stone Corp. v. Oldcastle Northeast, Inc.*, 507 F.3d 117, 123-24 (2d Cir. 2007) (plaintiffs "lack standing because their particular injury was not caused by an exercise of the defendant's newly acquired power to raise prices. Instead, the dealer's injury was caused by the manufacturer's decision to terminate their relationship, something the manufacturer could have just as well have done without having monopoly power").[14]

Courts routinely dismiss antitrust claims brought by plaintiffs who are not participants in the allegedly restrained market, and who therefore cannot claim to have been damaged by any reduction in competition in that market. See, *e.g.*, *Associated General Contractors v. Cal. State Council of Carpenters*, 459 U.S. 519, 539 (1983) (labor union lacked standing to sue for alleged restraint on the market for construction services, because "the Union was neither a consumer nor a competitor in the market in which trade was restrained," and "[i]t is not clear whether the Union's interests would be served or disserved by enhanced

[14] *Accord Norris v. Hearst Trust*, 500 F.3d 454, 466 (5th Cir. 2007); *S.W.B. New England, Inc. v. R.A.B. Food Group, LLC*, 2008 U.S. Dist. Lexis 14892, at *16 (S.D.N.Y. Feb. 27, 2008) ("There is nothing about RAB's alleged monopoly power over kosher foods that enabled the termination of the Distributorship Agreement. Since it cannot be said that SWB's injury is caused by an exploitation of RAB's monopolistic position, that injury is not an 'injury of the type the antitrust laws were intended to prevent'").

competition in the market"); *S.D. Collectibles, Inc. v. Plough, Inc.*, 952 F.2d 211, 213 (8th Cir. 1991) ("standing is generally limited to actual market participants, that is, competitors or consumers"); *Fischer v. NWA, Inc.*, 883 F.2d 594, 600 (8th Cir. 1989) ("Fischer failed to prove that it has suffered an antitrust injury. Fischer does not contend that it was a customer of Northwest forced to pay increased prices. Nor was Fischer a competitor injured by Northwest's acquisition of monopoly power"); accord *South Dakota v. Kansas City S. Indus.*, 880 F.2d 40, 47 (8th Cir. 1987); *General Indus. Corp. v. Hartz Mountain Corp.*, 810 F.2d 795, 809 (8th Cir. 1987); *Henke Enters., Inc. v. Hy-Vee Food Stores, Inc.*, 749 F.2d 488, 489-90 (8th Cir. 1984); *Serfecz v. Jewel Food Stores*, 67 F.3d 591, 597-99 (7th Cir. 1995).

Plaintiffs' brief discusses *Blue Shield of Virginia v. McCready*, 457 U.S. 465 (1982), apparently in support of their standing to sue. Pl. Br. at 20-21. However, plaintiffs never distinguish between standing to sue for restraints on the market for medical services (which was the only standing issue in *McCready*) and standing to sue for restraints on the market for health insurance (which is the only standing issue here). McCready, who was a customer in the allegedly restrained market for psychotherapy services (Br. at 8), never alleged any restraint on the market for health insurance. As Eighth Circuit precedent makes clear, *McCready* does not extend standing to sue to plaintiffs who are not participants in the allegedly

restrained market. *South Dakota v. Kansas City Southern Industries, Inc.*, 880 F.2d 40, 46 n.16 (8th Cir. 1989) ("the fact that a party is not a participant in the relevant market must be weighed heavily against a grant of standing"); *Henke Enters.,* 749 F.2d at 489-90 (finding a lack of standing because, "[u]nlike the plaintiff in *McCready* who was a consumer within the market affected by the anticompetitive activity, Henke's hardware store was neither a competitor, participant, nor consumer within the retail grocery market) (citations omitted); *see Norris v. Hearst Trust*, 500 F.3d 454, 466-67 (5th Cir. 2007) (collecting cases holding that *McCready* does not extend standing to plaintiffs who are not customers or competitors in the restrained market).

Plaintiffs are not participants in the market for health insurance. They neither buy nor sell health insurance, and they do not claim to have been injured by any restraint on competition among health insurers. Therefore, plaintiffs lack standing to sue for any such restraint, and Counts 5-7 therefore were properly dismissed.

B. Counts 5-7 fail because they do not define a plausible relevant geographic market.

Plaintiffs' allegations of monopolization of the health insurance market also fail because plaintiffs' alleged relevant geographic market is implausible on its face, and is contradicted by a wealth of information included in the complaint and

its exhibits. The case law firmly establishes that courts may dismiss antitrust complaints that allege an implausible or excessively narrow market.[15]

Plaintiffs allege that the Health Plan Defendants monopolized the market for health insurance in a geographic market defined as "the cities of Little Rock and North Little Rock." Complaint ¶ 39, JA 130. The complaint correctly acknowledges that

> "A relevant geographic market for antitrust purposes is not defined by the service area or trade area of the parties to the lawsuit. Instead it is defined by the geographic area in which consumers can obtain reasonable substitutes for the relevant product or service."

Id. ¶ 40, JA 130. Therefore, Little Rock cannot be a relevant geographic market unless consumers in Little Rock cannot or will not buy health insurance from insurers located outside Little Rock.[16]

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[15] *See, e.g., Michigan Division, Monument Builders of N. Am. v. Michigan Cemetery Ass'n*, 524 F.3d 726, 733 (6th Cir. 2008) ("the fact that market definition generally requires discovery has not prevented this court, and others, from affirming grants of motions to dismiss on the basis of an insufficiently pled or totally unsupportable proposed market").

[16] See *Bathke v. Casey's General Stores, Inc.*, 64 F.3d 340, 346 (8th Cir. 1995) ("'trade area' considers the extent to which customers will travel in order to do business at Smith's. 'Relevant market' considers the extent to which customers will travel in order to avoid doing business at Smith's"); Areeda & Hovenkamp, *Antitrust Law* ¶ 550b2 ("Although first intuitions sometimes suggest the contrary, a relevant geographic market is not the same as a firm's 'trade area,' or the area from which it draws its customers. Even if all of a store's customers were from the immediate vicinity, there might be numerous others residing in that area who purchase elsewhere. Further, the relevant inquiry is not how far customers

The complaint does not say that Little Rock consumers cannot buy insurance from companies located outside Little Rock. To the contrary, the complaint admits that Little Rock consumers buy insurance from a long list of national companies, including giant health insurers such as UnitedHealth Group (headquartered in Minneapolis), Aetna (Hartford), CIGNA (Philadelphia), Health Care Service Corp. (Chicago), and WellPoint (Indianapolis). *Id.* ¶ 98, JA 149-50. This suggests that health insurance is a national business. Many courts have so found. See, *e.g.*, *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986) (Easterbrook, J.) ("The 'productive asset' of the insurance business is money, which may be supplied on a moment's notice, plus the ability to spread risk, which many firms possess and which has no geographic boundary"); *Total Benefit Servs., Inc. v. Group Ins. Admin., Inc.*, 875 F. Supp. 1228, 1237 (E.D. La. 1995) (There is "no credible evidence to support limiting the geographic market to New Orleans. . . . [C]ustomers looked to suppliers from all over the country. Indeed, most of the licensed suppliers of third party administration services in Louisiana are from out of state") (footnote omitted). If the relevant geographic market is nationwide, then the Health Plan Defendants have an insignificant market share and could not be, or hope to become, monopolists.

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currently travel in order to buy from the defendant, but how far they are willing to travel in order to avoid paying the defendant monopoly prices").

But the Court need not determine that the health insurance business is nationwide to affirm dismissal of Counts 5-7 on this ground. It is enough to observe that the complaint includes ***no factual allegations*** to support its conclusion that the relevant geographic market for health insurance is limited to Little Rock. Courts disregard conclusions unsupported by facts, *Twombly*, 127 S.Ct. at 1965, and plaintiffs' proposed market is not just unsupported; it is contradicted by the factual allegations of the complaint. Therefore, plaintiffs' allegation that the Health Plan Defendants have a large share of the Little Rock "market" is legally meaningless, and the counts that rely on that allegation were properly dismissed.

CONCLUSION

Judge Holmes properly concluded that all of the claims against the Health Plan Defendants are barred by the statute of limitations. Those claims were also properly dismissed because they are based on incoherent and legally unsupportable market definitions. The dismissal of Counts 5-7 was also correct because plaintiffs lack standing to assert those claims, and because their definition of the geographic market failed as a matter of law. Therefore, the judgment dismissing the third amended complaint with prejudice should be affirmed.

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Respectfully Submitted,

Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company; USAble Corporation; and HMO Partners, Inc.

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CERTIFICATE OF SERVICE

I hereby certify that on January 21, 2009, I served by U.S. Mail, all postage fully prepaid, two copies the foregoing brief, along with a compact disc containing the brief, to the following counsel of record:

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C) and Eighth Circuit Rule 28A(c), the undersigned certifies that this brief complies with the applicable type-volume limitations and that, exclusive of the portions exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii), this brief contains 11,966 words. This certificate was prepared in reliance on the word count of the word processing system (Microsoft Word 2003) used to prepare this brief. I further certify that the computer disk submitted with this brief has been scanned for viruses and is virus-free.

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