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

THE SHANE GROUP, INC. et al. Plaintiffs, on behalf of themselves and all others similarly situated v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	)	Case No. 2:10-cv-14360-DPH-MKM Judge Denise Page Hood Magistrate Judge Mona K. Majzoub

NOTICE OF FILING PUBLIC VERSION OF DEFENDANT'S RESPONSE TO PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL [DKT. #139]

On October 11, 2016, pursuant to the Court's August 25, 2016 Scheduling Order [Dkt. #262], the Parties filed a Notice of Documents Previously Filed Under Seal Agreed to Be Unsealed [Dkt. #266] and updated that Notice on October 14, 2016 [Dkt. #273]. Defendant Blue Cross Blue Shield of Michigan (BCBSM) now files full versions of briefs previously filed under seal, making public the portions of those documents that the Parties and Third Parties have agreed they will not move to seal, along with public copies of the corresponding exhibits as listed in Exhibit 1 to the October 14, 2016 Notice. Attached hereto as Exhibit 1 is

Defendant's Response to Plaintiffs' Motion for Class Certification and Appointment of Class Counsel [Dkt. #139] and corresponding exhibits.

This 14th day of October 2016.

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CERTIFICATE OF SERVICE

I hereby certify that on October 14, 2016 I electronically filed the foregoing paper with the Clerk of the Court using the ECF system, which will send notification of such filing to all parties of record. I further certify that I have caused the foregoing document to be sent by email or U.S. Mail to all individuals or entities who filed objections to the previous Settlement Agreement or, for those individuals or entities represented by counsel, their counsel.

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EXHIBIT 1
Part 1 of 2

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

THE SHANE GROUP, INC. et al.	)	
	)	
Plaintiffs, on behalf of themselves and all others similarly situated	)	Case No. 2:10-cv-14360-DPH-MKM
	)	
v.	)	Judge Denise Page Hood
	)	Magistrate Judge Mona K. Majzoub
BLUE CROSS BLUE SHIELD OF MICHIGAN,	)	
	)	
Defendant.	)	

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STATEMENT OF ISSUES PRESENTED

I. Should the Court certify the proposed class under Federal Rule of Civil Procedure 23 and appoint co-lead counsel for the proposed class?

a. Plaintiffs' Answer: Yes.

b. BCBSM's Answer: No.

CONTROLLING AUTHORITY

Federal Rule of Civil Procedure 23

Comcast Corp. v. Behrend, 133 S. Ct. 1426 (2013)

Wal-Mart Stores, Inc. v. Dukes, 131 S. Ct. 2541 (2011)

Reeb v. Ohio Dep't of Rehab. & Corr., 435 F.3d 639 (6th Cir. 2006)

Sprague v. General Motors Corp., 133 F.3d 388 (6th Cir. 1998)

In re Am. Med. Sys., Inc., 75 F.3d 1069 (6th Cir. 1996)

Romberio v. UnumProvident Corp., 385 Fed. App'x 423 (6th Cir. 2009)

Rodney v. Northwest Airlines, Inc., 146 Fed. App'x 783 (6th Cir. 2005)

Federal Rule of Evidence 702

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INTRODUCTION

With the benefit of discovery, Plaintiffs now admit that they cannot prove their original claim – namely, that most favored nation clauses ("MFNs") in BCBSM's hospital agreements raised hospital costs, thereby causing increased prices to *all* commercial payors and *all* consumers who paid for hospital services at those hospitals with MFNs. In an attempt to salvage their case, Plaintiffs have drastically narrowed their class, and now allege that MFNs increased prices at only a handful of Michigan hospitals, and even then only to a small number of commercial payors.

Plaintiffs' cherry-picked "class," which includes only those who directly paid for hospital services under select agreements at 13 of Michigan's 144 hospitals,[1] cannot satisfy Rule 23. The proposed class is composed of a disparate set of specific claims at specific hospitals. Thus, there are no common allegations across the market for the sale of health insurance. Putative class members' payments for hospital services were made at different hospitals, for different services, under different contracts, at different times. As a result, there is no common set of proof that can be used to prove the claims of any alleged class members.

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[1] *See* Plaintiffs' Brief In Support of Motion for Class Certification ("Pls. Br.") [Doc. 133] at 4-5.

Plaintiffs' own expert repeatedly acknowledges this lack of commonality, testifying that his determination of impact at one hospital would do nothing to establish impact at any other hospital. He thus admits that there is no way to determine impact to the class using common evidence.[2] Therefore, the Court should deny Plaintiffs' motion for class certification.

STATEMENT OF FACTS

I. Plaintiffs' Initial Class Definition.

Plaintiffs originally filed this class action alleging that BCBSM's contracts with hospitals containing MFNs "have caused Michigan hospitals to charge supracompetitive prices to BCBSM's competitors and other direct purchasers of hospital services *throughout Michigan*, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, and Section 2 of the Michigan Antitrust Reform Act, M.C.L. § 445.772."[3] Plaintiffs claimed that the MFN clauses, which required hospitals to give BCBSM a discount as favorable as or better than the discount given to any other non-governmental provider, "artificially inflated prices for Hospital

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[2] In addition, there are numerous issues that would preclude class certification even for each individual combination of an "affected" payor and "affected" hospital that Plaintiffs' expert identifies. Plaintiffs did not move for certification of any such classes and did not put forward any evidence suggesting that such a class could or should be certified.

[3] Pls. Consolidated Amended Compl. ¶ 7 [Doc. 78] ("Compl.") (emphasis added).

Healthcare Services *throughout* Michigan."[4]

Plaintiffs' initial class definition reflected their theory that MFNs in BCBSM hospital agreements impacted commercial payors and subscribers. Plaintiffs' proposed class included: (1) *every* commercial health insurance payor; (2) *every* self-insured employer and their employees; and (3) *every* individual insured, who directly paid for hospital services at prices set by reimbursement agreements at a hospital with an MFN.[5]

II. Discovery.

Unlike many potential class plaintiffs, Plaintiffs had the benefit of full discovery prior to filing their motion for class certification.[6] Discovery revealed that even if MFNs had any impact on reimbursement rates at Michigan hospitals, which they did not,[7] a separate analysis of, at the very least, each hospital would be

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[4] Compl. ¶ 30 (emphasis added).

[5] *Id.* ¶ 26 (emphasis added). BCBSM was excluded from the class. *Id.*

[6] Plaintiffs filed this action as a companion case to two prior actions claiming similar antitrust violations, *United States v. Blue Cross Blue Shield of Mich.*, No. 2:10-cv-14155, and *Aetna v. Blue Cross Blue Shield of Mich.*, No. 2:11-cv-15346. Plaintiffs were allowed access to the millions of pages of documents produced by the parties and third-parties in each case and were present at virtually all depositions. In total, over 150 depositions were completed, including depositions of BCBSM representatives, competitors, hospitals, agents, and customers.

[7] Hospital executives repeatedly testified that MFNs had no effect on their rate negotiations with other commercial payors, including the 13 hospitals in Plaintiffs' revised class definition, discussed *infra*. *See e.g.*, [redacted]

necessary to determine any alleged impact. This is because, among other things, the outcome of individual negotiations between hospitals and commercial payors depend on a variety of factors, including whether a hospital belongs to a system of hospitals, whether the commercial payor is owned by a competing hospital,[8] the hospital's geographic location and proximity to other hospitals,[9] a commercial

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[redacted] Andrews (Three Rivers Health) Dep. at 269 (App. 2) (testifying that Three Rivers Hospital would have sought increases from other commercial payors separate and apart from the MFN because of the hospital's financial condition); [redacted] Jackson (Charlevoix) Dep. at 193 (App. 7) (testifying that Charlevoix Area Hospital would have sought increases from other commercial payors separate and apart from any MFN); Leach (Munson) Dep. at 62 (App. 8) (testifying that reimbursement rate increases from Priority Health at Paul Oliver and Kalkaska were sought prior to MFNs being in place); Roeser (Sparrow Ionia) Dep. at 51-52 (App. 9) (testifying that Sparrow Ionia's decision to raise Priority Health's reimbursement rate was not related to BCBSM's contract).

[8] *See, e.g.*, Reichle (Sparrow Health) Dep. at 32 (App. 10) ("Priority is owned by Spectrum Health system in Grand Rapids, which we consider one of our competitors, so that, from a strategic standpoint, we are not interested in inviting competitors into our market.").

[9] *See, e.g.*, *id.* at 31 ("Again, Sparrow Ionia is the only hospital in Ionia County. Ionia, the city of Ionia, where the hospital is located, is approximately 45 minutes from Lansing and 45 minutes from Grand Rapids, so there is very little access to

payor's need for access at a particular hospital, and a hospital's financial condition,[10] strategic goals, and relationship with that particular commercial payor.[11] A hospital's quality, size, reputation, range of special services, and affiliations with universities and physicians also can influence negotiations.[12] In short, many factors affect reimbursement rates between hospitals and commercial payors. *See generally* Sibley Report ¶¶ 40-46 (App. 11) (discussing the importance of these factors).

Hospitals confirmed that they sought increased reimbursement rates from commercial payors for many reasons – financial needs attributable to the hospital's economic conditions,[13] reductions in reimbursement levels from government

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care in Ionia, so it provides a very necessary service there . . . .").

[10] [redacted]

[11] *See, e.g.*, Reichle (Sparrow Health) Dep. at 232 (App. 10) ("I have long-standing relationships with the people at Blue Cross, the people that negotiate our contracts, and, you know, they are based on trust and mutual respect, and assistance when we need help."); *id.* at 115 ("A. I think I ended up giving United a discount and Aetna not a discount. Q. And do you recall why you made that choice? A. Because Aetna was aggressive and became annoying.").

[12] For example, Sparrow Ionia Hospital sometimes bargains jointly with insurers over access to hospital services through the Sparrow Health System and to physicians through the Sparrow Physician Health Network, the exclusive negotiator for approximately 900 member physicians. *See* Reichle (Sparrow Health) Dep. at 9-11 (App. 10).

[13] *See, e.g.*, [redacted] elbinger (Ascension) Dep. at 214-17 (App.14); [redacted]

programs,[14] changes to a commercial payor's volume of business,[15] or simply because of standard increases in the hospital's chargemaster. The contract negotiation documents demonstrated that these agreements generally included multiple provisions and concessions from both sides.

III. Plaintiffs' Revised Class.

Admitting that "it may not be possible to prove damages at all the MFN hospitals," Plaintiffs removed all but one of their class representatives and now

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[redacted] Marcellino (Botsford) Dep. at 150 (App. 15); Gronda (Covenant) Dep. at 138, 153-54 (App.16) & BC Ex. 1301 (App. 17) (citing government shortfalls and financial troubles brought on by the recession); BLUECROSSMI-E-0043304 (App. 18) & BLUECROSSMI-08-021004 (App. 19) (citing Dickinson financial difficulties); Worden (Marquette) Dep. at 152-53 (App. 20); BLUECROSSMI-08-010215 (App. 21) (hospital financially distressed and about to default on bond covenants); Susterich (Metro Health) Dep. at 48-53 (App. 22); BLUECROSSMI-99-02238941 (App. 23) (hospital in "serious financial trouble"); Gov't Ex. 19 (Rodgers) (App. 24) (MidMichigan seeking to carry out new construction); Leach (Munson) Dep. at 183 (App. 8); BLUECROSSMI-10-008253 (App. 25) (citing Sparrow financial difficulties).

[14] [redacted] usterich (Metro Health Hospital) Dep. at 26-27 (App. 22) (stating that government reimbursement shortfalls is "a burden that we have to bear").

[15] [redacted]

seek to certify a significantly narrower class.[16] Plaintiffs define the narrowed class as:

> [A]ll persons and entities who during the relevant time period . . . alone or with a co-payor, directly paid a Michigan hospital (as listed below) for hospital healthcare services at the price provider in the provider agreement (as listed below).[17]

Plaintiffs' narrowed class includes MFN agreements at only 13 out of 144 total hospitals in Michigan.[18] Narrowing it even further, Plaintiffs' proposed class includes only those who paid hospitals pursuant to a select group of reimbursement agreements.[19] Only three commercial payors are included as putative class

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[16] *See* Pls. Mot. Add/Drop Named Pls. at 2 [Doc. 124]. *See also* Pls. Br. at 5 ("The above definition conservatively targets the purchasers of hospital healthcare services most clearly harmed by BCBSM's unlawful scheme, as revealed by the discovery evidence and the impact and damages analyses performed by Plaintiffs' economics expert.").

[17] Pls. Br. at 4. Plaintiffs' Motion for Class Certification describes the class limitations as follows:

> Excluded from the proposed class are (1) BCBSM, its officers and directors, and its present and former parents, predecessors, subsidiaries and affiliates, and (2) insureds whose only payments were (a) co-payments that do not vary with the size of the allowed amount, and/or (b) deductible payments where the hospital charge was larger than the deductible payment.

Id. at 5.

[18] Plaintiffs' motion for class certification ignores the fact that BCBSM had contracts with all 144 hospitals in Michigan. *See* "Largest Network," http://www.bcbsm.com/index/about-us/why-choose-us/largest-network.html (App. 29).

[19] Plaintiffs define these agreements as "affected provider agreements." Pls. Br. at

members: Aetna, Priority, and HAP.[20] Plaintiffs' expert categorized the class members' individual claims into 23 combinations. However, each combination simply identifies specific payor reimbursement agreements at separate hospitals during specific – and different – time periods. This is not an identification of a proposed class; it is merely an identification of individual and distinct claims.

a. Plaintiffs' "Affected" Payors and "Affected" Hospitals.

Despite Plaintiffs' initial claim that MFNs impacted competition and rates across Michigan, Plaintiffs' revised class only includes those who paid for hospital healthcare services at 13 of the 144 Michigan hospitals. Pls. Br. at 4-5.[21] Even at these 13 hospitals, however, Plaintiffs' narrowed class definition implicitly admits

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[20] Plaintiffs also allege that BCBSM's agreements at Beaumont and Ascension hospitals were "affected" by MFNs because BCBSM agreed to pay higher reimbursement rates to the hospitals in exchange for the hospitals' agreement to the MFNs. Pls. Br. at 3. BCBSM, however, is excluded from the class. *See id.* at 4.

[21] BCBSM categorizes hospitals as belonging to various Peer Groups ("PG"), with 1 representing the largest hospitals, and 5 the smallest, rural hospitals. *See, e.g.*, BLUECROSSMI-EM-0211752 at 787-88 (App. 30). Of the BCBSM hospital contracts that Plaintiffs complain of, eight of these clauses were contained in contracts with small rural, PG 5 hospitals, and required only that BCBSM's discount be at least as favorable as the best discount the hospital gave to any other non-governmental provider. Leitzinger Report Ex. 8 (App. 31). Five of these clauses were contained in contracts with PG 1-4 hospitals, and required a differential ("differential MFN"), *i.e.*, a margin between BCBSM's reimbursement rate and the reimbursement rate a hospital could offer other payors. *Id.*; *see also* Rule 1006 Summary of MFN Differential Contract Dates, Terms and Other Information (App. 32).

that there is no common impact. For example, Aetna had contracts with all 13 hospitals during the relevant time period, but Plaintiffs claim that Aetna was only impacted by MFNs at 2 of those hospitals. Pls. Br. at 4-5. Likewise, Priority had contracts at 11 of the hospitals, but Plaintiffs only claim damages for harm suffered at 6 hospitals. *Id.* Finally, HAP had contracts at 7 of the hospitals, yet Plaintiffs only allege that HAP was damaged at 3 of the hospitals. *Id.*

b. Plaintiffs' Proposed Class Representatives.

Plaintiffs' Amended Complaint originally included six named class representatives. Plaintiffs successfully argued in response to BCBSM's Motion to Dismiss that each had alleged sufficient facts to be included in the class. But more than a year later, Plaintiffs' counsel moved to drop all class representatives except the Michigan Regional Council of Carpenters Employee Benefits Fund ("Carpenters"), having discovered that many of the original class representatives could not have been injured and thus were not proper members of the class.[22] Carpenters "is a union health and welfare fund that self-insures its union members," Pls. Br. at 31, and provides a variety of coverage options and benefits individually tailored to its specific groups. Janks Dep. at 23-24 (App. 33). During the relevant time frame, Carpenters only contracted with HAP and BCBSM for administrative services. *Id.* at 67-68. Carpenters' members allegedly received

[22] *See* Pls. Mot. Add/Drop Named Pls.

hospital services at only five of the 13 "affected" hospitals under the "affected" payor agreements. Leitzinger Report ¶ 76, n.142.

At the same time, Plaintiffs also requested the addition of two new named Plaintiffs: Anne Patrice Noah ("Noah") and Susan L. Baynard ("Baynard").[23] Noah and Baynard, employees at Crystal Mountain, are fully insured subscribers under a Priority Health HMO plan. Crystal Mountain offers three different Priority coverage options to its employees, each of which have varying deductibles and cost sharing structures. Noah Dep. at 12-13 (App. 34). Available coverage options have changed several different times over the years. *Id*. Noah and Baynard allegedly received healthcare services at Paul Oliver Memorial Hospital. Pls. Br. at 31. They also received services at Munson Hospital. Baynard Dep. at 42-43 (App. 35); Noah Dep. at 36 (App. 34).

Both Carpenters and proposed Plaintiffs Plaintiffs Noah and Baynard testified that individualized inquiries would be required to determine whether each class member was injured. Janks Dep. at 28-29, 126 (App. 33); Noah Dep. at 89-90 (App. 34); Baynard Dep. at 81 (App. 35). Collectively, the proposed class representatives will represent only 13 of the 23 combinations in Plaintiffs' narrowed class definition.

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[23] *See* Pls. Mot. Add/Drop Named Pls. at 11.

IV. Plaintiffs' Expert Testimony.

Plaintiffs retained Dr. Jeffrey Leitzinger to offer an opinion on Plaintiffs' alleged antitrust impact and damages in relation to class issues. Leitzinger Report ¶ 9 (App. 31). Leitzinger conducted a "difference-in-differences" ("DID") regression analysis for each of the 23 "affected combinations." *Id.* ¶ 51 (App. 31).[24] Leitzinger admitted that he did no analysis to select the "affected combinations," but was simply provided these combinations by Plaintiffs' counsel. Leitzinger Dep. at 19, 68-69 (App. 36).

Leitzinger's DID regression analysis compared the supposed average reimbursement rate each allegedly "affected" payor paid an allegedly "affected" hospital before and after the implementation of the MFN to reimbursement rates at a control group of hospitals without MFNs. Leitzinger Report ¶ 51 (App. 31). In his deposition, Leitzinger admitted that his statistical analysis of Plaintiffs' alleged antitrust impact consisted of 23 *individualized* inquiries. Leitzinger Dep. at 40 (App. 36). Each inquiry utilized evidence and data unique to that particular combination. Leitzinger Dep. at 161 (App. 36) (testifying that "it would not be the same numbers", "it would not be the same contracts" and "it is not the same information in the data" for each combination). Leitzinger further testified that the

[24] By considering HAP's two PPO networks at the three Beaumont hospitals separately, Leitzinger determined that there were 23 combinations in Plaintiffs' proposed class.

results of these 23 DID regression analyses were independent of each other:

> Q: And how if at all does that economic evidence relating to Priority at Allegan affect your conclusion whether or not Aetna was affected at Three Rivers Hospital?
> A: It doesn't. . . .
> Q: How if at all does the economic evidence used to find impact to Priority at Charlevoix Hospital affect the ability to find impact to Aetna at Bronson LakeView?
> A: It doesn't.
> Q: And how if at all does the economic evidence for your conclusions that Priority was affected at the hospitals in your report assist you in determining whether or not for example HAP was impacted at any of the Beaumont facilities?
> A: It doesn't. . . .
> Q: How if at all, Doctor, does the economic evidence you found to conclude that Priority had impact at Allegan help you determine whether or not Priority has impact at Charlevoix?
> A: It doesn't . . . .
>
> *Id.* at 59-60.

In his deposition, Leitzinger conceded that the outcome of one regression analysis has no relevance to the outcome of any other regression analysis. *Id.* at 62 ("Q: Am I correct in understanding that the conclusion you reach about impact as to any affected combination does not tell you whether or not a different combination will feel impact? A: Yes, I think that's correct."); *id.* at 145-47 (acknowledging that what happens at one hospital is irrelevant to what happened at any other hospital).[25]

[25] Leitzinger's opinions are neither reliable nor relevant, and therefore do not meet the standards for admissibility under FRE 702. Accordingly, BCBSM has

V. BCBSM's Expert's Analysis.

BCBSM retained Professor David Sibley to examine Leitzinger's conclusions regarding Plaintiffs' alleged damages and purported antitrust impact in relation to class issues. Sibley Report ¶ 4 (App. 11). Sibley found that the individual rates charged by any hospital to any payor depend on unique factors present in each negotiation. *Id.* ¶ 11. Leitzinger, Sibley noted, did not examine the individualized price-setting process between hospitals and commercial payors,[26] instead using a group of "control hospitals" and "effectively assuming that economic and bargaining conditions are similar across all allegedly similar hospitals in the same control group." *Id.* ¶ 12. Thus, Sibley concluded, Leitzinger ignored the individualized issues that arise at each hospital and in each negotiation, which make common impact unlikely.[27] *Id.*

Sibley further concluded that Leitzinger's analysis, limited to a small, selected list of "affected combinations" involving only some hospitals and some commercial payors, is insufficient to establish antitrust impact. Sibley Report ¶¶

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concurrently filed a motion to exclude his testimony.

[26] *See* Leitzinger Dep. at 21, 39, 119, 136 (App. 36).

[27] Sibley also noted that Leitzinger ignored the alternative explanations that BCBSM deponents offered for the MFN agreements, including: (1) to appease other BCBSM divisions when BCBSM had to accede to higher rates at PG 1-4 hospitals; (2) to alleviate free riding concerns when BCBSM compensated PG 5 hospitals for government payment shortfalls and bad debts; and (3) to resolve uncertainty. Sibley Report ¶ 8 (App. 11).

14-15 (App. 11). And because Leitzinger's DID regressions only show that, at most, some consumers paid higher prices in one geographic location, Sibley found that Leitzinger's analysis did not, and could not, establish harm to competition as a whole. *Id.* ¶ 92. In addition, Sibley determined that because Leitzinger's DID analysis shows varying price effects at the identified hospitals, an individual analysis would be required to determine the degree to which the MFN, as opposed to other factors, caused prices at those hospitals to rise. *Id.* ¶ 99.

Finally, Sibley concluded that Leitzinger's statistical analysis is unreliable, in part because his methodology "calculates only aggregate overcharges and… offers no approach for determining overcharges to individual class members." *Id.* ¶ 24. Calculation of individual class members' overcharges (if any), Sibley found, would require consideration of numerous individualized issues, including (1) the effect of cost-sharing provisions, which determine whether the insured, insurer, or fully-insured employer was allegedly harmed by the overcharge; (2) issues of quality and access to healthcare services, which may lead to net benefits for some and whose value varies from class member to class member; and (3) whether the amounts billed were actually paid by the commercial payor/subscriber. *Id.* ¶ 24.

STANDARD OF REVIEW

"A class action is not maintainable as a class action by virtue of its designation as such in the pleadings." *In re Am. Med. Sys., Inc.*, 75 F.3d 1069,

1079 (6th Cir. 1996) (citing *Cash v. Swifton Land Corp.*, 434 F.2d 569, 571 (6th Cir. 1970)). Instead, Plaintiffs bear the heavy burden of proving that Rule 23 is satisfied. *Achem Products v. Windsor*, 521 U.S. 591, 614 (1997). Here, Plaintiffs must demonstrate that: (1) all four prerequisites of Rule 23(a) – numerosity, commonality, typicality, and adequate representation – are satisfied; (2) the proposed class is ascertainable;[28] and (3) Rule 23(b)(3)'s predominance and superiority requirements are met.

The Court may not simply accept as true Plaintiffs' bare statement that a prerequisite is met. *See Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011) ("Rule 23 does not set forth a mere pleading standard."); *In re Am. Med. Sys., Inc.*, 75 F.3d at 1079 ("Mere repetition of the language of Rule 23(a) is not sufficient."). Rather, the Court must conduct a "rigorous analysis" to determine whether Plaintiffs "[have] affirmatively demonstrate[d] [their] compliance with [Rule 23]." *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2541. "Frequently that 'rigorous analysis' will entail some overlap with the merits of the plaintiff's underlying claim. That cannot be helped." *Id.* at 2551-52 (internal citations omitted); *see also In re Rail Freight Fuel Surcharge Antitrust Litig.*, 725 F.3d 244, 253 (D.C. Cir.

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[28] Rule 23 also requires, as an implied prerequisite to the maintenance of a class action, that the class members be ascertainable through objective criteria without the need for individualized determinations. *See Romberio v. Unum Provident Corp.*, 385 Fed. App'x 423, 431 (6th Cir. 2009).

2013) ("It is now indisputably the role of the district court to scrutinize the evidence before granting certification, even when doing so 'requires inquiry into the merits of the claim.'") (quoting *Comcast Corp. v. Behrend*, 133 S. Ct. 1426, 1433 (2013)).

I. Plaintiffs Cannot Meet the Commonality or Predominance Requirement for the Class They Propose.

Even under Plaintiffs' narrowed class definition, there are no central questions of law or fact common to the proposed class, let alone common questions that predominate over the numerous individual issues inherent in the proposed class. This lack of commonality is conceded by Plaintiffs' expert, who repeatedly admits that the 23 so-called "affected combinations" have nothing in common and that putative class members' claims cannot be proven through common evidence.[29]

The commonality and predominance requirements are often considered together. *See Georgine v. AmChem Products, Inc.*, 83 F.3d 610, 627 (3d Cir. 1996), *aff'd sub nom*, *AmChem Products, Inc. v. Windsor*, 521 U.S. 591, 623 n.18 (1997). Rule 23(a)(2) requires that "there are questions of law or fact *common to the class*." Fed. R. Civ. P. 23(a)(2) (emphasis added). Not every common question will suffice – the Supreme Court has explained that the usual litany of "common"

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[29] See discussion in Section I(a) of the brief, *infra*.

questions is meaningless. *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551.[30] Instead, courts must determine whether there is truly a central common question, the answer to which is core to the case. *Id.* at 2551 (noting that Rule 23(a) requires a "common contention . . . capable of classwide resolution" such that "the determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke").

Rule 23(b)(3)'s predominance inquiry is "more demanding" than Rule 23(a)'s commonality prong, requiring that common questions predominate over any individual questions of the class. *Comcast*, 133 S. Ct. at 1432; *Arlington Video Prod., Inc. v. Fifth Third Bancorp*, 515 Fed. App'x 426, 444 (6th Cir. 2013) (noting that the predominance requirement "parallels the commonality inquiry" but is "more stringent"). To satisfy the predominance requirement, a plaintiff "must be able to demonstrate that all members of the class had a common injury that could be demonstrated with generalized proof, rather than evidence unique to each class member." *Sprague*, 133 F.3d at 397.[31]

a. Plaintiffs' expert repeatedly admits the lack of common evidence to prove the proposed class members' claims.

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[30] *See also Sprague v. General Motors Corp.*, 133 F.3d 388, 397 (6th Cir. 1998).

[31] *See also Halvorson v. Auto-Owners Ins. Co.*, 718 F.3d 773, 778 (8th Cir. 2013) ("[T]he predominance inquiry requires an analysis of whether a prima facie showing of liability can be proved by common evidence or whether this showing varies" with each class member).

Plaintiffs' own expert admits that his model can, at most, only determine potential impact of an MFN through examination of evidence unique to each identified combination. *See* Leitzinger Dep. at 59-62 (App. 36). This concession is sufficient on its own to defeat Plaintiffs' motion.

Leitzinger conducted a separate regression analysis for each individual hospital contract, using different inputs. Leitzinger Dep. at 40 (App. 36); Leitzinger Report ¶ 51 (App. 31). He admits, as he must, that each "affected combination" analysis had no bearing on any other "affected combination" analysis. *See* Leitzinger Dep. at 59 (App. 36) ("Q: And how if at all does that economic evidence relating to Priority at Allegan affect your conclusion whether or not Aetna was affected at Three Rivers Hospital? A: It doesn't."); *id.* at 62 ("Q: Am I correct in understanding that the conclusion you reach about impact as to any affected combination does not tell you whether or not a different combination will feel impact? A: Yes, I think that's correct."); *id.* at 145-47 (acknowledging that what happens at one hospital is irrelevant to what happened at any other hospital). And as BCBSM's expert demonstrates, Leitzinger's DID regressions are not capable of showing harm to competition, let alone that such an issue can be proven with evidence that is common to the class. Sibley Report ¶¶ 16-18 (App. 11). Moreover, Leitzinger admits that his damages model only is a "starting point" to determining how much any individual class member overpaid a Michigan hospital

and that the results of his model provide just "a piece of the puzzle" in determining whether any putative class member was injured. Leitzinger Dep. at 143-44 (App. 36). And any "benefit in the nature or quality of care associated with increased reimbursement," Leitzinger admits, "would necessarily involve a look at what happened at each of the affected hospitals." *Id.* at 175; *see also* Sibley Report ¶¶ 165-73 (App. 11) (explaining the importance of this factor).[32]

Plaintiffs' expert testimony contains the same flaws as the expert testimony in *Rodney v. Northwest Airlines, Inc.*, 146 Fed. App'x 783 (6th Cir. 2005). In *Rodney*, the plaintiff brought a class action against Northwest Airlines, alleging that Northwest violated § 2 of the Sherman Act by creating a monopoly at three hubs. *Id.* at 784. The district court denied the plaintiff's motion for class certification, holding that the plaintiff had failed to satisfy Rule 23(b)(3)'s predominance requirement. *Id.* at 784-85. The Sixth Circuit affirmed, finding that the plaintiff's experts' "analysis of whether a competing airline's flight offerings

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[32] Even though Plaintiffs claim that the separate analyses for each combination shows an MFN effect, as Dr. Sibley demonstrates (a) alleged "MFN effects" are found even when analyzing hospitals without MFNs, thus demonstrating that Leitzinger's model is not designed to and cannot show injury caused by MFNs, Sibley Report ¶ 22 (App. 11); and (b) after fixing statistical concerns with Leitzinger's model or removing certain questionable control group hospitals, the MFN effects at many of the hospitals disappear, thus demonstrating that the model does not even show what Plaintiffs claim it shows. Sibley Report ¶ 23 (App. 11). These are additional reasons why Leitzinger's model cannot provide the common evidence necessary to certify Plaintiffs' proposed class.

differs from Northwest's offerings suggests that individual issues will predominate over the question of market definition." *Id.* at 787. In explaining its holding, the Sixth Circuit pointed to the expert's report, which stated that a comparison of flight offerings must consider factors like "flight frequencies, flight times, size of airports, the existence of a layover, and duration of the flight" and that this comparison would have to be conducted "on a route-by-route basis" for each of the 74 routes at issue. *Id.* at 787.[33]

Like the plaintiff in *Rodney*, Plaintiffs' "case relies almost exclusively on a report" of its expert. *Id.* at 785. And Leitzinger, like the experts in *Rodney*, admits that his regression model must be applied separately and differently "to each of the [23] combinations" to ascertain MFN impact. Leitzinger Dep. at 220 (App. 36). He further admits that he utilizes different evidence for each combination. *Id.* at 161 (admitting that application of his model to each identified combination would "not [involve] the same contracts" or "the same information in the data").[34]

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[33] The Sixth Circuit found that the same issue would pervade the determination of Northwest's alleged monopoly power. *Id.* at 789 ("Rodney's use of 'data screens' does little to assuage our concern that proving monopoly power will cause the class action to degenerate into a series of mini-trials inasmuch as Rodney's own experts describe the 'data screens' as a 'Market-By-Market Analysis of Market Power.'").

[34] This is precisely why Plaintiffs' reliance on *Messner v. Northshore University HealthSystem*, 669 F.3d 802 (7th Cir. 2012), is misplaced. *See* Pls. Br. at 45-46. The Seventh Circuit noted in *Messner* that the expert's multiple DID analyses "all rely on common evidence – the contract setting out the non-uniform price

Therefore, Plaintiffs cannot satisfy the commonality or predominance requirements of Rule 23.

b. Plaintiffs "common" questions are either incapable of classwide resolution or are generalized questions of the type categorically deemed insufficient.

Aside from unjustifiable reliance on their expert, Plaintiffs identify six questions that they claim are common to the class.[35] Most of these questions are the type of meaningless, generalized questions categorically rejected by the Supreme Court. *See Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551 ("Commonality requires the plaintiff to demonstrate that the class members 'have suffered the same injury.' This does not mean merely that they have all suffered a violation of the same provision of law.") (internal citations omitted); *see also Reeb v. Ohio Dep't of Rehab. & Corr.*, 435 F.3d 639, 644 (6th Cir. 2006) (rejecting the

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increases . . . ." *Id.* at 819. "The ability to use such common evidence," the Court noted, "is sufficient to support a finding of predominance on the issue of antitrust impact for certification under Rule 23(b)(3)." *Id.* Here, Plaintiffs' own expert admits that there is no constant input (*i.e.* common evidence) for his 23 separate DID analyses. Leitzinger Dep. at 161 (App. 36).

[35] Plaintiffs claim the following six questions are common to each class member's claims: (1) "[w]hether BCBSM agreed to MFNs in its contract with hospitals"; (2) "[w]hether the use of MFNs by BCBSM is anticompetitive"; (3) "[w]hether [BCBSM] violated the Sherman Act through use of MFN contracts"; (4) "[w]hether [BCBSM] violated the Michigan Antitrust Reform Act through use of MFN contracts"; (5) "[w]hether Defendant's actions caused injury to Plaintiffs and the Class in the form of inflated prices for hospital healthcare services"; and (6) "[t]he appropriate measure of damages." Pls.' Br. at 27.

argument that a question such as "whether the defendant violated Title VII" can satisfy the commonality element because if that "were the test, every plaintiff seeking to certify a class in a Title VII action would be entitled to certification"). Such generalized assertions prevent the Court from conducting the "rigorous analysis" that is required under Rule 23. *Wal-Mart Stores Inc.*, 131 S. Ct. at 2541; *Reeb*, 435 F.3d at 644 (holding that Rule 23(a)(2) requires an examination of "the precise nature of the various claims").

And the question "[w]hether Defendant's actions caused injury to Plaintiffs and the Class in the form of inflated prices for hospital healthcare services" is not a common question because it is not susceptible to common proof. Pls. Br. at 27. Proof that a named Plaintiff was injured by an MFN at a particular hospital does not prove that other potential class members were harmed at the same hospital, much less the other hospitals included in the class definition. For example, even assuming that proposed Plaintiff Noah can prove an MFN caused her injury in the form of an overpayment made at Paul Oliver, this does nothing to prove that an individual who received care as a HAP insured at Beaumont was injured. Thus, this question is not a "common contention" capable of resolving an issue central to each class member's claim in "one stroke." *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551.

Finally, Plaintiffs' assertion that the "appropriate measure of damages" is a

question common to the class is paradoxical because Plaintiffs' class definition demonstrates that Priority, HAP and Aetna did not face common increases in hospital costs at the same hospitals. For example, Aetna had contracts with all 13 hospitals during the relevant time period, but, according to Plaintiffs, was only impacted by MFNs at 2 hospitals. Pls. Br. at 4-5. Likewise, Priority had contracts at 11 of the "affected" hospitals, but Plaintiffs only claim damages for harm suffered at 6 hospitals. *Id.* Finally, HAP had contracts at 7 of the "affected" hospitals, yet Plaintiffs only allege that HAP was damaged at 3 of the hospitals. Id. Plaintiffs, through their class definition, implicitly admit that an MFN at one hospital might impact one commercial payor at that hospital but not another, thereby making common impact of the MFN impossible. Therefore, Plaintiffs' claimed common questions do not satisfy Rule 23(a).

c. Plaintiffs do not meet Rule 23(b)(3)'s requirement that common issues predominate.

Plaintiffs cannot satisfy Rule 23(b)(3)'s predominance requirement because the individualized issues are overwhelming. The predominance inquiry focuses on "how a trial on the merits would be conducted if a class were certified," and requires the Court to consider the elements of Plaintiffs' claims and whether the evidence that Plaintiffs will use to prove those elements is common to the class. *Rodney*, 146 Fed. App'x 783, 786 (6th Cir. 2005) (when analyzing predominance courts "inquire into the substance and structure of the underlying claims" (internal

citation omitted)). To establish its § 1 Sherman Act claim, Plaintiffs must prove that BCBSM "(1) participated in an agreement that (2) unreasonably restrained trade in the relevant market." *Worldwide Basketball & Sports Tours v. NCAA*, 388 F.3d 955, 959 (6th Cir. 2004).[36] If Plaintiffs can prove that MFNs constitute an unreasonable restraint, they then must prove that their "damages were caused by the unlawful acts of the defendant," *MCI Commc'ns Corp. v. Am. Tel. & Tel. Co.*, 708 F.2d 1081, 1161 (7th Cir. 1983), and that competition as a whole "suffered as a result of the challenged business practice." *CBC Companies v. Equifax, Inc.*, 561 F.3d 569, 571-72 (6th Cir. 2009).

As discussed above, there is no single common set of proof for all of the identified combinations that make up the proposed class. According to Plaintiffs' own expert, Plaintiffs' proposed class requires separate and distinct proof of 23 separate and unique "affected combinations." If proposed named Plaintiffs Noah and Baynard were able to show that the MFN at Paul Oliver Memorial Hospital raised the price for hospital services under their Priority HMO contract, that

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[36] The analysis is identical in regards to Plaintiffs' claims under the Michigan Antitrust Reform Act, M.C.L. § 445.772. This statute mirrors Section 1 of the Sherman Act, 15 U.S.C. § 1 and is interpreted in the same manner. *See* M.C.L. § 445.784(2) ("It is the intent of the Legislature that in construing all sections of this act, the courts shall give due deference to interpretations given by the federal courts to comparable antitrust statutes, including, without limitation, the doctrine of per se violations and the rule of reason.").

evidence would not prove that HAP's PPO rates at Beaumont Grosse Pointe were also raised. Nor would it disprove it. The evidence would simply be irrelevant to that question.[37]

Similarly, such proof would be irrelevant to the question whether Priority PPO subscribers, or other Priority HMO subscribers,[38] paid increased hospital healthcare prices at Paul Oliver.[39] An analysis of the discounts provided to an "affected" payor at an "affected" hospital before and after the MFN as well as

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[37] It is worth noting that the services putative class members received at non-"affected" hospitals may also be relevant to this inquiry. For example, proposed Plaintiffs Noah and Baynard sought services at Paul Oliver Memorial Hospital, an "affected" hospital, and Munson Medical Center, a non-"affected" hospital. Noah Dep. at 36 (App. 34); Baynard Dep. at 42-43 (App. 35). Both hospitals are owned and operated by a parent company, Munson Healthcare, who handles rate negotiations for both hospitals. Leach Dep. at 52 (App. 8). As such, a reimbursement rate increase at one hospital in the system may be offset by corresponding reimbursement rate decrease at another hospital within the system. *Id.* at 99 (stating that Munson Healthcare agreed to decrease Priority Health's reimbursement rate at Munson Medical Center in exchange for increased reimbursement rates at Kalkaska and Paul Oliver). Thus, an alleged overcharge paid by a putative class member at one hospital within the system may have been offset by a decreased charge at another hospital within the system, further demonstrating the need for hospital-by-hospital and individualized analysis. *See* Sibley Report ¶¶ 150-54 (App. 11).

[38] The court cannot, as Plaintiffs do, simply assume that all Priority PPO subscriber contracts are the same. Rather, Plaintiffs must meet their burden of proving this claimed similarity with actual evidence.

[39] This is because each "affected" combination involves an endless number of contracts between commercial payors and their customers, which vary in payment terms, cost sharing structure, benefits, and hospital network depending on the subscriber's needs. Thus, there is no commonality even within each combination.

potential causes of that change will need to be conducted on an individualized basis.[40]

Plaintiffs' expert's own analysis shows varying price effects at the "affected" hospitals. In many cases, the results of Leitzinger's analysis shows that prices at MFN equal-to hospitals rose even higher than the MFN required (accepting for sake of argument that Leitzinger's analysis shows a causal effect at all) with amounts above compliance level varying from 2 to 26 points. *See* Sibley Report ¶ 99 (App. 11). Prices above MFN compliance level suggest that causal factors other than or in addition to the MFN may have been at work, such as a hospital's desire to raise prices to respond to financial difficulties. *Id.* Sorting out the degree to which the MFN, as opposed to these other factors, caused prices to rise, requires an individual analysis of the impact of these factors. *Id.*[41]

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[40] An analysis of the discounts (reimbursement rate) is a fact intensive, data driven, process that must be done individually for each "affected provider" at each affected hospital. The actual discount rate cannot be determined by examining a particular contract, but rather, as Plaintiffs' expert testified, must be determined from an analysis of the data. Leitzinger Dep. at 48 (App. 36).

[41] Plaintiffs cannot use their truncated class definition to block inquiry into the procompetitive effects of the MFNs, such as reducing the rates BCBSM paid at numerous PG 5 hospitals (beyond those selected by Plaintiffs), facilitating contracting by other insurers (such as Priority), and producing lower rates for other insurers at certain hospitals. But assessing these issues will balloon the individualized issues already pervading the proposed classes to reach hospitals, insurers, and insureds left entirely out of Plaintiffs' proposed proofs, further demonstrating that class certification is inappropriate. *See Rodney v. Northwest*

Similarly, to prove anticompetitive effects in a relevant geographic market, Plaintiffs would need to prove BCBSM's market power, which they cannot do with common evidence. That is because, as BCBSM's expert demonstrates, there are two sides to hospital negotiations, which depend on both the degree of market power possessed by the commercial payor and the degree of market power possessed by the hospital. Sibley Report ¶ 78 (App. 11). The net effect of the market power considerations that affect the outcome of negotiations, and hence the prices paid, depends on a host of factors. Each of these factors is highly individualized and will vary from hospital to hospital and commercial payor to commercial payor.[42] *Id.* ¶¶ 73-78. For example, St. John Hospital and Medical Center ("St. John") leveraged the power of Ascension Michigan system hospitals in its negotiations with BCBSM to achieve price increases at each member hospital; Sparrow Health System ("Sparrow") was apparently willing to walk away from negotiations; other hospitals had different views and strategies. Id. ¶ 42. Thus, common evidence cannot be used to prove market power or the effect of such market power on hospital rates. *See Rodney*, 146 Fed. App'x at 788.[43]

Airlines, Inc., 146 Fed. App'x 783, 786 (6th Cir. 2005).

[42] For example, despite BCBSM's large market share and its alleged market power, only some hospitals in Michigan have an MFN, and (according to Plaintiffs) only some hospitals with MFNs experienced overcharges.

[43] Dr. Sibley's report further demonstrates that the lack of MFNs at most Michigan

The individual issues that pervade every possible hospital-commercial payor combination overwhelm any thread of commonality holding Plaintiffs' claims together.[44] Thus, Plaintiffs cannot satisfy the predominance requirement of Rule 23(b)(3).

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hospitals demonstrates the need for individualized analysis. "A coherent theory of harm must explain why an allegedly profitable tool is applied so selectively. This likely depends on the specific bargaining power of each hospital with respect to each payer and would vary from hospital to hospital and negotiation to negotiation." Sibley Report ¶ 7 (App. 11).

[44] Plaintiffs also cannot satisfy the predominance prong of Rule 23(b)(3) because the model Plaintiffs' expert uses to determine the impact of the MFNs on class members is not based on the class's theory of antitrust harm. *See* BCBSM's Br. Supp. Mot. Exclude Expert Testimony Dr. Jeffrey Leitzinger, at 24-25 (explaining the disconnect between Plaintiffs' theory of antitrust harm and their expert's model); *see also* Sibley Report ¶ 18 (App. 11) (explaining that applying Leitzinger's methodology to the eight PG5 hospitals he considered, BCBSM's rates often declined, which "contradicts a necessary element of plaintiffs' theory of harm, that BCBSM paid more for MFNs"). Without tying their model of injury to antitrust liability (including that MFNs increased BCBSM's monopoly power in the commercial health insurance market), Plaintiffs "cannot show Rule 23(b)(3) predominance." *See Comcast*, 133 S. Ct. at 1433 ("[A]t the class certification stage (as at trial), any model supporting a plaintiff's damages case must be consistent with its liability case, *particularly with respect to the alleged anticompetitive effect of the violation*.") (emphasis added). By disconnecting their proposed class from their liability theory, Plaintiffs not only leave themselves with no proffered way to prove their antitrust claims (on a common basis or otherwise), but also offer only circular reasoning to support certification. Plaintiffs' proposed proof does nothing more than show that at Plaintiffs' hand-picked "affected" combinations, some payer rates supposedly rose after the MFNs. But of course, Plaintiffs knew that had happened when they picked those combinations. Plaintiffs offer no way to prove whether those few rate changes were caused by the MFNs, as opposed to coinciding with them. Indeed, the fact that Plaintiffs do not assert any such MFN effect at the overwhelming majority of potential hospital/payer combinations in Michigan confirms that no such causal link exists

d. Plaintiffs cannot manufacture predominance by labeling BCBSM's conduct a "conspiracy."

Trying to take advantage of case law suggesting that in price-fixing cases the question whether a conspiracy exists is a predominant common issue, Plaintiffs ask the Court to ignore numerous individual issues inherent in their proposed class claims by labeling BCBSM's conduct a "conspiracy." Pls. Br. at 35-36. But this case does not involve a price-fixing "conspiracy." Rather, it is a case where everyone agrees that an "agreement" exists. The MFNs are included in written contracts; they are not the product of secret agreements made in dark rooms that must be proven with detailed and sometimes ambiguous evidence. "Proving" the existence of the MFNs hardly advances the ball on Plaintiffs' claims. Indeed, even Plaintiffs' expert admits the obvious – that Plaintiffs are not bringing a conspiracy case. *See* Leitzinger Dep. at 12 (App. 36) ("I don't understand the conduct that's alleged in this case to be – to have involved a conspiracy."). Thus, the individual issues detailed above and conceded by Plaintiffs' expert are far and away the predominant issues in this litigation, and Plaintiffs' somewhat strange attempt to describe their claims as "conspiracy" claims cannot change this fact.

II. The Named Plaintiffs' Claims are Not Typical of Absent Class Members' Claims.

Plaintiffs' class also fails Rule 23's typicality requirement because resolution of the named Plaintiffs' claims does nothing to resolve the claims of the

class. *See Beattie v. CenturyTel, Inc.*, 511 F.3d 554, 561 (6th Cir. 2007) ("[T]he typicality requirement is not satisfied when a plaintiff can prove his own claim but not 'necessarily have proved anybody else's claim.'") (quoting *Sprague v*, 133 F.3d at 399). Rule 23(a)(3) requires courts to determine whether the "claims or defenses of the representative parties are typical of the claims or defenses of the class." Courts look at the *dissimilarities* between the named plaintiffs and putative class members when evaluating typicality. *See In re Northwest Airlines Antitrust Litig.*, 208 F.R.D. 174, 218 (E.D. Mich. 2002) (noting that although "commonality and typicality inquiries overlap to a degree, commonality focuses on similarities, while typicality focuses on differences").

Here, there are so many differences between the named Plaintiffs and the putative class members that resolution of the named Plaintiffs' claims would not resolve all class members' claims. Plaintiffs' proposed class is a diverse group of individual insureds, commercial payors, and large, self-funded employers. These individuals' and entities' payments for hospital services were made at different hospitals, for different services, under different contracts, at different times. Leitzinger Dep. at 161 (App. 36) (noting that "it would not be the same numbers", "it would not be the same contracts" and "it is not the same information in the data" for each "affected combination"). The conclusion reached for any single "affected combination" has no relevance to the conclusion for another "affected

combination." *Id.* at 62. Thus, proving the claims of named Plaintiffs will do little or nothing to prove the claims of absent class members.[45]

Moreover, the claims of Carpenters and proposed Plaintiffs Noah and Baynard collectively represent only 13 of the 23 combinations. Thus, even assuming that resolution of the named Plaintiffs' claims resolved the claims of putative class members who fell under the same combination, which they do not, *see* Section I(c) *infra*, there are still 10 remaining combinations with no representative plaintiff.

Plaintiffs argue that the typicality requirement is satisfied because BCBSM's use of MFNs "violates state and federal antitrust law and caused purchasers to pay inflated prices for healthcare services at the affected hospitals." Pls. Br. at 29-30 (Dkt. 133). It is not enough to claim that named Plaintiffs' claims are typical of the class because they rest on an alleged violation of the same statute. *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2551. "The premise of the typicality requirement is simply stated: as goes the claim of the named plaintiff, so go the claims of the class." *Sprague*, 133 F.3d at 399. Because resolution of the named Plaintiffs' claims does nothing to resolve the claims of the class, class certification is

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[45] *See Sprague*, 133 F.3d at 398 ("Proof that GM had contracted to confer vested benefits on one early retiree would not necessarily prove that GM had made such a contract with a different early retiree.").

inappropriate.

III. The Diverging Interests Between Named Plaintiffs and Putative Class Members Prevent Named Plaintiffs From Adequately Representing the Interests of the Entire Class.

The diverging interests between named Plaintiffs and putative class members prevent named Plaintiffs from adequately representing the interests of the class. Rule 23(a)(4) requires that "the representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). This requirement seeks "to uncover conflicts of interest between named parties and the class they seek to represent," *Arlington Video Prod., Inc. v. Fifth Third Bancorp*, 515 Fed. App'x 426, 442 (6th Cir. 2013), by ensuring that "a class representative . . 'possess the same interest and suffer the same injury' as the class members." *Wal-Mart Stores, Inc.*, 131 S. Ct. at 2550 (internal citations omitted); *Young v. Nationwide Mut. Ins. Co.*, 693 F.3d 532, 543 (6th Cir. 2012).

Plaintiffs propose two very different types of class plaintiffs: (1) subscribers, those individuals and groups who are consumers of hospital healthcare services, and (2) the commercial payors that sell health insurance products. Named Plaintiffs are all subscribers. They seek only damages for the alleged overcharges caused by MFNs. For example, proposed Plaintiff Baynard testified that the remedy she seeks has nothing to do with harm to a commercial payor's competitive position, but only that she would "like the class to be compensated for

monies that they have over-spent because of the Blue Cross Most Favored Nation agreements with hospitals in this complaint."[46] Baynard Dep. at 59 (App. 35). Aetna, on the other hand, a commercial payor (and putative class member), has brought its own lawsuit against BCBSM for the same alleged antitrust violations, but seeks damages for harm to its competitive position in the market. Complaint ¶¶ 59-63 [Doc. 1], *Aetna v. Blue Cross Blue Shield of Mich.*, No. 2:11-cv-15346 (E.D. Mich. Dec. 6, 2011). Though Plaintiffs' expert acknowledged that HAP, Aetna, and Priority's competitive positions could have been impacted by MFNs, he testified that he did no analysis of the payors' competitive positions and that his damages model could not answer the question whether these companies were competitively disadvantaged. Leitzinger Dep. at 43-44, 46, 56-58 (App. 36).

Because no commercial payors are included as named Plaintiffs, there are no representatives similarly situated to protect the distinct interests of these class members. Thus, named Plaintiffs are not adequate representatives of the class. *See Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 338 (4th

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[46] *See also* Noah Dep. at 31 (App. 34) ("Q. Are you seeking to recover any profits that Priority may have lost because of use of MFNs? . . . A. No."); and Janks Dep. at 96-97 (App. 33) ("Q: Is Carpenters interested in seeking to recover any profits that Priority might have lost as a result of MFNs? A: The Carpenters is not. Q: Are the Carpenters seeking to recover any profits that United or HAP might have lost because of the MFN provisions? A: The Carpenters are not seeking a profit.").

Cir. 1998) (holding that the named plaintiffs were not adequate representatives because they had differing interests in pursuing damages remedies than other members of the class). As such, the Court should deny class certification for any commercial payor claims.

IV. Class Certification Is Inappropriate Because Individualized Inquiries Are Necessary To Ascertain Class Members.

Certification also is improper because Plaintiffs' proposed class is not ascertainable given the individualized determinations required to identify class members. An "implied prerequisite of Federal Rule of Civil Procedure 23" is "[t]he existence of an ascertainable class of persons to be represented by the proposed class representative." *John v. Nat'l Sec. Fire & Cas. Co.*, 501 F.3d 443, 445 (5th Cir. 2007); *Romberio v. UnumProvident Corp.*, 385 Fed. App'x 423, 431 (6th Cir. 2009).[47] A class is ascertainable if class members can be readily identified through objective criteria and without the need for individualized determinations. *See Crosby v. Soc. Sec. Admin.*, 796 F.2d 576, 580 (1st Cir. 1986) (explaining that a class definition should be based on objective criteria so that class members may be identified without individualized fact finding).

In this case, a highly individualized inquiry is necessary to determine who

[47] *See also* 5 Moore's Federal Practice, § 23.21(1) ("[B]efore a class can be certified under Rule 23, the class description must be sufficiently definite so that it is administratively feasible for the court to determine whether a particular individual is a member of the proposed class").

meets the class definition. Even assuming that each putative class member's health insurance plan stayed constant during the relevant class period – a questionable assumption given that individuals frequently change health plans or coverage options due to changes in employment, family or marital status, or financial circumstances – the Court will be required to make thousands of individualized inquires. At a minimum, the Court will have to inquire as to (1) whether the person or entity made a direct payment to the hospital and, if so, in what amount; (2) if the only payment was a co-payment, whether the co-payment varied with the size of the amount allowed; (3) if the only payment was a deductible payment, whether the hospital charge was larger than the deductible payment; and (4) an examination of the claims histories of each potential plaintiff to determine where care was received; the type of service received; whether that service was a covered benefit; and whether the individual exhausted his deductible through services at hospitals not included in the class definition. Issues relating to the cost-sharing rules that govern payments of deductibles, copays, and stop-loss provisions in ASO contracts will further complicate this process. Baynard Dep. at 17-18 (App. 35) (testifying that in order to determine the type of plan that she had from her employer, including the deductible associated with that plan, she would need to examine the records for each relevant plan year).

Such individualized inquiries must be made to determine the identity of each

putative class member. Leitzinger Dep. at 191 (App. 36); Janks Dep. at 111-112 (App. 33) ("Q: And determining where a Carpenters member sought services in a given year wouldn't do anything to help you determine where a non-Carpenters member sought services in any given year? A: Correct. Q: And . . . determining that a Carpenters member was subject to certain deductible, co-pay, and co-insurance limits wouldn't do anything to help you determine whether a non-Carpenters employee had the same or different co-pay, deductible, or co-insurances levels . . . A: Correct."); Baynard Dep. at 78-79 (App. 35) (testifying that determining the level of deductible applicable under her health insurance plan for any given year, whether she met or exceeded her deductible, or even whether she made direct payment for hospital services in any year would do nothing to determine the same information for any other class member).

Even for the named Plaintiffs, this information is not easily accessible and will require the cooperation of both commercial payors whose agreements have been allegedly impacted by the MFNs and hospitals that provided the services. For example, proposed Plaintiff Noah testified that in order to determine the amount of out-of-pocket costs for non-covered services from 2006 to present, she would have to "look at payments received by the named hospitals that [she] sought services from, [her] checking account and paid receipts [she] kept in [her] own records." Noah Dep. at 27-28 (App. 34).

As hard as it would be for the named Plaintiffs, it would be much harder, if not impossible, for the unnamed class members. Discovery is complete and little, if any, of the information necessary to make these determinations is in the record. For example, Plaintiffs successfully argued in response to BCBSM's Motion to Dismiss that they only needed to plead boilerplate facts about their named Plaintiffs rather than sufficient facts to establish that the class representatives had suffered any alleged injury. More than a year later, Plaintiffs discovered that in fact many of the original Plaintiffs were not even allegedly injured and were not proper members of the class, leading to Plaintiffs' Motion to Add and Drop Plaintiffs. Even knowing the difficulties they previously had, Plaintiffs still appear unable to distinguish class members from non-class members. The evidence suggests that Susan Baynard, one of the two individuals who Plaintiffs have proposed as additional class representatives, is not a member of the class.[48] Given

[48] The only evidence of Baynard's payment for hospital healthcare services to any of the 13 "affected" hospitals during the relevant period is a Priority Health Explanation of Benefits form, along with a cancelled check for part of Baynard's deductible. *See* Baynard Ex. 1 (App. 37) and Ex. 3 (App. 38) The benefits form shows that: 1) Baynard had an individual deductible limit of $250; 2) she incurred a deductible charge of $102.26 on September 11, 2009 for lab services (for which she produced a copy of check to Paul Oliver dated Oct. 1, 2009); 3) this deductible charge brought her up to a total of $186.22 in deductibles; and 4) she then incurred a further hospital charge at Paul Oliver on September 14, 2009 in the amount of $550.20. Because that $550 hospital charge is "larger than the deductible payment[s]" she made (even if Baynard later hit her $250 deductible cap), Baynard would be excluded under the proposed class definition if her 2009 deductibles

the substantial amount of time and discovery it has taken (and will continue to take) Plaintiffs to ascertain whether their own class representatives were proper members of their class, and because individualized inquiries into the facts and circumstances of each putative class member are required to ascertain class members, certification is inappropriate.[49]

CONCLUSION

For the foregoing reasons, BCBSM respectfully requests that the Court deny

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were the "only payments" she made to an "affected" hospital. There is no evidence in the record indicating that Baynard made any other payments to Paul Oliver (or any other hospital) for "hospital healthcare services" during the relevant class periods. Baynard did produce a copy of one additional check to Paul Oliver in the amount of $15.19 dated November 1, 2010 but she could not recall what that amount was for. Baynard Dep. at 47 (App. 35); Baynard Ex. 2 (App. 39), and she did not produce any documentation that it was for medical services received from Paul Oliver. If Baynard turns out to be a class member based on other yet to be discovered evidence, this just further demonstrates the difficulty in ascertaining whether any particular individual is a class member.

[49] *See, e.g.*, *Romberio v. UnumProvident Corp.*, 385 Fed. App'x 423, 425-31 (6th Cir. 2009) (holding that the district court improperly certified a class of ERISA plan participants who had been "subjected to any of the practices alleged in the Complaint" because individualized determinations would be required to evaluate whether plan participants had been subjected to such practices); *Cerdant, Inc. v. DHL Express (USA), Inc.*, No. 2:08-cv-186, 2010 WL 3397501, at *5-6 (S.D. Ohio Aug. 25, 2010) (denying class certification because an individualized fact inquiry was necessary to identify persons who contested their shipping bill within 180 days of shipment, a requirement that was necessary for persons to have standing to assert the claim); *Snow v. Atofina Chem., Inc.*, No. 01-72648, 2006 WL 1008002, at *7-8 (E.D. Mich. Mar. 31, 2006) (finding that persons who suffered a diminution in value to their real property from an explosion in a chemical plant were not sufficiently ascertainable as a class because identification of class members would require individual proofs relating to their property).

Plaintiffs' Motion for Class Certification.

Respectfully submitted,

HUNTON & WILLIAMS LLP

By: /s/ Todd M. Stenerson

Todd M. Stenerson (P51953)
Attorney for Defendant
2200 Pennsylvania Ave, N.W.
Washington, D.C. 20037
(202) 955-1500
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Attorney for Defendant

February 3, 2014

CERTIFICATE OF SERVICE

I hereby certify that on February 3, 2014, I caused the foregoing

DEFENDANT'S MOTION TO EXCLUDE THE EXPERT TESTIMNONY OF DR. JEFFREY LEITZINGER be served via electronic mail upon:

Attorneys for Plaintiffs - The Shane Group, Michigan Regional Council of Carpenters Employee Benefits Fund, Scott Steele, Bradley A. Veneberg, Abatement Workers National Health and Welfare Fund, and Monroe Plumbers & Pipefitter Local 671 Welfare Fund:

Daniel Small: dsmall@cohenmilstein.com
Brent Johnson: bjohnson@cohenmilstein.com
Meghan Boone: mboone@cohenmilstein.com
Mary Jane Fait: fait@whafh.com
John Tangren: tangren@whafh.com
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Dan Gustafson: dgustafson@gustafsongluek.com
Dan Hedlund: dhedlund@gustafsongluek.com
E. Powell Miller: epm@millerlawpc.com
Jennifer Frushour: jef@millerlawpc.com
Casey Fry: caf@millerlawpc.com

HUNTON & WILLIAMS LLP

By: /s/ Todd M. Stenerson
Todd M. Stenerson (P51953)
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tstenerson@hunton.com

APPENDIX 2

UNITED STATES DEPARTMENT OF JUSTICE

EASTERN DISTRICT OF MICHIGAN

- - - - - - - - - - - - - - - x

United States and State :

of Michigan, :

:

Plaintiffs, :

:

vs : Civil Action No.

: 2:10-cv-14155-DPH-MKM

Blue Cross Blue Shield :

of Michigan, :

:

Defendant. :

- - - - - - - - - - - - - - - x

Deposition of STEVE ANDREWS, taken in the above-entitled matter before Notary Public, Patricia A. Lutza, CSR, CRR, at Three Rivers Health, 701 S. Health Parkway, Three Rivers, Michigan, on Wednesday, November 2, 2011, commencing at about 9:00 a.m.

MR. SMALL: Object.

MR. GRINGER: Object.

THE WITNESS: No.

BY MR. STENERSON:

Q. Do you agree with me that even separate and apart from the MFN, all of the rates that you received from those payors were rates that you needed to seek and would have sought because of the financial condition for your --

MR. GRINGER: Object to foundation.

MR. SMALL: Object to foundation.

THE WITNESS: I believe that, based on our financial condition, we would have sought those rates anyways.

VIDEO TECHNICIAN: Disc 7 of the video deposition of Steve Andrews. We are going off the record at 5:11.

(Off the record.)

VIDEO TECHNICIAN: This is disc 8 of the deposition of Steve Andrews. We are going back on the record at 5:16 p.m.

APPENDIX 7

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN,	)	Civil Action no.:
Plaintiffs,	)	2:10-cv-14155-DPH-MKM
v.	)	
BLUE CROSS BLUE SHIELD OF MICHIGAN	)	Judge Denise Page Hood
Defendant.	)	Magistrate Judge Mona K. Majzoub

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

AETNA INC.,	)	
Plaintiff,	)	Civil Action No.
v.	)	2:11-cv-15346-DPH-MKM
BLUE CROSS BLUE SHIELD OF MICHIGAN	)	
Defendant.	)	

Charlevoix, Michigan

Friday, March 2, 2012

Confidential Video Deposition of:

WILLIAM JACKSON,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at AmericInn, 11800 US-31, Charlevoix, Michigan, before Michele E. French, RMR, CRR, Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:07 a.m., when were on behalf of the respective parties:

most favored nation or MFN agreements limit competition and push hospital costs higher." Quote, "'Did it have any impact on our ability to do business? No,' Jackson said." **15:00:42**

Is that consistent with your memory?

A Yes.

Q Do you agree with that statement today? **15:00:53**

A I made that statement then. I stand by it today.

Q And in Jackson 13, Miss Sole is a negotiator for Priority; correct?

A Yes, she is. **15:01:09**

Q And her e-mail to your CFO says, "I heard you and Bill loud and clear last year about your expectation that Priority Health meet your Blue Cross reimbursement levels in 2009." Correct?

A Yes. **15:01:25**

Q And did I understand correctly your prior testimony that that was Charlevoix's expectation of where the reimbursement rate for Priority should be, separate and apart from any MFN clause?

MR. DANKS: Object to form. **15:01:38**

THE WITNESS: That has been my position for a long time.

BY MR. STENERSON:

APPENDIX 8

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action no.: 2:10-cv-14155-DPH-MKM Judge Denise Page Hood Magistrate Judge Mona K. Majzoub

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

AETNA INC., Plaintiff, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No. 2:11-cv-15346-DPH-MKM

Traverse City, Michigan
Thursday, March 15, 2012

Confidential Video Deposition of:

STEVEN LEACH,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at the Alpha Center, 3668 North US-31, Traverse City, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:52 a.m., when were present on behalf of the respective parties:

THE WITNESS: They're all independent analysis. Again, Kalkaska is publicly owned and does not relate to Munson directly at all, so they -- they can establish their prices however they see fit. We do work -- we, Steve Leach, Steve Leach and his assistants, Tina and Lisa, work on that on their behalf. **10:41:06**

BY MR. GRINGER: **10:41:31**

Q So you negotiate with commercial health insurers on behalf of Kalkaska?

A Yes.

Q And what about Paul Oliver?

A Yes. **10:41:38**

Q And Munson Medical Center, too?

A Correct.

Q When you're negotiating with commercial health insurers, do you negotiate on behalf of all three hospitals at once? **10:41:47**

A No. Munson is always separate because they're the mother ship. They're the much larger facility and there's totally different reimbursement logic associated with them, but usually the other two are, if you will, together. **10:42:01**

I think I'm going to take that back. Oftentimes they're independent. You know, I would negotiate Paul Oliver separate from Kalkaska.

favored nations clause?

MR. STENERSON: Object to the form. **10:51:18**

THE WITNESS: No, not directly. It's still part of the deal, though. I mean, the most favored nation clause is still embedded in the PHA.

BY MR. GRINGER:

Q When you were discussing this arrangement with **10:51:32** regard to the most favored nations clause and the controlled charges arrangement with Mr. Darland, did Mr. Darland ever ask you anything about Blue Cross's price at Paul Oliver and Kalkaska?

A No. **10:51:49**

Q Did he ever ask you to lower Blue Cross's rate to what Priority was paying?

A No.

Q Did you ever tell him that you planned to increase Priority's rate to what Blue Cross was paying? **10:51:59**

A Yeah, I told him we would try to bring them into parity, or equilibrium, or whatever word I used, but....

Q And today, just so the record is clear, you believe you're in compliance with the most favored **10:52:20** nations clause at Paul Oliver and Kalkaska?

MR. STENERSON: Object to the form, misstates his testimony.

BY MR. GRINGER:

Q Today you do receive more money from Priority; right? 11:50:29

A Yes.

Q So what changed?

A We were able to negotiate an improved rate, as we discussed. And I think -- there's one other little point that I think needs to be mentioned, too, is that when we did go to a percent of charges deal with Priority, with Priority for Kalkaska and Paul Oliver, part of that negotiation did include a reduction to Munson's rate. 11:50:37 11:50:58

In other words, to get them to -- to improve their reimbursement, we would take a nick on Munson. So there was like, if you will, an offset there.

Q So correct me if I'm wrong -- 11:51:08

A I don't remember the exact -- when that exactly occurred, but go ahead.

Q One of the -- so you offered to Priority in return for an increased reimbursement at Kalkaska and Paul Oliver a slight decrease in reimbursement at Munson Medical Center? 11:51:20

A Yeah, yeah. I think it was 1 percent, I believe.

MR. GRINGER: Mr. Stenerson, are you saying that I can only ask questions about things that we claim are violations of the antitrust laws? **14:43:43**

MR. STENERSON: I'm just asking a clarification question.

MR. GRINGER: I'm not --

MR. STENERSON: Is the Government claiming -- **14:43:52**

MR. GRINGER: I'm not answering that question, Mr. Stenerson. I'm happy to discuss it --

MR. STENERSON: -- that this clause is being litigated? **14:43:55**

MR. GRINGER: I'm happy to discuss that with you at a different time, but now is not the time.

BY MR. GRINGER:

Q Can you just explain why it is that you didn't want the 2009 PHA to apply to Munson Medical Center? **14:44:17**

A Well, I think you're referring to the reimbursement logic that it's driving, and it's effectively a rebasing of our costs, and that would cost us money, and we wanted to hang on to the reimbursement we already had and didn't think it was appropriate nor fair, so we negotiated a separate deal. **14:44:38**

Q Can I ask you just to turn to B I of Exhibit 13. It's the page with Bates number MHC-EDMI-002551.

APPENDIX 9

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

UNITED STATES OF AMERICA and the STATE OF MICHIGAN, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No.: 2:10-cv-14155-DPH-MKM Hon. Denise Page Hood Mag. Mona K. Majzoub

Lansing, Michigan

Wednesday, August 8, 2012

Confidential Deposition of:

WILLIAM ROESER,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Foster, Swift, Collins & Smith, 313 Washington Square, Lansing, Michigan 48933, before Quentina R. Snowden, CSR-5519, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:00 a.m., when were present on behalf of the respective parties:

access hospitals get higher reimbursement?
A I don't know.
Q Are you aware of how Sparrow Ionia's obligation to guarantee Blue Cross the best discount was established? 10:03
A No.
Q You mentioned earlier that Sparrow Ionia Hospital negotiated a new contract with Priority Health as a result of the most favored discount clause in the Blue Cross provider agreement; is that right? 10:03
MR. MARTIN: Object to the form.
MR. MANDEL: I will object to it mischaracterizes the testimony.
MR. MARTIN: That's what I meant too.
THE WITNESS: It wasn't related to 10:03
the -- you know, the Blue Cross contract. It was related to we were getting way less reimbursement than we needed, and we basically went to Priority and said we have to have a competitive reimbursement if we're going to survive. 10:04
BY MS. BHAT:
Q And when you say "competitive reimbursement", what do you mean?
A Well, I think at the time they were reimbursing us less than 40 percent of our charges, and the 10:04

hospital was losing a million or more a year, and Priority was a relatively small amount of our business, but an important payor, since they have contracts in the -- in the Ionia area. And we basically said, to survive, we need a more, you know, favorable reimbursement. 10:04

Q Do you know what, if anything, would happen to Sparrow Ionia Hospital if it were not to comply with the Blue Cross most favored discount clause?

A Not specifically, but I believe the contract allows them to receive the lower of the rates. 10:05

Q Can you explain what you mean by that?

A My understanding of the clause is that if there's a payor that receives a lesser, you know, rate, that they would then be eligible to receive that rate. 10:05

Q So, would Sparrow Ionia Hospital receive less money from Blue Cross/Blue Shield if it were to not be in compliance with the most favored discount clause? 10:05

A My understanding is, yes, assuming they enforced it. I don't know how they do that.

Q Is -- is Blue Cross/Blue Shield currently aware that Sparrow Ionia Hospital is in compliance with the most favored discount clause? 10:06

APPENDIX 10

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action no.: 2:10-cv-14155-DPH-MKM Judge Denise Page Hood Magistrate Judge Mona K. Majzoub

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

AETNA INC., Plaintiff, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No. 2:11-cv-15346-DPH-MKM

Lansing, Michigan
Wednesday, August 8, 2012

Confidential Video Deposition of:

PAULA M. REICHLE,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Foster Swift Collins & Smith, at 313 South Washington Square, Lansing, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:14 a.m., when were present on behalf of the respective parties:

P R O C E E D I N G S

VIDEOGRAPHER: We are now on the record. This is the videotaped deposition of Paula Reichle, being taken on Wednesday, August 8th, 2012. The time is now 9:14 a.m. **09:15:27**

We are located at 313 South Washington Square, Lansing, Michigan. We are here in the matter of United States of America, et al., versus Blue Cross Blue Shield of Michigan. This is Case Number 10-cv-14155. This matter is being held in the United States District Court, Eastern District of Michigan, Southern Division. **09:15:51**

My name is Rachel Bierl, video technician. **09:16:13**

Will the court reporter swear in the witness and the attorneys briefly identify themselves for the record, please.

PAULA M. REICHLE, was thereupon called as a witness herein, and after having first been duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows: **09:16:22**

MR. McRAY: Gary McRay, I'm a partner with Foster Swift, and we represent Sparrow Health System. **09:16:29**

MR. DANKS: Ryan Danks for the United

States.

MR. SUKENIK: Michael Sukenik, Gibson Dunn, on behalf of Aetna. **09:16:40**

MS. BURNS: Erin Burns of RodaNast on behalf of the Private Class Plaintiffs.

MS. LIPPITT: Elizabeth Lippitt, State of Michigan. **09:16:51**

MR. HARRIS: Alan Harris, Bodman, co-counsel for Blue Cross Blue Shield Michigan.

MR. LASKEN: Jonathan Lasken, Hunton & Williams, also co-counsel for Blue Cross Blue Shield of Michigan. **09:17:00**

MR. STENERSON: Todd Stenerson on behalf of Blue Cross Blue Shield of Michigan.

EXAMINATION

BY MR. DANKS:

Q Good morning, Miss Reichle. **09:17:07**

A Good morning.

Q Have you ever been deposed before?

A It's been a long time, 20 years or so.

Q Okay. And in what context were you deposed?

A A lawsuit regarding the termination of a CEO of a company that I worked for. **09:17:17**

Q Was that company Sparrow?

A It was not.

Q A few ground rules as we get started here. I am going to do my best to ask questions clearly and concisely, but if I don't do so and you don't understand the question, please feel free to ask me to repeat it; is that okay?

A That's fine.

Q And do you understand that we need to give questions and answers verbally and not just by nodding or heads or -- **09:17:33** **09:17:44**

A Correct.

Q -- shaking or things like that?

A Um-hum. **09:17:54**

Q Okay. And then I guess the last thing I would ask is that we take care not to interrupt each other. If you will allow me to complete my question and then I will allow you to complete your answer before we continue; is that okay? **09:18:05**

A Sounds reasonable.

Q Excellent. In terms of breaks, my practice is usually to stop every hour, 70 minutes or so. If you need to take a break in the meantime, please just let me know. I will probably want to finish whatever question we're addressing, but otherwise I'd be happy to accommodate you. **09:18:18**

A Okay.

correct?

A That's correct. **09:45:21**

Q So why is it important for -- if the System has hospitals in Lansing itself, why is it important to have a hospital in St. Johns as well?

A St. Johns is a bedroom community of Lansing and is -- in Clinton County, there is no other hospital. **09:45:39** St. Johns is the only hospital. So it provides emergency services and outpatient services as well as some minor inpatient services to those residents who may choose not to drive all the way to Lansing or whose care may dictate that they don't really have time to get to **09:46:03** Lansing.

Q And how about with respect to Sparrow Ionia, which I understand to be in your secondary service area?

A Again, Sparrow Ionia is the only hospital in Ionia County. Ionia, the city of Ionia, where the **09:46:18** hospital is located, is approximately 45 minutes from Lansing and 45 minutes from Grand Rapids. So there is very little access to care in Ionia, so it provides a very necessary service there, hence the Critical Access definition. **09:46:41**

Q And what is the Critical Access definition?

A Basically, it's a special payment and a special designation for hospitals to be able to stay

open in areas that are under-served. That's my definition. I am sure there is a legal definition according to the Federal Government. **09:46:55**

Q And I was going to ask you, who makes the Critical Access determination?

A Centers for medical -- Medicaid and Medicare Services, CMS. **09:47:07**

Q You mentioned that the Sparrow Clinton and Sparrow Ionia can provide a source of tertiary referrals for Sparrow Health System.

A (Nodding head.)

Q Why is that important to the Health System? **09:47:24**

A Well, it helps support our operation. It is good for us financially. It helps increase our volumes. And those patients will go somewhere for those tertiary services, so when we have ownership interest or those Critical Access Hospitals are subsidiaries of Sparrow Health System, they are linked clinically to the tertiary provider, so we have a lot of physician-to-physician relationships, especially around specialty care, such as cardiology, oncology, et cetera. **09:47:45**

Q So is the idea there that the physicians at the Peer Group 5 hospitals have a relationship with the physicians at Sparrow Health System, thereby encouraging them to refer patients to the physicians at the Health **09:48:02**

Aetna.

Q Did he ever seek a change to Aetna's contract with Sparrow to allow Aetna to bid for business relating to Wal-Mart? 12:12:01

A Yes.

Q Okay. I'm going to hand you what I have marked as Reichle 9. I ask you to take a look at that. 12:12:15

(Government Exhibit Reichle 9 was marked.)

THE WITNESS: (Reviewing Government Exhibit Reichle 9.)

BY MR. DANKS: 12:12:25

Q Reichle 9, just for the record, is a three-page document with Bates numbers beginning Aetna-00502913 and ending with Aetna, same prefix, 2915.

The first page there is an e-mail from Mr. Winters to you, is it not? 12:12:48

A Um-hum, yes.

Q And he's sending you some information about an opportunity that Aetna has to bid on Wal-Mart business; is that correct?

A That's correct. 12:13:00

Q And he's referring to "...in advance of our discussion tomorrow." Do you know what he was referring to there?

A Correct.
Q And those contracts were contingent on the sale of PHP to Blue Care Network; is that correct? 16:15:48
A Correct.
Q And during the course of those negotiations, did either -- did Miss Horn or Mr. Koziara from Priority ever ask you how the rates being offered compared to -- how the rate Sparrow was offering them compared to the rates that Blue Cross was receiving? 16:16:06
A I don't think so.
Q How about for Mr. Helms and HealthPlus?
A They didn't -- did not ask that question. 16:16:20
Q Did they ask a similar question?
A They may have, you know, talked in general about being able to have rates that were competitive with Blue Cross. They never asked us what our rates were or for a specific number in relation to that; but they did ask questions like "We need to be competitive with the Blues." 16:16:37
Q And did they ever describe to you a range that would put some actual numbers on what they --
A They may have. I don't specifically recall, but they might have. 16:16:54
Q I think you testified earlier that you thought that Priority could well have expanded to meet the Tier

APPENDIX 11

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

CONFIDENTIAL--TO BE FILED UNDER SEAL
SUBJECT TO PROTECTIVE ORDER

THE SHANE GROUP, INC., et al., Plaintiffs, on behalf of themselves and all others similarly situated, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	**No. 2:10-cv-14360-DPH-MKM**

EXPERT REPORT OF PROFESSOR DAVID S. SIBLEY

February 3, 2014

I. INTRODUCTION

A. Qualifications

1. My name is David S. Sibley. I am the John Michael Stuart Centennial Professor of Economics at the University of Texas at Austin. In October 2004, I completed an eighteen-month term as Deputy Assistant Attorney General for Economic Analysis in the Antitrust Division of the U.S. Department of Justice, the highest-ranking economics position within the Division. In this capacity, I supervised all economic analysis within the Antitrust Division and directed its Economic Analysis Group. As Deputy Assistant Attorney General, I also contributed to the economic analysis of general policy issues and represented the United States in Organization for Economic Cooperation and Development discussions.

2. For the last forty years, I have carried out extensive research in the areas of industrial organization (a field of economics that examines the behavior of firms and the structure of markets), microeconomic theory, and regulation. My publications have appeared in a number of leading economic journals, including the *Journal of Economic Theory, Review of Economic Studies*, *RAND Journal of Economics*, *Journal of Industrial Economics*, *American Economic Review*, *Econometrica*, and the *International Economic Review*, among others.

3. I hold a Ph.D. in economics from Yale University and a B.A. in economics from Stanford University. Additional details regarding my qualifications and experience are given in my *curriculum vitae*, a recent copy of which is attached to this report as Appendix One.

B. Assignment

4. I have been asked by counsel representing defendant Blue Cross Blue Shield of Michigan ("BCBSM") to examine, from an economic perspective, the analysis and opinions

contained in the expert report of Dr. Jeffrey Leitzinger submitted in this proceeding on behalf of plaintiffs.[1] In doing so, I examine whether plaintiffs have demonstrated that they will be able to show, through common proof on a class-wide basis, that (1) members of the proposed class suffered economic injury from the alleged anticompetitive effects of BCBSM's agreements with hospitals that contain most favored nation provisions ("MFNs");[2] (2) BCBSM's agreements with MFN provisions harmed competition; and (3) a feasible and reliable approach exists for calculating damages to members of the proposed class. With some exclusions, the class includes persons and entities that directly paid for hospital healthcare services at prices set by certain provider agreements at thirteen Michigan hospitals during specified periods.

5. As part of my investigation into plaintiffs' claims, I (or staff working under my direction) have considered a number of documents and other sources of information. The materials I reviewed include, but are not limited to, the following: (1) the Consolidated Amended Complaint ("CAC"); (2) documents and databases produced in discovery; (3) publicly available data and information regarding hospitals in Michigan; (4) academic publications regarding economic issues relevant to this proceeding; (5) deposition testimony; (6) Plaintiffs' Motion for Class Certification and Appointment of Class Counsel ("Plaintiffs' Motion"); and (7) the expert report and supporting documentation of Dr. Leitzinger. I have also conducted telephone interviews with BCBSM personnel. Appendix Two provides a detailed list of the material I considered in the preparation of this report.

---

[1] Expert Report of Jeffrey Leitzinger, Ph.D. in Support of Plaintiffs' Motion for Class Certification, *The Shane Group, Inc., et al. v. Blue Cross Blue Shield of Michigan*, No. 2:10-cv-14360-DPH-MKM, October 21, 2013 (hereinafter "Leitzinger Report").

[2] Throughout this report, I use the term "MFN" to refer to agreements containing either of two types of MFN provisions. An *equal-to-MFN* provision states that BCBSM's rate should be at least as low as any other payer's rate; an *MFN-plus* provision states that BCBSM's rate should be lower than any other payer's rate by some specified amount.

6. I am being compensated at an hourly rate of $650, and my compensation is not contingent on the outcome of this proceeding. My research into the matters discussed above continues, and I reserve the right to modify or supplement my opinions as additional information becomes available.

C. Summary of conclusions

7. Plaintiffs' theory of harm features an inconsistency that I do not believe can be resolved with common evidence. Plaintiffs' theory is that BCBSM benefits by using MFNs in its hospital agreements to raise the costs of its rivals, thereby harming competition. Further, plaintiffs allege that BCBSM has significant market power across the state of Michigan. Under this theory, BCBSM should have MFNs in all its hospital agreements and rivals' costs should be raised throughout Michigan. However, apart from small Peer Group 5 hospitals, only a minority of Michigan acute care hospitals have MFNs in their agreements with BCBSM. Further, a substantial number of representatives of hospitals with MFNs have testified that the MFNs had no effect on the prices charged to BCBSM's rivals for hospital services. A coherent theory of harm must explain why an allegedly profitable tool is applied so selectively. This likely depends on the specific bargaining power of each hospital with respect to each payer and would vary from hospital to hospital and from negotiation to negotiation. This requires the use of individualized evidence.

8. Furthermore, aside from plaintiffs' theory, BCBSM deponents offer alternative explanations for the MFN agreements. For larger Peer Group 1-4 hospitals, BCBSM negotiators stated that the MFNs were sometimes enacted for bureaucratic purposes to appease other BCBSM divisions when BCBSM acceded to higher rates, and not to affect the rates given to their rivals. For Peer Group 5 hospitals, BCBSM negotiators stated that MFNs could alleviate

free riding. BCBSM wished to compensate these hospitals for government payment shortfalls and bad debts, but was concerned that rivals would use this to free-ride on this aspect of BCBSM pricing. Lastly, BCBSM negotiators stated that MFNs helped resolved uncertainty about hospitals' intentions to seek higher payments from all payers. All of these stated goals of MFNs explain why one might observe higher reimbursement rates but, unlike the plaintiffs' theory, indicate that the MFN is not the cause of these increases.

9. I do not believe that testing these alternative explanations and evaluating their explanatory power against the plaintiffs' theory can be achieved using class-wide evidence. To test the free-rider theory of MFNs, one would need to evaluate whether "affected hospitals" would have allowed free riding to occur absent the MFNs, which would depend on the specific situation of each hospital and its relationship with each payer. Similarly, understanding the relative role of strategic, bureaucratic, and information seeking roles of MFNs would require individualized analysis.

10. Dr. Leitzinger does not attempt to disentangle alternative explanations for MFNs. Instead, he concludes that the plaintiffs' theory of harm, BCBSM's alleged market power, and any relevant antitrust markets can all be evaluated using common evidence. He concludes that (1) overcharges paid by insurer class members are likely to cause insurance rates to rise for all class members and that this antitrust injury can be shown by common evidence, and (2) a reliable methodology for determining damages exists.

1. Class-wide versus individual issues

11. Dr. Leitzinger admits that he did not examine the individualized price-setting process between hospitals and payers or how it varies from one negotiation to another. I find that individual negotiations depend on a variety of non-class-wide factors, including whether a

hospital belongs to a system of hospitals, whether a hospital owns a competing insurance plan, and a hospital's financial condition, strategic goals, and relationship with a specific payer. Dr. Leitzinger ignores these individual issues. For example, by his own admission, he did not examine how the price-setting process is different at hospitals that belong to large systems versus at independent hospitals,[3] how prices hospitals set for insurance plans differ based on whether the hospital has a financial interest in the insurance plan,[4] or whether prices vary systematically by a hospital's location or local competitive environment.[5] He also admits to ignoring the role a hospital's finances play and the tradeoffs between hospital prices and a hospital's provision and quality of services.[6]

12. Rather than considering the complex negotiations and price-setting processes that govern rates in this industry, Dr. Leitzinger relies on a modeling approach based on groups of "control hospitals," effectively assuming that economic and bargaining conditions are similar across all allegedly similar hospitals in the same control group. Conversely, the facts I have gathered indicate that many of the issues that arise at each hospital and in each negotiation vary by individual hospital and are a significant factor in the price paid by each proposed class member. The specifics of each negotiation imply that different class members can be affected differently, including not being affected at all.

[3] Deposition of Dr. Jeffrey Leitzinger, 12/10/2013 (hereinafter "Leitzinger Deposition") at 21:5-10 ("Q. Would it matter to your analysis whether or not Blue Cross Blue Shield of Michigan negotiated its reimbursement rates with the entire hospital system as opposed to one hospital at a time? A. No, not in -- not in any way I've identified.").

[4] Leitzinger Deposition at 121:21-122:4.

[5] Leitzinger Deposition at 39:4-22; 119:5-12.

[6] Leitzinger Deposition at 136:5-8.

13. Economists studying antitrust issues regularly consider institutional context, even parsing institutional details and records.[7] Economists do not merely fit numbers to models, but carefully weigh all the relevant facts to inform the model and decide whether the facts affecting various class members are sufficiently similar (or different) to allow for unified economic analysis, or whether individualized analysis is required. Dr. Leitzinger sidesteps these considerations.

2. Antitrust injury

14. Dr. Leitzinger's injury analysis ignores some crucial individual issues and only partially considers others. Because Dr. Leitzinger's focus is on reimbursement rate increases at "affected" hospitals that are allegedly due to the MFNs, the obvious benchmark for MFN impact is the increase in reimbursement rates that would have occurred at the "affected" hospitals without the MFN. The record provides an abundance of documentary and empirical evidence on this point. Based on the evidence, I find: (1) some of the "affected" hospitals would have tried to raise revenues even absent an MFN; (2) to varying individual extents, they would have succeeded in doing so; and (3) estimating the difference between their actual reimbursement rates and those they would have achieved absent the MFN requires separate analysis at each hospital.

15. Second, Dr. Leitzinger's analysis is limited to a small, selected list of "affected combinations" involving only some hospitals and some insurers. Dr. Leitzinger does not appear

[7] See, for example, Robert H. Porter (1983), "A Study of Cartel Stability: The Joint Executive Committee, 1880-1886," *Bell Journal of Economics* 14(2), 301-314 (where statistical research into a historic cartel relied on contemporaneous newspaper accounts and institutional details were central to model formulation).

to offer any specific methodology for evaluating whether MFN provisions harmed competition in any relevant market based on the small number of "affected combinations."[8]

16. Third, Dr. Leitzinger's approach ignores the fact that insurer class members experienced benefits as well as costs due to the MFNs. For example, the record shows that in two cases, compensating price decreases at one hospital were negotiated to coincide with price increases at another. By focusing only on the "affected insurer," Dr. Leitzinger's class-wide finding of impact is likely to reward some insurers who actually gained from MFNs, or experienced no net effect. Moreover, Dr. Leitzinger admits that he does not propose any methodology for determining whether any insurer was harmed, in aggregate, by these agreements.[9]

17. Fourth, Dr. Leitzinger admits that he does not consider or offer any empirical methodology that informs whether BCBSM's MFNs resulted in competitive harm in the alleged market for commercial health insurance in Michigan. He admits that he has not analyzed the effect of MFNs in the actual market alleged by plaintiffs.[10] The entirety of Dr. Leitzinger's impact and overcharge analysis is based on a set of hospitals that account for approximately twelve percent of the total number of inpatient beds at Michigan hospitals.[11] The alleged aggregate overcharge is simply assumed to translate directly to general harm to downstream competition for commercial health insurance. Dr. Leitzinger claims that the impact of the

[8] Leitzinger Deposition at 84:6-23 (stating that his analysis does not examine the effect on any payers outside of the small list of "affected combinations"); 92:24-93:2 (stating that he has no opinion on whether MFNs generally impacted competition).

[9] Leitzinger Deposition at 84:6-23; 153:9-14.

[10] Leitzinger Deposition at 36:19-22; 44:12-23; 46:4-6.

[11] Based on 2011 American Hospital Association data as provided in Dr. Leitzinger's Exhibit 3.

overcharge on insurance rates (if any) can be shown by common evidence. For his assertion to be correct, however, it is necessary for there to be only one relevant antirust market for commercial health insurance. If this condition does not hold, then the effect of hospital overcharges on insurance prices will require individualized analysis to evaluate.

18. Fifth, Dr. Leitzinger's analysis does not fit the plaintiffs' theory of harm. For example, Dr. Leitzinger did not conduct a statistical analysis of BCBSM's rates (or the rates of more than a single BCBSM competitor) at any of the eight Peer Group 5 hospitals he considered. When I applied his method to BCBSM rates at those hospitals, I found that BCBSM's rates often declined. Under the logic of Dr. Leitzinger's approach, this finding contradicts a necessary element of plaintiffs' theory of harm, that BCBSM paid more for MFNs. In fact, Dr. Leitzinger only alleges that MFNs increased BCBSM rates at five hospitals, whereas the plaintiffs' theory of harm requires that BCBSM rates should have risen everywhere. Of the five, based on his own analysis, two effects are not statistically different from zero at standard levels of significance and one appears implausibly large. In the remaining two hospitals, he admitted that he does not examine whether or not MFNs led to any increase in the rates paid by a BCBSM competitor.[12]

19. Further, the MFNs may also have benefitted individual members of the proposed class in ways not acknowledged by Dr. Leitzinger. For example, added revenues resulting from higher reimbursement rates may have allowed hospitals to improve quality and access to hospital service, benefitting individual class members in various ways depending on their utilization of hospital services and their individual preferences. Even assuming class members paid more due to MFNs, individualized analysis would be required to identify which class members

[12] Leitzinger Deposition at 91:18-22 ("Q. Did you give an opinion that any other payer at those two hospitals paid more? A. No. I haven't given that opinion. I haven't said it didn't happen, but I just haven't analyzed that.").

experienced a price increase or a price decrease on a quality-adjusted basis. Dr. Leitzinger did not consider this issue.

3. Dr. Leitzinger's methodology is not reliable

20. Dr. Leitzinger's statistical analysis purports to show that average reimbursement rates rose faster for some select combinations of hospitals and payers than they did, on average, at select (and variable) groups of "control hospitals." As I discussed above, I do not believe that his approach is sufficient to show net antitrust impact in any market or on any payer. Other aspects of his analysis cast doubt on its reliability. First, Dr. Leitzinger's aggregate overcharge analysis does not adequately take into account other factors that also may have contributed to higher rates at the affected hospitals at the time that MFNs were being negotiated.

21. For example, the poor financial condition of some hospitals and the strategic goals of others may have given them unusually large needs to seek higher reimbursement rates with or without MFNs. Thus, from an economic perspective, I see no basis to conclude that his calculated "effects" flow directly from MFNs instead of the other way around. In reviewing the record, I find that a number of factors apart from the MFNs may have contributed to changes in reimbursement rates. These factors imply that individualized proof is required to show impact and damages.

22. Second, logical application of Dr. Leitzinger's methodology identifies "MFN effects" even at some control group hospitals where no MFN exists. I examine what happens if I apply Dr. Leitzinger's methodology to some hospitals without MFNs. If the correlations that he calls "MFN effects" flow solely from the MFNs, I should find no effect. To the contrary, in these examples, I find several statistically significant "MFN effects" in the absence of any MFN. Clearly, the correlations that he refers to as "MFN effects" can reflect other factors of hospital

pricing and cast doubt on the reliability of his conclusion that they result solely from MFNs. In Dr. Leitzinger's procedure, any hospital with rates that rise faster than the average of the control group by an amount that is statistically significant is likely to be seen as "affected," not because of any MFN but because his procedure ignores causation and seeks only correlations.

23. Third, I found Dr. Leitzinger's approach raises statistical issues not discussed in his report. Dr. Leitzinger apparently attempted to address one such issue by adopting a particular statistical estimation procedure. However, when I adopted an alternative statistical method that also addresses that issue, I found many "MFN effects" are not statistically significant at levels generally applied in professional research. If Dr. Leitzinger's approach were reliable, the results should not change so much simply due to an alternative approach to dealing with the same issue. Using his own statistical approach, I also found that in two "affected" combinations (accounting for about 7 percent of his total alleged overcharges), his results are no longer statistically significant when I remove a single, questionable control group hospital.

24. Fourth, Dr. Leitzinger has not established that a reliable, formulaic approach exists for calculating class-wide damages. As Dr. Leitzinger's methodology for estimating damages relies on the same statistical analysis he performs to show impact, his calculation of total overcharges suffers from the same issues discussed above. Further, as discussed above, some of these issues are significantly individualized and are therefore unlikely to be amenable to any formulaic class-wide method. Dr. Leitzinger also admits that he calculates only aggregate overcharges and he offers no approach for determining overcharges to individual class members.[13] Thus, he fails to address potentially complex data issues that relate to the calculation

[13] Leitzinger Deposition at 155:19-156:9.

of overcharges (if any) to individual class members. These issues include the inability to identify payments that are subject to cost-sharing provisions between the insured and the insurer and issues of quality and access to healthcare services which may lead to net benefits for some and whose value varies from class member to class member.

II. REVIEW OF ALLEGED CONDUCT

A. Proposed class

25. Plaintiffs seek to represent a class of people and entities purportedly harmed by most favored nation agreements between BCBSM and Michigan hospitals. The scope of the class has narrowed significantly since the initial filings.

26. In the CAC, the proposed class consisted of every individual and entity that directly paid for hospital services at every hospital in Michigan with a BCBSM MFN contract.[14] Specifically, the class included every health insurance company (with the exception of BCBSM), every self-insured employer and their employees, and every individual insured, who paid for hospital services at a rate set in negotiations between BCBSM or any other insurer and a hospital with an MFN.

27. In their Motion, plaintiffs limited the proposed class to a select group of hospitals and payers. The amended class pertains only to the MFN agreements at thirteen "affected hospitals."[15] At each hospital, the class pertains only to certain "affected provider agreements"

[14] CAC at ¶ 10.

[15] Allegan General Hospital; Beaumont Hospital – Grosse Pointe; Beaumont Hospital – Royal Oak; Beaumont Hospital – Troy; Bronson LakeView Hospital; Charlevoix Area Hospital; Kalkaska Memorial Health Center; Mercy Health Partners – Lakeshore; Paul Oliver Memorial Hospital; Providence Park; Sparrow Ionia Hospital; St. John Hospital and Medical Center; and Three Rivers Health. Plaintiffs' Motion at 4-5; Leitzinger Report at ¶ 7.

which include twenty combinations of an "affected hospital" and one of four payers (HAP, Priority, Aetna, and BCBSM), which vary from hospital to hospital. The affected periods vary by agreement, but all fall between 2006 and early 2013. In total, with some exclusions, the motion restricts the class to all persons and entities that directly paid "affected hospitals" in Michigan for hospital healthcare services under "affected provider agreements.[16] By considering HAP's two PPO networks at the three Beaumont hospitals separately, Dr. Leitzinger arrives at twenty-three "affected combinations."[17]

28. Overall, the thirteen hospitals included in his "affected combinations" accounted for approximately twelve percent of the total number of inpatient beds at Michigan hospitals.[18]

29. Excluded from the proposed class are "(1) BCBSM, its officers and directors, and its present and former parents, predecessors, subsidiaries and affiliates, and (2) insureds whose only payments were (a) co-payments that do not vary with the size of the allowed amount, and/or (b) deductible payments where the hospital charge was larger than the deductible payment."[19]

30. The only named plaintiff among those initially listed in the CAC is the Michigan Regional Council of Carpenters Employee Benefits Fund ("Carpenters"). The plaintiffs have proposed adding Patrice Noah and Susan Baynard.[20]

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[16] Plaintiffs' Motion at 4-5, and also Leitzinger Report at ¶ 7, Table 1.

[17] Leitzinger Report at ¶ 7 and corrected Exhibits 8 and 9.

[18] Based on 2011 American Hospital Association data as provided in Dr. Leitzinger's Exhibit 3.

[19] Plaintiffs' Motion at 5.

[20] Plaintiffs' Motion at note 1 ("If the Court denies the motion to add Patrice Noah and Susan Baynard as named plaintiffs, Plaintiffs request that the Court construe this motion for class certification as being filed solely by named plaintiff Carpenters.").

B. Alleged anticompetitive conduct

31. Plaintiffs allege that the MFN agreements entered into between BCBSM and "affected hospitals" were anticompetitive and led to higher prices for hospital services in Michigan. Plaintiffs argue that BCBSM paid hospitals rates in excess of what those hospitals would have otherwise obtained as inducement to accept the MFN agreements.[21] Plaintiffs contend that these MFN agreements then required hospitals to raise rates (or not to lower rates) paid by BCBSM's competitors, raising their costs.[22] These two effects allegedly led to higher negotiated hospital prices for BCBSM's customers and for its rivals. Plaintiffs further contend that the alleged conduct allowed BCBSM to "maintain, if not enhance, its position as the dominant commercial health insurer in Michigan" and "caused members of the proposed class to pay inflated prices for hospital services."[23]

C. Summary of Dr. Leitzinger's economic analysis

32. Taking the list of "affected provider agreements" as given, Dr. Leitzinger undertakes a largely statistical analysis to evaluate antitrust injury and damages. He uses what is termed a "difference-in-differences" (DID) regression analysis.[24] His proposed implementation of that approach begins by calculating the change in the average reimbursement rate a provider pays to a hospital before and after some event, such as the MFN effective date.[25] To account for

[21] Plaintiffs' Motion at 3 ("BCBSM offered increased reimbursement rates to obtain MFN provisions," calling such payments a "quid pro quo").

[22] Plaintiffs' Motion at 3 ("… the scheme ensured that [BCBSM's] rival insurers' costs were even higher…").

[23] Plaintiffs' Motion at 4.

[24] Leitzinger Report at ¶ 51.

[25] The reimbursement rate refers to the percentage of a hospital's *billed* amount represented by the *allowed* amount. A hospital grants a discount relative to its "list price" (also known as its "chargemaster" price) when its allowed

general changes in hospital rates that may occur over the same period, the change experienced contemporaneously at a group of "control hospitals" without MFN agreements is subtracted from the change at the hospital with the MFN. For each "affected combination," Dr. Leitzinger's control group consists of a subset of Michigan hospitals without MFNs that are in the same (or adjacent) BCBSM-designated hospital "peer group" as the "affected hospital."

33. From his DID analysis, Dr. Leitzinger claims that the average rate for each "affected combination" rose more than did the average rate charged to the same payer at a control group of hospitals, accounting for several other factors he considered in his model. The difference between the two is his alleged "MFN effect" (measured in percentage points). He assumes that the change in the average control group rate mostly captures the effects of all influences except the MFN at the affected hospital. For each of his twenty three "affected combinations," his damages methodology is based on the same DID model used to measure antitrust injury. In particular, he uses the percentage point "MFN effect" derived from his DID analysis, plus an intermediate calculation, to calculate aggregate class-wide dollar "overcharges."[26]

34. From the fact that the DID method is used to calculate alleged overcharges at each affected combination, Dr. Leitzinger concludes that there is a common methodology for evaluating injury and damages.[27] Next, Dr. Leitzinger reviews the reimbursement methodologies

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(eligible) charges are less than the billed amount. I use the terms "reimbursement rate" and "rate" interchangeably throughout my report. In the analyses conducted in my report, I adopt Dr. Leitzinger's procedure for calculating reimbursement rates in hospital-insurer-product agreements. In doing so, I do not endorse his methodology and I reserve the right to modify the procedure at a later date.

[26] Leitzinger Report at ¶ 75- ¶ 76 and Exhibit 9.

[27] Leitzinger Deposition at 143:3-6 ("I have performed analysis to determine that damages can be measured in a formulaic class-wide manner, and indeed that is what Exhibit 9 is intended to show.").

of the affected payers and argues that rates move in tandem for "all or virtually all" class members, and therefore that the effects of "elevated reimbursement rates" would translate into common impact for all (or virtually all) class members.[28]

III. INDUSTRY BACKGROUND

A. Financial conditions at Michigan Hospitals and the background leading up to MFNs

35. According to a study conducted by Hal Cohen, Inc., from 2005-2007, Michigan hospitals had lower operating margins than hospitals nationwide and in the Great Lakes region.[29] As shown in Table 1, during the 2005-2007 period, many of the "affected hospitals" had margins on net patient income that were negative.[30]

36. Starting in 2003–2004, the Michigan Hospitals Association ("MHA") and many individual hospitals urged BCBSM to increase its reimbursements. The need for this was largely due to the fact that BCBSM, facing competitive forces, had begun to offer PPO plans and BCBSM members had begun to shift away from traditional indemnity insurance to the BCBSM PPO products. Since PPO products have lower rates than traditional indemnity products, hospital revenues had been in a state of decline for some time. Beginning in 2004, senior management at BCBSM and the MHA began to meet in order to develop a new reimbursement mechanism, to be embodied in a revised Participating Hospital Agreement ("PHA"). The PHA would form the standard contract between BCBSM and a hospital.

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[28] Leitzinger Report at ¶ 59.

[29] BLUECROSSMI-99-01584986 at BLUECROSSMI-99-01585007.

[30] Net patient income is defined as net patient revenue less total operating expenses. The margin on net patient income equals net patient income divided by net patient revenue.

37. The effort proceeded in two phases.[31] Hospitals in Peer Groups 1-4 were generally medium-to-large hospitals and their PHA was completed in the spring of 2006 after a lengthy process of joint consultation between BCBSM and the MHA. This PHA served as a template for reimbursement and contained the default financial parameters of a cost-based reimbursement model. However, many hospitals in Peer Groups 1-4 chose to depart from the default template and instead negotiated their own financial terms with BCBSM. The basic thrust of this PHA was to give Peer Group 1-4 hospitals reimbursement equal to [redacted].[32] [redacted].[33] This PHA did not include an MFN.

38. Small rural hospitals in Peer Group 5 have a somewhat different payment mechanism than the larger hospitals. Finalized in 2007, the Peer Group 5 model was also based on [redacted] The thrust of the Peer Group 5 model was to lower reimbursement to hospitals.[34] However, the Peer Group 5 margin was larger than that in the Peer Group 1-4 PHA because it included additional allowances that were not explicitly part of the Peer Group 1-4 model. These included extra allowances for [redacted] which are especially important to Peer Group 5 hospitals due to their relatively large proportions

[31] For the complete chronology, see "Participating Hospital Agreement, Status Update Report," BLUECROSSMI-E-0021634-81.

[32] BLUECROSSMI-EM-0211752-0211814 at BLUECROSSMI-EM-0211789. The [redacted] does not include [redacted]

[33] Deposition of Peter Schonfeld (Senior Vice President of Policy and Data Services, Michigan Health and Hospital Association), 11/2/2012, at 191-193.

[34] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 106:5-107:1.

of Medicare and Medicaid patients. The total margin in the PHA for Peer Group 5 hospitals was [redacted] in anticipation of [redacted].[35]

39. In the case of Peer Group 5 hospitals, BCBSM was concerned that competitors were "free riding" on the payments made by BCBSM. This concern was a major impetus for the inclusion of MFN clauses in the Peer Group 5 PHA.

B. Reimbursement rates are the results of individualized negotiations between hospitals and insurers

1. Hospitals vary in their bargaining power

40. Although Dr. Leitzinger provides an overview of hospital reimbursement methodologies, he does not discuss the process whereby prices are actually set in this industry. I view Dr. Leitzinger's discussion as akin to assuming that BCBSM were a monopsonist—the sole buyer of hospital services—and assuming that all hospitals were merely price takers. There is little hint in his discussion that hospitals can do anything but accept terms from BCBSM. This may be a correct assumption for some hospitals, but is unlikely to be true at all hospitals, including some of those in "affected" combinations. In particular, it is hard to square the assumed dominance of BCBSM with the fact that of the 95 Peer Group 1-4 acute care hospitals in Michigan, less than one third had MFN provisions with BCBSM.[36] Through this omission, Dr. Leitzinger ignores the long economic tradition of examining bargaining power and its effect on

[35] BLUECROSSMI-EM-0211752-0211814 at BLUECROSSMI-EM-0211801.

[36] See Leitzinger Report, Exhibit 3.

negotiated outcomes.[37] A hospital that is the only or the primary hospital in an area may leverage significant power over payers that wish to market plans in the region. Hospitals that are part of hospital systems may gain additional power by negotiating with payers collectively.[38] Likewise, hospitals that offer physician networks in addition to hospital services may leverage additional bargaining power.[39]

41. Depending on their size, quality, available services, degree of competition, financial condition, and other unique attributes, hospitals vary greatly in the power they wield over payers and in the approaches they take to win price concessions. Consider two hospital systems involved in the plaintiffs' affected combinations: [redacted] and Ascension Health ("Ascension") system[40]. Both the [redacted] and Ascension-Michigan systems perceived some of their hospitals to be important to insurers.[41] While I do not opine on the veracity of this claim, such a perception clearly can be a source of

[37] See, for example, Alan T. Sorensen (2003), "Insurer-Hospital Bargaining: Negotiated Discounts in Post-Deregulation Connecticut," *Journal of Industrial Economics* 51(4).

[38] See Alison E. Cuellar and Paul J. Gertler (2005), "How the Expansion of Hospital Systems has Affected Consumers," *Health Affairs* 24(1); John M. Brooks, Avi Dor, and Herbert S. Wong (1997), "Hospital-Insurer Bargaining: An Empirical Investigation of Appendectomy Pricing," *Journal of Health Economics* 16(4), at 431 ("We also found that hospitals within multi-hospital systems enjoy significantly greater bargaining power. Perhaps membership in a multi-hospital system gives hospitals a credible threat that signals the willingness of the hospital to withstand intense negotiations.").

[39] For example, Sparrow Ionia Hospital sometimes bargains jointly with insurers over access to hospital services through the Sparrow Health System and to physicians through the Sparrow Physician Health Network, the exclusive negotiator for approximately 900 member physicians. Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 16-19.

[40] The relevant BCBSM contract involving St. John Hospital and Medical Center and Providence Park Hospital was negotiated by Patrick McGuire, the CFO of the St. John Providence system, which is part of Ascension Health. I refer to St. John Providence system as "Ascension-Michigan," and refer to St. John Hospital and Medical Center as ("St. John").

[41] [redacted] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 69:1-4, 70:23-25 (stating that St. John is a hospital that BCBSM needs to carry to be competitive).

bargaining power. Sparrow Ionia Hospital also considers itself an important hospital to payers, though due to its geographic remoteness rather than its size.[42] [redacted]

42. These differences in perceived bargaining power partly account for hospitals adopting very different strategies in their negotiations with payers. For example, St. John Hospital and Medical Center and Providence Park Hospital did not negotiate contracts individually with BCBSM after being acquired by Ascension Health. Rather, their rates were negotiated as part of a single contract that covered numerous other hospitals, implying considerable bargaining power. The Chief Financial Officer of Sparrow Health System ("Sparrow") was apparently willing to walk away from negotiations[44] and viewed the system as having more bargaining power than the payers with whom it negotiates:

> To be honest with you, you know, the payors have way more to lose than we do. Patients are going to come to Sparrow regardless. They're just going to carry a different insurance card. So, you know, sometimes it's not worth our effort to negotiate with another payor. There's a lot of administrative duties and it's a lot of work to add more and more and more contracts to your portfolio.[45]

[42] Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 31:16-22 ("Again, Sparrow Ionia is the only hospital in Ionia County. Ionia, the city of Ionia, where the hospital is located, is approximately 45 minutes from Lansing and 45 minutes from Grand Rapids. So there is very little access to care in Ionia, so it provides a very necessary service there, hence the Critical Access definition.").

[43] [redacted]

[44] The CFO of Sparrow cites the source of this bargaining power as the power to limit access to Sparrow's hospitals. Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 203:1-3, 203:4-8.

[45] Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 203.

43. Although Ascension-Michigan was willing to terminate or threaten to terminate agreements, other hospitals like [redacted] and Three Rivers Health ("Three Rivers") felt much less empowered to make such threats to BCBSM, although they may have felt differently about other insurers.[46] [redacted]

44. Bargaining strategies do not follow directly from hospital size. [redacted] On the other hand, while some small, financially-distressed hospitals may feel they have little leverage over BCBSM, others may derive bargaining power from their financial situation. After all, without higher rates from payers, hospital cutbacks would lead to a deterioration of access and service for the payers' customers. Further, many of these small hospitals are the only hospitals in their communities.[49] For both of these reasons, insurers may agree to pay more. These factors can empower even small, financially-distressed hospitals to seek higher prices.[50]

45. Although I undertake a more detailed analysis of each of these hospital's situations later in my report, these examples illustrate the fact that hospitals' own perceptions of their bargaining power with BCBSM and with other payers varied markedly. Hospitals identified different sources of their bargaining power. An economic analysis rooted in "average" rates at

[46] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 48:4-49:13.

[redacted]

[49] CAC at ¶ 58.

[50] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 269:5-9, 270:12-14.

"average" hospitals is unlikely to account for idiosyncratic differences in bargaining power, which can lead to the correlations that Dr. Leitzinger identifies as MFN effects.

46. Further, a hospital's bargaining power with one of its payers may be interrelated with the hospital's relationships with its other payers. Plaintiffs allege that MFNs with BCBSM strengthen hospitals' bargaining power with other payers. Even if true for some hospitals, it is still just one of many aspects of a hospital's bargaining power that cannot be reliably disentangled from other idiosyncratic aspects on a class-wide basis. Further, if BCBSM, as plaintiffs allege, paid consideration to hospitals in return for the MFNs, this may serve to soften hospitals' bargaining power with rival payers. This is because these higher payments would weaken a hospital's ability to claim financial distress as a cause for demanding higher rates from payers other than BCBSM. This could lead some payers not subject to the MFN to negotiate lower prices than they would have in the absence of an MFN.

47. Dr. Leitzinger pays no explicit attention to these factors. Instead he may implicitly assume that they are captured adequately in the comparisons between the reimbursement rates in affected contracts and in control group hospitals. These comparisons are made in the context of a regression analysis that includes various explanatory variables proposed by Dr. Leitzinger.

2. The complex and multifaceted nature of contracting

48. Dr. Leitzinger ignores the complex and multifaceted nature of contracting. Some economic factors that affect negotiations include distance from rival hospitals, a hospital's occupancy rate,[51] a payer's need for access for its members to a hospital's services,[52] a hospital's

[51] BLUECROSSMI-99-848256: Participating Hospital Agreement Workshop 1 at 43 (citing [redacted] as measures that are "used as a part of negotiation" with hospitals).

financial condition, the amount of Medicare and Medicaid patients and bad debts in the total patient mix at the hospital,[53] the strategic goals of hospitals, payers, and Administrative Service Organizations ("ASOs"), including whether an entity is for-profit or non-profit,[54] and many other idiosyncratic factors. They also reflect individual relationships[55] and individual personalities[56] of the negotiators, which are clearly not amenable to analyzing with class-wide evidence.

49. A contract is rarely just an MFN. Typically, each contract includes multiple provisions and concessions from both sides.[57] These carry contemporaneous changes in terms

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[52] BLUECROSSMI-99-848322: Participating Hospital Agreement Workshop 1 at 95. BCBSM [redacted] and recognizes that this serves as a leverage point for hospitals in negotiations with BCBSM.

[53] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 184 [redacted] and at 185 [redacted]

[54] Not-for-profit hospitals often have concerns beyond profit-maximization, including the devotion of financial resources to increasing quality of care and access to care. See, for example, Daniel Deneffe and Robert T. Mason (2002), "What Do Not-for-profit Hospitals Maximize?" *International Journal of Industrial Organization* 20, 461-492, at 486 ("Our results … are consistent with [not-for-profit hospitals having] an objective function that places positive utility weight upon both social welfare and profits."). Also see Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland. BCBSM, unlike some rival insurers, shares these goals and is concerned with hospital viability. See Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 278 [redacted] BCBSM's support of hospitals' missions and its local presence can provide it a special place in negotiations. For example, William Beaumont (hospital)'s CFO, Dennis Herrick, expressed concern about BCBSM's competitors' motives: "we are equally concerned about the long-term consequences of assisting new market entrants and their dedication to the principles of non-profit care." Deposition of Douglas Darland Government Exhibit 4, BLUECROSSMI-08-004240 at BLUECROSSMI-08-004244 and [redacted]

[55] See, for example, Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 245-246 ("I have long-standing relationships with the people at Blue Cross, the people that negotiate our contracts. And, you know, they are based on trust and mutual respect, and assistance when we need help. And sometimes when we screw up, we need them to help us and not hold us to whatever rule there was.").

[56] See, for example, Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 126 ("A. I think I ended up giving United a discount and Aetna not a discount. Q. And do you recall why you made that choice? A. Because Aetna was aggressive and became annoying.").

[57] BLUECROSSMI-99-848227. Participating Hospital Agreement Workshop 1 at 26 (showing that complex contracts can cover many components, providing the example of Sparrow). For example, a single contract negotiation between BCBSM and MidMichigan Health included discussion of (i) [redacted]

that collectively may well have effects that dwarf those of an MFN.[58] Dr. Leitzinger does not attempt to disentangle these factors or to address attribution seriously, and he fails to discuss the possibility that it is wrong to attribute all sources of rate changes to just one contract provision. Any potential effect of MFNs needs to be separated from the effects of other contemporaneous contract provisions.

IV. Dr. Leitzinger Does Not Establish That Common Evidence is Capable of Proving Antitrust Injury to Class Members

A. Dr. Leitzinger's approach to common proof

50. Generally, economic demonstration of common impact requires a plausible economic theory that fits the facts of the case and then a reliable methodology that shows a common effect of the alleged acts on prices across the class. That is, if MFNs are assumed to be anticompetitive, then a demonstration of injury for one class member should indicate likely injury to another class member. However, Dr. Leitzinger specifically admits in his deposition that his analysis does not generalize from one plaintiff to another:

> Q. Am I correct in understanding that the conclusion you reach about impact as to any affected combination does not tell you whether or not a different combination will feel impact?

[redacted] BLUECROSSMI-E-0008311-8315.

[58] See, for example, Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 234-236 (stating that, at Sparrow, the BCBSM pay-for-performance program represented a significant increase in the hospital's margins, from 7 percent to 12 percent) and at 233-234 (stating that contract duration can have a significant impact on negotiated rates).

A. Yes, I think that's correct.[59]

He also admits that his analysis implies little about whether alleged anticompetitive effects can be shown by class-wide evidence in any alleged market for commercial health insurance.[60]

51. Instead, Dr. Leitzinger's approach to showing impact by common evidence consists of three main steps. First, Dr. Leitzinger estimates alleged overcharges which he believes are due to the MFNs. Second, he asserts that these overcharges will cause the rates of each hospital service to rise. Third, he argues that a link between his overcharges and increased insurance prices exists and can be demonstrated by evidence common to the class. Throughout, he ignores quality effects. He considers one possible pro-competitive benefit of MFNs and concludes that its importance can be determined with class-wide evidence.

52. I structure the balance of my report around (1) the crucial issues on which Dr. Leitzinger is silent and (2) logical and statistical challenges with the issues he does address.

B. Dr. Leitzinger does not show that the plaintiffs' theory of harm can be proven with class-wide evidence

1. *Inquiry into the twenty-three affected combinations is unconnected to the basic antitrust theory as expressed in plaintiffs' motion*

53. I begin with the plaintiffs' conceptual theory of harm and a basic question: under plaintiffs' economic theory of harm, is proof of class-wide impact by class-wide evidence even possible?

[59] Leitzinger Deposition at 62:19-25 (*objection omitted)*.

[60] Leitzinger Deposition at 36:19-22.

54. My reading of plaintiffs' theory of harm is that it contains three main contentions:

- A contention that BCBSM had market power in the sale of commercial health insurance in all of Michigan.[61]
- A contention that BCBSM leveraged that market power[62] to force a "statewide institution of MFNs."[63]
- A contention that that these MFN agreements, by their very nature, serve to increase the costs faced by BCBSM's rivals.[64]

55. Notably, this theory asserts an unambiguous causal link from BCBSM's presumed statewide market power to the institution of MFNs to the alleged anticompetitive harm. Plaintiffs claim that BCBSM has market power over the entire state of Michigan and that MFNs have a common impact that includes both anticompetitive harm *and* a benefit to BCBSM. The MFNs, in this theory, are the instrument of this market power. But if this theory is correct, then it is unclear (1) why every hospital in Michigan does not have an MFN, and (2) why all insurers at the "affected hospitals" are not considered to be affected by the MFN.

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[61] Leitzinger Report at ¶ 100 ("The question here is whether BCBSM competes in a statewide market for health care insurance or whether that competition is more localized in nature. … it is implausible that the effects of BCBSM's MFNs on its monopoly power as a seller of health insurance, if any, would come down to highly localized geographic markets within the State.") and at ¶¶ 102-103 ("BCBSM's share of hospital reimbursements in the State of Michigan averages just under 60 percent between 2005 and 2010. … BCBSM had about 63 percent of the commercial self-insured market in 2012.").

[62] Leitzinger Report at ¶ 38 ("In particular, by contractually guaranteeing that it would have the most favorable discount from hospitals (and, in many cases, the most favorable discount by a contractually stipulated margin), BCBSM *forced those hospitals* to set reimbursement rates with other insurers higher than they would have otherwise." *Emphasis added*); Plaintiffs' Motion, at 14 ("And there is no mystery to why BCBSM sought the MFNs so *forcefully*…" *Emphasis added*) and at 1-2 ("BCBSM's 'equal-to' MFNs *forced* hospitals to set the overall annual reimbursement rate for the services…" *Emphasis added.*)

[63] Leitzinger Report at ¶ 111.

[64] Leitzinger Report at ¶ 83 ("By raising the costs of inputs to health insurance networks, MFNs effectively placed a floor not only [sic] under rates for hospital healthcare services.").

56. These two observations do not support Plaintiffs' theory of common class-wide, statewide effects. Any coherent theory of harm from MFNs must be able to reconcile these facts. That is, it must explain not only the presumably anticompetitive effect at "affected" hospitals for "affected" payers but also explain why some hospitals have MFNs and some do not despite alleged market power on the part of BCBSM that allows it to force MFNs upon hospitals. Further it must explain why all insurers at the "affected" hospitals are not considered to be affected. Not only does Dr. Leitzinger offer no explanation for why MFNs might allegedly have an effect at some hospitals but not at others, but he admits that he did not even look at any other MFN agreement outside the affected combinations or its effect on prices.[65] For this reason, the limited scope of Dr. Leitzinger's analysis means that it cannot show that the plaintiffs' claims can be proven by class-wide evidence.

2. The BCBSM explanation for MFNs

57. Although Dr. Leitzinger's theory of MFNs cannot explain why MFNs are not universal and why all insurers are not affected at hospitals with MFN provisions, BCBSM's negotiators proffer an explanation for MFNs that can do so. BCBSM's negotiators, mainly Messrs. Douglas Darland and Gerald Noxon, were from the contracting organization of BCBSM. According to them, MFNs were used primarily for two reasons: a bureaucratic motive to signal to other BCBSM divisions, such as marketing, that the negotiators achieved relatively low prices for BCBSM; and a free-rider motive to make sure that any financial assistance offered by BCBSM went to the benefit of the hospital and not to BCBSM's competitors.

[65] Leitzinger Deposition at 27:12-21, 28:2-8.

58. BCBSM negotiator Mr. Darland offers a colorful motivation for seeking MFNs: they were introduced to "stop the [BCBSM] marketing people from complaining about us poor slobs in contracting"[66] and to have "the [BCBSM] marketing people stop yelling at us" by demonstrating that BCBS obtained good prices from hospitals relative to its competitors.[67]

59. Antitrust economists have recognized that MFNs often reflect the business realities of rewarding and evaluating negotiators.[68] In some cases, "[t]he MFN serves as a 'trophy' that the negotiator uses to certify to his employer that he drove a hard bargain"[69] without any competitive effects. MFNs sometimes serve to reflect reality rather than change it. MFNs may also operate "operate as little more than a statement of parties' expectations, with little or no impact on the actual prices paid."[70]

60. The record evidence lends plenty of support for the idea that, in some cases, MFNs were sought to assure BCBSM that it is receiving good prices.[71] For example, BCBSM's

[66] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 77.

[67] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 27 ("The purpose, from my perspective, was to have the marketing people stop yelling at us for having this differential shrink and making their job more difficult. And so that's -- I was sick and tired of them whining about this tremendous discount advantage that we had shrinking marginally over a couple of years. And so I wanted to take away from them this tool that they used to yell at us.") and at 30 ("And my purpose for that was so I could go to the marketing people and say… I got this thing that says we're going to have the best discount. So you do your job, as good as I do mine, and we'll be all set.") and at 64 ("[The MFN] kind of acts as proof that it exists, so I can show that to our marketing team. It's not the driver that allows for us achieving the best rate.") and at 76 and at 168 ("My purpose was to show something to our marketing team to get them off my back…").

[68] Jonathan B. Baker and Judith A. Chevalier (2013), "The Competitive Consequences of Most-Favored-Nation Provisions," *Antitrust* 27(2), at 22.

[69] Jonathan B. Baker and Judith A. Chevalier (2013), "The Competitive Consequences of Most-Favored-Nation Provisions," *Antitrust* 27(2), at 22.

[70] Stephen Smith (2013), "When Most-Favored is Disfavored: A Counselor's Guide to MFNs," *Antitrust* 27(2), at 12.

[71] Deposition of Robert Milewski, 10/11/2012, at 363, 376, 390; Deposition of Kevin Seitz, 11/01/2012, at 242 ("So an MFN is a way of helping you feel more comfortable that your discount is really best in class and reflective of the partnership"); Deposition of Gerald Noxon, 10/04/2012, at 87 ("To know if people, you know, are telling me the

negotiator stated that MFNs generally were raised in negotiations only after he obtained "the absolute best bargain that [he] could."[72] [redacted]

Evidence such as this suggests that high reimbursement rates may have "caused" the MFNs, rather than the reverse, as assumed by Dr. Leitzinger. Similarly, a representative from Sparrow testified that its rates were not altered as a result of the MFN.[76] Three Rivers aimed to bring Priority's rates in line with BCBSM rates in its 2006 negotiations, but an MFN was not a factor in this goal.[77] Three Rivers' CFO stated that the MFN did not lead to higher payments from BCBSM.[78]

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truth, or, you know, if finding out what the spread actually is."). Also see Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 31:22-23 ("I don't think it ever amounted to anything in terms of getting a better discount.") and 64:23-64:1 ("I would say that the discount advantage is more an illustration of kind of proof.").

[72] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 30.

[redacted]

[74] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 81.

[redacted]

[76] Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 158-159 ("Q. Has any single patient since you've been CFO of Sparrow Hospital paid a penny more in hospital services at Sparrow because of the Blue Cross MFN? A. No.") and at 160 ("Q. So at any time since you've been CFO, has Sparrow refused to enter into a commercial payer contract with any commercial payer because of the Blue Cross MFN? A. No.").

[77] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 132-133.

[78] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 267-268 (objection omitted) (Q. Am I correct in my conclusion that it is not your view that the Blue Cross MFN actually caused Blue Cross to pay you more money? THE WITNESS: I do not believe that it caused them to pay us more money." and at 197 ("I would say that there

[redacted] Other hospitals also acknowledged that the MFN was irrelevant to the hospital but was seen as very important to BCBSM for bureaucratic reasons.[80]

62. BCBSM's negotiators offer a second motive for MFNs, rooted in the prevention of free riding by BCBSM's competitors. The goal of the MFN, in part, was "so that if we are providing a hospital with more money, it's not -- the money is not going to increase rates, increase rates at the community, going to our competitors; it was going for the hospital."[81]

> … if we have to give you more money than what we really think is a reasonable level of reimbursement, we want some protection that you're using the money for the purposes you're telling us, to help your open heart program, to help your community to provide services, et cetera.[82]

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were some payors, though, specific payors, that -- and we had identified even prior to this -- that we thought the rates were too low and we had already talked about those; UHC, Cofinity.").

[redacted]

[80] Deposition of Richard Felbinger, 8/29/2012, at 63 ("From my position, and for some of the other negotiating parties, that was fine with us. It didn't make a difference. We wouldn't give anybody else that low of a rate anyway and stay in business. And if that's what they had to do internally to sell our higher rate, that's fine. It was a matter of -- they are very bureaucratic in Blue Cross. It's got to be done on their spreadsheet in their format. And what I was telling them, that I didn't care about that. I cared about we need these rates, and they needed to figure out some way to give us our rates, somehow, and sell it within their organization, whatever they had to do. It did not matter to me how they did it. It just we needed these rates. [sic]")

[81] Deposition of Robert Milewski, 10/11/2012, at 30; Also at 170 ("We were negotiating with Covenant, and we -- they were asking for more money, more than we were comfortable with. We finally did get down to what I thought was a reasonable contract, but we wanted to make sure that the money was going for the purposes we stated; for the community, for growth and programs, for servicing the community.").

[82] Deposition of Robert Milewski, 10/11/2012, at 32.

63. In the case of Peer Group 5 hospitals, BCBSM believed that covering government shortfalls or bad debt is a burden to be shared by all commercial payers or none of them, and not shouldered single-handedly by BCBSM.[83]

> And so, it was -- it was really kind of a strange situation to be talking to them [hospitals] and have them state that they need more money from Blue Cross, but they don't need more money from those smaller plans.
> …
> Well, we were trying to support the financial viability of these hospitals in rural areas, and felt that it was a responsibility that needed to be shared. I mean, we -- these other plans are for-profit; we're not-for-profit. We're willing to step up and make sure that there's access in these rural hospitals -- rural areas, and felt that -- well, as I said, that that had to be something that the other hospital -- plans participated in as well.[84]

64. This motivation for an MFN has nothing to do with a theory of exclusionary harm. Rather, its effects are likely to enhance market efficiency. Because quality improvements are available to *all* patients even if their costs are borne by only BCBSM, competing payers can easily free ride on additional investments. Further, hospitals can exploit BCBSM's investment by offering the service to BCBSM's competitors at a lower price.

65. The avoidance of free riding is closely related to another function of MFNs, determining the veracity of hospital claims that they "need" additional funding. These claims, and their veracity, will vary across hospitals. To understand this motive, consider the following scenario: A hospital approaches BCBSM and explains that it is in dire financial need; it explains

[83] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 84-88; 91 ("We feel that part of our mission is to support access to healthcare in rural areas. But we didn't want to -- we didn't feel it was appropriate for us to be the only payor that was -- that was stepping up to that challenge of supporting that access.").

[84] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 87-88.

that it plans on asking all payers for higher reimbursement rates to ensure the hospital's financial viability and to reinvest that money into service and quality improvements. How should BCBSM respond? If it refuses, it risks that the hospital may close down, cut access, or offer poorer quality of service to its members. If it agrees, then it creates a perverse incentive for hospitals; all hospitals wish for more money, and some would feign need even where none exists, or when there is really no intent to negotiate for such payments from all payers.

[redacted]

[85] With these assurances and the reduction in risk and uncertainty, "the buyer is more willing to enter into a mutually beneficial long-term contract with the seller." William J. Lynk (2000), "Some basics about most favored nation contracts in health care markets," *Antitrust Bulletin* 45 at 519. [redacted]

67. Large service quality improvements may require simultaneous commitments from multiple payers. How can a payer receive assurances that its competitors will fund these improvements on comparable terms?

> An MFN may thus serve not only to encourage investment in a joint enterprise, but also to maximize its value, by preventing one or more parties from free-riding on the investment of others.[86]

68. Juxtaposing this BCBSM theory and the antitrust theory advanced by plaintiffs, it is clear that testing one theory against the other can only be done on an individualized basis. Consider the two Ascension-Michigan hospitals that are in the "affected" group, St. John and Providence Park. [redacted] This fits well with Mr. Darland's assertions that some MFN clauses were included to satisfy interests internal to BCBSM and were not intended to have any market effect. To analyze plaintiffs' antitrust theory, one would need to explain the anticompetitive motive for including an MFN provision that did not disadvantage rival insurers.

69. Now consider the Peer Group 5 hospitals. BCBSM personnel often mention the free-rider problem in connection with these hospitals. To test the free-rider theory of MFNs, one would need to see whether or not affected hospitals would have allowed free riding to occur absent the MFNs. The answer to this question almost certainly would require individualized analysis. Some hospitals might have sought proportional assistance from all payers for bad debts

[86] Stephen Smith (2013), "When Most-Favored is Disfavored: A Counselor's Guide to MFNs," *Antitrust* 27(2), at 13.

[87] [redacted]

and government payment shortfalls. Others might not, once having extracted a rate increase from BCBSM.

70. To test the plaintiffs' antitrust theory, one would have to explain a striking pattern in the data. Although some hospitals raised rates to some payers up to the BCBSM level post MFN, others raised rates far above the BCBSM rate and kept them there (see Figures 1-5).[88] Very different economic forces appear to be at work in these two cases, and it does not seem plausible for the plaintiffs' antitrust theory to describe both on a class-wide basis.

3. The role of market power and bargaining power: BCBSM market share does not imply market power in hospital services at each hospital.

71. Two necessary ingredients for plaintiffs' theory of harm are (i) BCBSM's alleged market power over hospitals in Michigan,[89] and (ii) BCBSM's alleged expansion of that market power through its use of MFNs.[90] Dr. Leitzinger is silent on whether BCBSM actually experienced any growth of market power, and admits in his deposition that his regression analysis cannot speak to this issue.[91]

72. Dr. Leitzinger states that "the assessment of market power proceeds with an examination of market shares, market concentration, demand elasticity and barriers to entry."[92] He then proceeds to cite estimates of BCBSM share of various segments of an alleged

[88] See also Leitzinger Report, Exhibit 6.

[89] Plaintiffs' Motion at 7-8.

[90] See, for example, Plaintiffs' Motion at 29 ("The scheme allowed BCBSM to maintain and enhance its market dominance.").

[91] Leitzinger Deposition at 45:16-21 ("Q. … Does the regression that you've performed in this case, any of the 23, tell you anything about whether Blue Cross increased its market power in the market for commercial insurance? A. No.").

[92] Leitzinger Report at ¶ 101.

downstream market for commercial health insurance.[93] However, Dr. Leitzinger never explicitly draws a link between these downstream shares and the alleged market power over hospitals in the upstream market that is a necessary ingredient of his theory of harm. In fact, economists who have studied the healthcare industry recognize that such a link need not exist, in general.[94]

73. Economists have recognized several reasons that an insurer's market share need not translate into market power over all hospitals.[95] Any payer's market power is driven largely by its *relative* bargaining power, requiring analysis of each payer's bargaining power with respect to each hospital. Further, market power may depend not only on the size of a payer but also on its ability and willingness to exclude a hospital from its network. This willingness will vary across each combination of hospital and insurer. Put simply, bargaining power arises in large part from the willingness to walk away if a favorable agreement is not reached.[96] There is consensus among economists that market power in this industry requires an examination not only of market shares but of a payer's willingness and ability to exclude hospitals from its network

[93] Leitzinger Report at ¶¶ 102-103.

[94] Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland, at 49. ("Blue Cross market share (or any other measure of health insurance market structure) is not the conceptually appropriate measure of the structure of the market for *selling* hospital services. … it does not follow that an insurer with monopoly power will possess monopsony power. A monopoly health insurer may face a perfectly elastic supply of hospital services.").

[95] Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland.

[96] Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland, at 48. ("While monopsony power is normally defined as the ability to price below marginal factor cost, it is clear that this ability is predicated on the purchaser's ability to buy elsewhere.").

and to move its customers from one hospital to another.[97] Such efforts can only be evaluated by individualized evidence.

74. Dr. Leitzinger does not consider the professional economics literature, instead drawing a simplistic link from BCBSM commercial health insurance market share to its purported power over hospitals.[98] More troubling, economic reasoning suggests not only that a payer's market share is a poor predictor of market power over hospitals, but also that the effect of market size can even run in a direction contrary to that asserted by Dr. Leitzinger. Large plans can find themselves with less bargaining power over some hospitals than their smaller competitors:

> [T]he larger the percent of a hospital's total patient days accounted for by a plan, the greater the leverage the plan has with the hospital. However, beyond a certain point there are diminishing returns. When a plan becomes relatively dependent upon a hospital

[97] Alan T. Sorensen (2003), "Insurer-Hospital Bargaining: Negotiated Discounts in Post-Deregulation Connecticut," *Journal of Industrial Economics* 51(4) at 469 ("Payer size appears to affect bargaining power, but the effect is small. Much larger than the effect of payer size is the influence of payers' abilities to 'move market share' by channeling patients to hospitals with which favorable discounts have been negotiated."); Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland, at 48. ("If insurers have no power to control the providers from which their patients obtain care, they cannot possibly exercise monopsony power.").

[98] Even if market shares were to convey the importance of a payer to a hospital, Dr. Leitzinger's methodology in which he excludes government payers (e.g., Medicare and Medicaid) is incorrect. While BCBSM's insurance products may not compete directly against government insurance programs, these programs are a vital part of hospitals' revenues and thus affect the commercial significance of private payers to the hospital. Sparrow's CEO, when asked about BCBS share of *commercial* insurance, defaulted to thinking about share of total payments. Deposition of Paula Reichle (Sparrow Health), 8/8/2012, at 42 ("Q. About what percentage of the Hospital's commercial insured payments are from Blue Cross? … A. I believe about 25 percent. … Q. And so is that 25 percent of total commercial payments or 25 percent of total payments? … A Total. Total total."). They are regularly included in economic and antitrust analysis of market power and hospital pricing. See Department of Justice, "Background to Closing of Investigation of UnitedHealth Group's Acquisition of Oxford Health Plans" (July 20, 2004) available at http://www.usdoj.gov/atr/public/press_releases/2004/204676 htm ("In addition, the investigation suggested that government payer business is a significant factor in determining whether or not the merged company would be able profitably to decrease its reimbursement levels to providers. Therefore, in analyzing competitive effects, the Division's analysis took into account all payers for medical services from hospitals and physicians, including government payers, such as Medicare and Medicaid.").

> (i.e., a relatively large share of a plan's patients use a single hospital), the plan pays higher prices.[99]

This point of "diminishing returns" will vary by insurer and hospital.

75. As larger insurers require more hospital beds, insurer size can imply a greater difficulty in directing patients to rival hospitals and a larger reliance on a given hospital in small markets, all of which can temper market power. Dr. Leitzinger acknowledges that BCBSM has almost every Michigan hospital in its PPO network[100] but fails to recognize that BCBSM's commitment to including as many hospitals as possible may reduce its market power over some hospitals.[101] Conversely, a smaller insurer that seeks only one provider in a market can play several hospitals off each other to secure the best deal.

76. This bargaining vulnerability on the part of BCBSM, ignored by Dr. Leitzinger, was recognized by some hospitals in their negotiations, which Dr. Leitzinger states that he did not consider.[102]

77. Thus, even to the extent that downstream market size is one of many factors that impact a payer's market power over hospitals, it is not the simplistic relationship that Dr. Leitzinger implies. At the least, it requires analysis of each payer's ability to channel patients to alternate hospitals. Dr. Leitzinger acknowledges that the substitutability of hospital services

[99] Kelly J. Devers, et al. (2003) "Hospitals' Negotiating Leverage with Health Plans: How and Why Has It Changed?" *Health Services Research*, 38(1) Part II, at 422-423.

[100] Leitzinger Report at ¶ 35.

[101] BCBS lists as one of its "Guiding Principles" [redacted]" Blue Cross, "Enhance Health Care ValueStrategy: 2008 Plan," 7/9/2010, BLUECROSSMI-E-0004031.

[102] Leitzinger Deposition at 76-80.

varies by market region and by plaintiff.[103] One payer may have alternative local trauma services through its contract with a rival hospital, for example, while another may not.[104] Such influences on bargaining power are not amenable to determination by common evidence.

78. In summary, Dr. Leitzinger fails to demonstrate that BCBSM's market power in a market for hospital services can be shown through common evidence. He incorrectly infers that an analysis of such market power can come primarily from flawed and selective data on commercial health insurance market shares. He does not consider the economic realities and analytical methods required to characterize a highly differentiated market with varying degrees of market power on both sides. Further, any evidence required to determine the balance of market power cannot be resolved simply by citing market shares or revenue shares, but requires fact-specific evidence and individualized analysis that varies from hospital to hospital and from payer to payer.[105]

[103] Leitzinger Report at fn. 68, quoting Peter R. Kongstvedt (2013), *Managed Care: What it is and How it Works, Third Edition*, Jones and Bartlett Publishers, at 75 ("Access is also a function of the services provided. For example, two nearby hospitals may differ in the services that they offer; only one of the two may offer obstetric services, whereas the other might be the sole provider of trauma services. An MCO must take the types of services into account, as well as location, when building its network of providers."). The need to take such issues "into account" implies that they influence the existence and strength of market power with a given hospital.

[104] Also see CAC at ¶ 95 ("The two largest hospitals in the Lansing area, and the only ones that offer tertiary care, are Sparrow Hospital and McLaren–Greater Lansing Hospital ("MGLH") (formerly Ingham Regional Medical Center). Each of these two major hospitals has strengths in different fields. Lansing area employers and employees generally prefer health insurers that can provide network access to (and discounts at) both hospitals. Consequently, each of these hospitals is important to health insurers that seek to offer a provider network in the Lansing area.").

[105] See Katherine Ho (2009), "Insurer-Provider Networks in the Medical Care Market," *American Economic Review* 99(1), at 417 ("More generally, hospitals are likely to demand different prices from different plans depending on the degree to which their services complement those of the hospital (and therefore on the hospital's likely attractiveness to the plans' enrollees).").

4. Hospitals can have significant bargaining power

79. Hospital prices are determined through individual negotiations between each payer and hospital or system of hospitals. While market power in some industries is characterized primarily by market share data on one side of the transaction, "[i]n health care, however, bilateral market power is definitely an issue which should not be ignored."[106] Dr. Leitzinger's analysis of BCBSM market power that ignores the countervailing (and individually variable) market power of hospitals is incomplete and incorrect.[107]

80. In analyzing market power, Dr. Leitzinger ignores that this crucially depends on each hospital's market power, as well.[108] While citing BCBSM insurance share figures, Dr. Leitzinger overlooks the fact that hospitals can have varying and sometimes very large market shares in their immediate geographic environs. Such hospitals may hold local market power over payers due to the payers' need to include them in its network.[109] For some hospitals with few nearby alternatives, plaintiffs acknowledge that both business goals [110] and regulatory

[106] Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland, at 52.

[107] See Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland, at 52. ("…estimates of monopoly or monopsony conduct which assume the absence of one will underestimate the true value of the conduct parameter, since what is identified is monopoly relative to monopsony power, not the absolute values of either.").

[108] Kelly J. Devers, et al. (2003) "Hospitals' Negotiating Leverage with Health Plans: How and Why Has It Changed?" Health Services Research 38(1) Part II, at 421 ("While there is variation across markets and within the hospital sector, a major change over the past five years is that many hospitals are now willing, and successfully able, to exercise market power in contract negotiations.").

[109] Indeed, the CAC recognizes that the desire to carry a hospital gives the hospital power over BCBSM competitors, but somehow overlooks that the same economic logic applies to BCBSM as well. CAC at ¶ 112 ("In each case, the BCBSM competitor concluded that it needed the community hospital to be able to offer a network that would allow it to compete with BCBSM, and thus agreed to pay, and is paying, higher hospital prices.").

[110] "… access to a provider network is an essential ingredient of commercial health insurance from the point of view of most health plans, because providers' non-discounted rates are, in most cases, prohibitively expensive. It is only

requirements[111] place pressure on a payer to conclude a deal with those hospitals. [redacted]

81. Even when a hospital is not the sole provider in a given region, it may nevertheless amass significant market power. For example, hospitals that are part of hospital systems may gain additional power by negotiating with payers collectively.[113] Thus, while BCBSM's size may suggest market power over some hospitals, other hospitals may have sufficient countervailing power due to their size or due to BCBSM's inability to direct patients to rival hospitals. Evaluating BCBSM's market power would require individualized inquiry into each hospital.

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through access to a network that most plans can affordably cover the health care services procured by their members." (CAC at ¶ 46); "Commercial health insurers believe they must include community hospitals within these areas in order to be able to compete effectively in the sale of commercial health insurance to health plans that require coverage in these areas." (CAC at ¶ 57).

[111] "Michigan law mandates that members of HMO plans have access to a network of affiliated providers sufficient to assure that covered services are available without unreasonable delay" (CAC at ¶ 41) and "Under Michigan law, HMO 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." (CAC at ¶ 46) and "Commercial health insurers are required by Michigan law to include in their HMO networks nearby hospitals for any location in which an HMO product is offered." (CAC at ¶ 58).

[redacted]

[113] Alison Evans Cuellar and Paul J. Gertler (2005), "How the Expansion of Hospital Systems has Affected Consumers," *Health Affairs* 24(1) at 213 (finding that "… the evidence suggests that [hospital] system formation has primarily served to increase [hospital] market power") and at 217 (finding that, following the formation of hospital networks, "hospital market power, not the efficiency of care delivery, increased.").

82. Even in a geographic region with many hospitals, each hospital may have market power due to product differentiation. Sources of differentiation include hospital quality,[114] hospital size,[115] the existence and range of special services,[116] affiliations with universities and physicians, and reputation.[117] For example, hospitals with different specialties will each exploit the need to access that specialty for market power. A factor such as a hospital's religious affiliation or even the quality of its waiting rooms, to the extent that it is an important distinction for some patients, serves as a point of differentiation and thus bestows market power on a hospital.[118]

83. Hospital market power varies greatly not only from hospital to hospital but also within a hospital from payer to payer and, depending on the special services provided and demanded, from patient to patient. This power depends, for example, on the importance of a hospital to the payer's offerings and the alternatives that the payer has in terms of other hospitals

[114] See, for example, Abigail Tay (2003), "Assessing Competition in Hospital Care Markets: The Importance of Accounting for Quality Differentiation," *RAND Journal of Economics* 34(4), 786-814 (arguing that an analysis of market power requires consideration of hospital quality and quality differences among neighboring hospitals).

[115] See, for example, CAC at ¶ 70 ("Marquette General Hospital [is] the largest hospital in the Upper Peninsula and the only Upper Peninsula hospital providing tertiary care, …"), at ¶ 85 ("Marquette General offers more complex surgeries (such as neurosurgery and cardiac surgery), trauma care, and other services that are not available at any other hospital in the Upper Peninsula.") and at ¶ 86 ("commercial health insurers that seek to market a competitive health insurance plan in the central and western Upper Peninsula must contract with Marquette General …").

[116] See, for example, John M. Brooks, Avi Dor, and Herbert S. Wong (1997), "Hospital-Insurer Bargaining: An Empirical Investigation of Appendectomy Pricing," *Journal of Health Economics* 16(4), at 428 ("A hospital that tends to specialize in cardiac surgery may not necessarily compete for the patients of a neighboring hospital that specializes in oncology.").

[117] See Katherine Ho (2009), "Insurer-Provider Networks in the Medical Care Market," *American Economic Review* 99(1), at 393-430 (finding that top hospitals in the eyes of consumers have significant bargaining power over payers).

[118] See Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland, at 3-4.

or facilities in the payer's network.[119] Analysis of market power thus varies for each hospital-payer pair and, in my opinion, cannot be determined by common class-wide evidence.

5. BCBSM market power is not an issue that can be deduced by common evidence

84. The use of common proof would require that MFNs leveraged market power in essentially the same way over all hospitals in all markets for hospital services. However, bargaining is fundamentally different at hospitals of different size and in regions with and without significant competition. Even within a specific geographic region, prices (which partly reflect relative bargaining power) may vary greatly across hospitals.[120]

85. The bargaining relationship between a payer and a hospital varies from one case to the next and is not amenable to Dr. Leitzinger's formulaic simplification. Among the many factors that influence market power are the location of hospitals and alternatives, hospital quality, whether the hospital is part of a hospital system,[121] the financial health of a hospital, parties' negotiating skill, hospital utilization,[122] and the strategic goals of each hospital and

[119] Robert Town and Gregory Vistnes (2001), "Hospital Competition in HMO Networks," *Journal of Health Economics* 20(5), at 734 ("… a hospital's bargaining position with a plan, and hence its price, depend on the incremental value that hospital brings to the plan's network. A hospital's incremental value, in turn, is a function of the plan's opportunity cost of turning to its next-best alternative network that excludes the hospital.") and at 735 ("the hospital's incremental value [to a payer] will depend on the extent to which hospitals outside the network are good substitutes.").

[120] Chapin White, Amelia M. Bond, and James D. Reschovsky (2013), "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power," *Center for Studying Health System Change Research Brief No* 27, September at 1 (noting differences in the level and dispersion of hospital prices across several Michigan localities; "The variation in hospital and specialist physician prices within communities underscores that some hospitals and physicians have significant market power to command high prices, even in markets with a dominant insurer.").

[121] See Katherine Ho (2009), "Insurer-Provider Networks in the Medical Care Market," *American Economic Review* 99(1), 393-430 (arguing that hospitals in systems have higher leverage against payers than those not in systems).

[122] A hospital at capacity has less reason to offer price discounts. See Katherine Ho (2009), "Insurer-Provider Networks in the Medical Care Market," *American Economic Review* 99(1), at 394 ("Capacity constraints seem to

payer. Dr. Leitzinger ignores these issues. For the location of hospitals, for example, he claims that he didn't see "a need as an economic matter to make some accounting for that."[123] For the financial health of hospitals, Dr. Leitzinger admits that he simply didn't consider it.[124] For whether a hospital negotiated independently or as part of a large hospital system, Dr. Leitzinger claims that it does not matter to his analysis.[125] Market power will depend on the specific hospital's capabilities, the capabilities of its nearby rivals, the local nature of competition, and the specific needs of a payer and that payer's customers in that geographic region. These cannot be determined with common evidence.

6. Market definition

a. Dr. Leitzinger erroneously confuses and conflates distinct product markets

86. Health insurers have a dual role in health care both as purchasers of hospital services and sellers of health insurance. Each of these roles operates in distinct markets worthy of independent careful analysis. Both plaintiffs and Dr. Leitzinger appear to confuse upstream and downstream competition, drawing unwarranted parallels across the two markets. Just as the global market for crude oil differs from the local market for gasoline, the markets for *hospital services* and *commercial health insurance* are quite distinct.

87. In defining a relevant product market, the CAC, Plaintiffs' Motion, and Dr. Leitzinger all reference commercial health insurance as a relevant market or markets in which

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give the hospital additional leverage in the bargaining process, perhaps by acting as a commitment device to persuade plans that it will choose to contract selectively.").

[123] Leitzinger Deposition at 39:21-22.

[124] Leitzinger Deposition at 136:5-8.

[125] Leitzinger Deposition at 21:5-10.

antitrust injury occurred for all class members.[126] The allegations of market power are also made in that market: "[c]learly, BCBSM is the dominant seller in the commercial health insurance market in Michigan."[127] However, Dr. Leitzinger does not convincingly show that injury in the market(s) for commercial insurance can be established by common proof.

88. The entirety of Dr. Leitzinger's injury and overcharge analysis is calculated for the cost of *hospital services*. Dr. Leitzinger appears to believe that it is obvious that cost increases will translate directly to downstream market(s) for commercial health insurance.[128] Dr. Leitzinger offers no analysis about class effects in the specified, downstream market apart from one brief assertion, and admits in his deposition that any market for commercial health insurance is irrelevant to his methodology for estimating injury and damages.[129] If we were to define the market for some type of commercial health insurance, a proper analysis of damages faced by consumers would involve, at the least, consideration of insurance premiums, deductibles, and many other facets of commercial health insurance products. Dr. Leitzinger admitted in his deposition that he "does not show whether or not any class member paid higher insurance premiums"[130] and that the entirety of his numerical analysis "does not relate to prices for

[126] CAC at ¶ 46; Plaintiffs' Motion at 29; Leitzinger Report at ¶ 11.

[127] Plaintiffs' Motion at 6. Also see Leitzinger Report at ¶ 93. Notably, Dr. Leitzinger never shows that BCBSM has market power in the market for hospital services. Instead, market power for *insurance* is *assumed* to translate to the upstream market for hospital services. As discussed above, this is an entirely unwarranted assumption. It is akin to arguing that a gasoline company with retail market power somehow necessarily has market power over OPEC.

[128] Leitzinger Report at ¶ 79-84.

[129] Leitzinger Report at ¶ 81 and Leitzinger Deposition at 44:12-23.

[130] Leitzinger Deposition at 46:4-6.

commercial health insurance."[131] It is hard to see how his analysis shows that injury can be proven by class-wide evidence for any alleged commercial health insurance market.

89. Dr. Leitzinger provides no specific guidance as to how he would carry out a market delineation exercise in any market for commercial health insurance. He discusses the *conceptual* exercise as explained in the *FTC/DOJ Horizontal Merger Guidelines* ("Guidelines").[132] Dr. Leitzinger offers no hint of the operational technique he would employ or even if any class-wide data are available to conduct an inquiry into consumer behavior in any market for health insurance. Where would individual consumers and entities reasonably turn for health insurance in response to a hypothetical monopolist's small increase in price in one area? Dr. Leitzinger argues that the "evidence one would use in answering these questions" is common[133] but does not specify what that evidence might be. For example, Dr. Leitzinger distinguishes between a "PPO market" and an "HMO market"[134] but does not analyze whether consumers see one as a reasonable alternative to the other. In fact, Dr. Leitzinger admits that he gave no consideration to whether PPO and HMO plans should be considered together or separately,[135] and admits generally that he does not know anything about the product designs of the companies.[136]

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[131] Leitzinger Deposition at 36:21-22.

[132] Leitzinger Report at ¶¶ 86-93; U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC), Horizontal Merger Guidelines, 2010.

[133] Leitzinger Report at ¶ 94.

[134] Leitzinger Report at ¶¶ 29, 31, 33.

[135] Leitzinger Deposition at 105:1-8.

[136] Leitzinger Deposition at 70:3-7 ("Q Do you know anything about Aetna's product design of its commercial insurance products over the relevant period? A No, I do not." *Objection omitted*), 70:9-13 ("Q Do you know anything about Priority's product design of commercial health insurance over the relevant period? A No, I do not." *Objection omitted*), 70:16-20 ("Do you know anything about Blue Cross's product design of its commercial

b. Dr. Leitzinger does not explain correctly why Michigan may be a relevant antitrust market for commercial health insurance

90. While Dr. Leitzinger offers no conclusion about the relevant geographic market, he does assert that its determination depends on class-wide evidence.[137] Although Dr. Leitzinger cites the *Guidelines* and the "small but significant, nontransitory increase in price" (SSNIP) test as his approach to market delineation,[138] he consistently contradicts the Guidelines in his analysis. First, he proposes to follow a political (rather than economic) boundary of the state of Michigan,[139] despite contradictory information presented in the CAC.[140] Second, he argues that it is "implausible" for the health insurance market to be localized because insurers "offer insurance plans broadly to residents of the State."[141] A map would show that Exxon, Shell, and Chevron have gas stations across America, but this certainly does not make gas stations compete in a national market.[142] Dr. Leitzinger also does not explain how he would handle self-insured local

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insurance products over the relevant period? A No." *Objection omitted*), 69:22-70:1 (stating that he is not aware of the number of products offered by HAP), 70:22-71:4 (stating that he is not aware of the number of levels of deductibles offered by Aetna, BCBSM, HAP, and Priority).

[137] Leitzinger Deposition at 35:17-22 ("I don't come to a conclusion about a specific geographic market in the report. I discuss the issue associated with geographic market definition and my view about the evidence that would be common to the class associated with geographic market definition.").

[138] Leitzinger Report ¶¶ 91-92.

[139] As economists have argued, "… there is no evidence that individual states constitute relevant geographic markets for health insurance—and there is considerable evidence to the contrary. … Bluntly stated, if an entire state is not a relevant geographic market, the existence of high HHIs in that state has no competitive (or probative) significance." David Hyman and William Kovacic (2004), "Monopoly, Monopsony, And Market Definition: An Antitrust Perspective on Market Concentration among Health Insurers," *Health Affairs* 23(6): at 27.

[140] For example, plaintiffs allege that "BCBSM raised its health insurance premiums in the Upper Peninsula by 250% from 1999 to 2004, "*well out of proportion to the rest of the state.*" CAC ¶ 84, *emphasis added*. Dr. Leitzinger offers no suggestion for how data could explain these variations or why markets in Michigan with widely different price dynamics are sufficiently similarly situated to be amenable to analysis with common evidence.

[141] Leitzinger Report at ¶ 100.

[142] Further, such analysis ignores the *Guidelines* requirement to analyze *demand* rather than *supply* factors in market delineation ("Market definition focuses solely on demand substitution factors" *Guidelines §4*). Meanwhile, the Complaint admits that some class members "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." CAC at ¶ 52.

employers of companies that may negotiate special discounts on hospital services and insurance rates.

c. There are many local geographic markets for hospital services

91. There is economic evidence that markets for *hospital services* are quite local. This is consistent with Dr. Leitzinger's expert report.[143] Economists estimate that geographic markets for hospital services vary in size, and include ranges, for example, of a few miles and 20 miles, depending on the density of the region.[144]

92. The reason the existence of distinct local markets matters is that each market has different hospital (and non-hospital) alternatives (some without MFNs), different market and bargaining conditions, a different competitive climate, substitutability options,[145] portion of hospitals/patients/beds covered by MFNs, and other factors,[146] which influence the price a given payer obtains at a hospital. The price effects of hospital and insurer bargaining power vary from market to market.[147] Therefore, a finding that a group of consumers in one geographic market for

[143] Leitzinger Report at ¶ 34 ("Employees and individuals demand access to health care near where they live and work.").

[144] See, for example, Robert Town and Gregory Vistnes (2001), "Hospital Competition in HMO Networks," *Journal of Health Economics* 20(5), at 735 (finding that markets are much smaller than counties or metropolitan areas); Abigail Tay (2003), "Assessing Competition in Hospital Care Markets: The Importance of Accounting for Quality Differentiation," *RAND Journal of Economics* 34(4), 786-814 (finding that hospital closures do not have any significant effects on demand for hospitals more than 20 miles away.).

[145] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 235 ("I mean, you could say that negotiating a contract with higher rates potentially could lessen your overall net revenue because you are not getting the same patients coming through that you used to get; that's one thing you do have to consider. … because there are other providers in the area that may charge less as an employer, you are going to want that, so I can say that can happen, yeah.").

[146] The necessary pervasiveness of MFNs to trigger potential anticompetitive effects is market-specific, but is unlikely to be below 30%. See Stephen Smith (2013), When Most-Favored is Disfavored: A Counselor's Guide to MFNs, *Antitrust* 27(2), at 11.

[147] See Robert Town and Gregory Vistnes (2001), "Hospital Competition in HMO networks," *Journal of Health Economics* 20(5), at 735.

hospital services was injured would not extend to any other geographic market. To show liability and impact, individualized analysis is needed for each geographic market. As noted, "…only factual investigation can determine whether in any actual market the balance of consumer benefits from MFNs is positive or negative."[148]

d. Dr. Leitzinger provides no evidence that the relationship between hospital costs and commercial health insurance costs can be shown with common evidence

93. A key issue in Dr. Leitzinger's discussion of market definition concerns the linkages between alleged increases in the costs of hospital services and class-wide proof of injury in the market(s) for commercial health insurance. As he describes the issue, "the evidence necessary to demonstrate the relationship between hospital costs and insurance rate setting is the same for all Class members."[149]

94. Dr. Leitzinger considers it obvious that an increase in hospital charges will necessarily cause all insurance rates to rise in unspecified downstream insurance markets. Note that Dr. Leitzinger states in his deposition that he "does not show whether or not any class member paid higher premiums"[150] and that his numerical analysis "does not relate to prices for commercial health insurance."[151]

95. Dr. Leitzinger does not opine on whether or not there is more than one relevant geographic market for insurance, or about the type and number of relevant product markets. His

[148] William J. Lynk (2000), Some Basics About Most Favored Nation Contracts in Health Care Markets, *Antitrust Bulletin* 45, at 502.

[149] Leitzinger Report at ¶ 84.

[150] Leitzinger Deposition at 46:4-5.

[151] Leitzinger Deposition at 36:21-22.

link between hospital costs and insurance rates is to assert that all class members will pay higher prices for commercial health insurance due to the alleged increase in the cost of hospital services. However, this claim fails.

96. To see why, note that Dr. Leitzinger does not render an opinion about the number and contours of the relevant product and geographic markets. Suppose that there are two relevant antitrust markets for commercial health insurance in Michigan, be they different product or geographic markets. Suppose, hypothetically, that Priority is overcharged to some degree and is considering whether to recoup its cost increase through price increases in one or both markets. From an economic perspective, its decision would depend on such factors as the relative levels of competitiveness in the two markets, their price elasticities of demand, growth rates, and other factors. Depending on these factors, Priority might decide to raise prices in market 1 but not market 2. Assuming that some of its subscribers participate in market 2, they are not injured by increased commercial health insurance prices. Only Priority subscribers in market 1 are injured. If Priority decides to raise prices in both markets, then all are injured by reduced competition in the commercial health insurance markets. However, to determine which case holds requires markets to be defined (which Dr. Leitzinger has not done) and the competitive factors in each market to be investigated (which he has not done). The evidence linking hospital costs to insurance rates in market 1 does not imply the effect in market 2 (i.e., zero).

97. This example shows that there is not a simple link between alleged overcharges for hospital services and the downstream prices of commercial health insurance. As Dr. Leitzinger's analysis of antitrust injury to any commercial health insurance market assumes such a simple link, he does not provide any method for determining injury in any relevant market using common evidence.

C. Dr. Leitzinger's overcharge analysis is flawed

1. Dr. Leitzinger's analysis of average rates before and after the MFN

98. Prior to conducting his statistical analysis for each "affected agreement," Dr. Leitzinger compared BCBSM reimbursement rates before and after the relevant MFN effective date to insurer reimbursement rate before and after the "affected" insurer contract date (see Leitzinger, Exhibit 6).[152] He states that "where the reimbursement rate being paid by a competing insurer was below the level required by the MFN, one would expect to observe an increased reimbursement rate on the part of that insurer under its next effective contract to a level sufficient to bring it under compliance."[153] Dr. Leitzinger describes these increases as economic evidence capable of showing the MFN agreements led to higher reimbursement rates for hospital healthcare services.[154]

99. However, this analysis is deficient because it does not attempt to determine the reimbursement rates that would have been paid but for the MFN provision. Dr. Leitzinger's Exhibit 6 shows insurer reimbursement rates increased to levels that *exceeded* the BCBSM reimbursement rate in each of the eleven affected combinations involving equal-to-MFN provisions by amounts ranging from 2 to 26 percentage points. Payment above the MFN level may simply be a sign that the MFN was irrelevant, and the hospital would have received the same payments even without the MFN. The existence of payments in excess of compliance levels and the significant variation in the level of such payments highlight the need to consider

[152] In some cases, the insurer contract date is before the MFN effective date.

[153] Leitzinger Report at ¶ 47.

[154] Leitzinger Report at ¶ 46. In his deposition, he clarifies that "I am simply showing in this exhibit that the pattern of rates before and after the MFN … are consistent with the impact on the part of the MFN." Leitzinger Deposition, at 164:24-165:3.

individualized factors when estimating what reimbursement rates would prevail but for the MFN. For example, some of the affected hospitals may have had unusually high financial or strategic need for higher revenues. Clearly, the dynamics of price negotiation varied significantly across hospitals.

100. After presenting the rate comparisons discussed above, Dr. Leitzinger presents a statistical analysis of reimbursement rates. Below I review Dr. Leitzinger's statistical methodology and discuss (1) statistical issues raised by his proposed methodology and (2) the fact that his methodology does not allow one to differentiate adequately between any price effects of MFNs and the effects of other, contemporaneous changes.

2. Statistical analysis of difference-in differences in reimbursement rates

101. Dr. Leitzinger employed a statistical analysis that he alleges shows inflated reimbursement rates at all "affected combinations." As explained above, the type of analysis that he proposes is referred to as "difference-in-differences." This is because the impact of an event (in this case the adoption of an MFN provision in BCBSM hospital agreements) is measured as the difference in an average outcome in a treatment group before and after treatment minus the difference in average outcome in a control group before and after treatment. He implements this method using a linear regression model which provides (i) a single ("point") estimate of the difference-in-differences effect (or "DID effect" or "MFN effect"); (ii) the standard error of the estimate, which indicates the precision of the point estimate;[155] and (iii) a test statistic used for

[155] The standard error is an estimate of the sampling variability of a coefficient in the regression equation.

determining if the point estimate is statistically meaningful, meaning that it is unlikely to be positive or negative simply by chance even when, in reality, there is no effect.[156]

102. The outcome proposed to be measured by Dr. Leitzinger is the average reimbursement rate for all healthcare services purchased under an insurer agreement (e.g., Priority – PPO) at a given hospital (e.g., Allegan General). The healthcare services included in his average combine all DRGs provided to inpatient services as well as all outpatient services. There are literally thousands of such individual services offered by general acute care hospitals.

103. The treatment group in Dr. Leitzinger's proposed method consists of a single "affected combination" (e.g., Beaumont Hospital – Gross Pointe / HAP HMO).[157] Dr. Leitzinger's proposed control group consists of the "affected insurer's" agreement for the same network at non-MFN hospitals in the same BCBSM-designated peer group as the "affected hospital."[158] Dr. Leitzinger does not provide a detailed attempt to determine whether his control group hospitals (or any other hospitals) have cost and demand conditions similar to his "affected hospitals" or if his control group hospitals' reimbursement rates respond to changes in supply and demand in the same manner as his "affected hospitals." Instead, he simply relies on the "peer group" system established by BCBSM and claims that this system "effectively accounts for economic characteristics that are generally described in the literature as important to levels of hospital costs, which influence directly levels of reimbursement negotiated by hospitals and

[156] A DID effect is statistically significant when the null hypothesis of no effect (that MFNs did not impact prices) can be rejected at a certain level of statistical significance, usually 5 percent (or even 1 percent) in economic research.

[157] The term "treatment" originates from medical experiments in which one group of patients receives a drug and a control group of patients does not.

[158] For example, since Beaumont Hospital at Gross Pointe is a Peer Group 2 hospital, for the affected combination "Beaumont Hospital at Gross Pointe – HAP HMO," his proposed control group consists of non-MFN Peer Group 2 hospitals operating under a HMO contract with HAP.

insurers."[159] As discussed above, bargaining power and economic conditions likely vary even among seemingly similar hospitals.

104. In any case, Dr. Leitzinger's use of peer groups is logically inconsistent. As noted by Dr. Leitzinger, his control group selection method poses a problem for "affected combinations" that involve Peer Group 5 hospitals. Namely, there are no non-MFN Peer Group 5 hospitals. For this reason, he claims that Peer Group 4 hospitals provide an adequate control group for Peer Group 5 hospitals, effectively arguing against his own analysis of Peer Groups representing distinct market realities. While admitting that Peer Group 5 hospitals have "unique characteristics,"[160] the only difference Dr. Leitzinger admits between Peer Groups 4 and 5 is (potentially) a 50-bed size count. This, of course, ignores many other potentially significant differences including different pricing and reimbursement methodologies and levels,[161] differing financial conditions of the hospitals, and differing degrees of bargaining power.

105. Dr. Leitzinger implements his DID approach for twenty-three "affected combinations" that span thirteen hospitals and four healthcare insurers. For each of these twenty-three "affected combinations," he performs a separate statistical analysis. These twenty-three combinations represent only a small fraction of the total number of contracts negotiated between hospitals and insurers at hospitals that agreed to MFN provisions with BCBSM. The process by which these combinations were determined to be "affected" is unknown to Dr. Leitzinger who

[159] Leitzinger Report at ¶ 53.

[160] Leitzinger Report at note 128.

[161] Leitzinger acknowledges (but does not analyze) this in his report at ¶ 39 ("BCBSM employed a different reimbursement model for PG 5 hospitals than it did for PG 1 - PG 4 hospitals.") and note 128 ("On top of the overall payment model illustrated above, due to their smaller size and other unique characteristics, BCBSM also compensates PG 5 hospitals for a share of the cost of uncompensated care (i.e., underfunding by government, bad debt and charity) and potential pay-for-performance.").

also admitted during his deposition that he was unaware of how the specific dates of the "affected purchases" were determined.[162] The alleged affected combinations and dates of purchases are shown in Table 1 of Dr. Leitzinger's report; he states that this information was supplied to him by plaintiffs' counsel.

106. Application of the DID method based on twenty-three affected combinations stands in contrast to the theory of harm alleged in the CAC in which BCBSM's contracts with MFN provisions are alleged to have resulted in antitrust impact and damages throughout Michigan. As noted, proposed economic analysis based on a limited number of combinations raises important methodological questions: (1) how were the "affected combinations" chosen; (2) what individualized analysis went into their selection; and (3) what theory of harm leads to effects at some hospitals but not others? Dr. Leitzinger's report provides no information with respect to these questions.

107. In their Motion, plaintiffs' counsel indicated that they narrowed the class definition based on discovery evidence and analysis performed by their economics expert.[163] As noted above, during his deposition, Dr. Leitzinger admitted that he did not participate in any such analysis, nor did he have any knowledge regarding how such an analysis may have been performed. This raises a potential statistical issue. Across the set of possible combinations, one might observe increases in reimbursement rates (relative to a control group) at some hospitals, simply based on the idiosyncratic features of the hospitals that have nothing to do with the MFN, or simply by chance. Obviously, if statistical analysis were conducted only on a group of such

[162] Leitzinger Deposition at 110:20-21 ("I'm relying on counsel for those dates."), 113:12-14 ("I'm taking the start dates as essentially an assumption. It's by way of the class definition for purposes of my analysis."), 113:15-114:9 (stating that he conducted no independent economic analysis to verify the relevant dates).

[163] See Plaintiffs' Motion at 5.

hospitals implementation of the DID analysis would be circular: it would only confirm an effect on the limited sample of hospitals for which an effect was previously found (perhaps by chance).

108. Another potential problem raised by Dr. Leitzinger's proposed methodology is that his treatment groups (i.e., the "affected combinations") are not randomly assigned. The term "treatment" commonly applied to such analysis (and used by Dr. Leitzinger) originates from medical experiments in which one group of patients receives a drug and a control group does not. A critical feature of such experiments is that assignment to the treatment and control groups is random. Nonrandom assignments (as is the case here) are problematic when the treatment depends on a variable that affects the outcome. For example, if only the sickest patients are assigned to the "treatment" and the healthiest to the "control," bad outcomes in the treatment group may be the result of prior condition and not the treatment itself. Similarly, some hospitals may pursue higher rates with greater urgency than others, perhaps due to their strategic goals, changes in cost structure, internal corporate pressure, or other reasons. If such hospitals were more likely to negotiate contracts with MFN provisions, then this may imply that they would have negotiated higher reimbursement rates relative to the control group absent the MFN. This potentially confounds the "MFN effect" Dr. Leitzinger seeks to identify, because it implies that the treatment hospitals may differ from the control hospitals due to unobserved factors not related to the MFNs.

3. Interpreting Dr. Leitzinger's statistical results

109. In his expert report, Dr. Leitzinger presents only a small part of the results yielded by his DID analysis. Exhibit 8 of his report contains his DID estimates of the effects of MFNs

(based on linear regression) for the twenty-three "affected combinations."[164] In his expert report, he does not present the coefficient estimates for other explanatory variables in his model, the levels of statistical significance of any variable (importantly, including the DID effect of MFNs), or any statistical measure of the model's "goodness of fit" (i.e., how much of the variation in reimbursement rates is explained by the explanatory variables included in his model and whether the results are likely to have been obtained by chance). Dr. Leitzinger does not discuss the statistical significance of his results, or any statistical issues related to his proposed application of the DID methodology. Measures of statistical significance are provided only in his supporting documentation.

110. Focusing on Dr. Leitzinger's DID analysis, it does not support the three underlying elements of plaintiffs' theory of competitive harm. As I noted above, I understand plaintiffs' theory contains the following elements: (1) BCBSM paid more to some hospitals in consideration for hospitals agreeing to MFNs; (2) other insurers' rates increased as a result of the MFNs; and (3) the increase in rates attributable to the MFNs resulted in downstream harm in an alleged market for commercial health insurance in Michigan. As Dr. Leitzinger noted in his deposition, his proposed DID analysis says nothing in itself about competition in any downstream market for commercial health insurance.[165] Thus, his DID analysis provides no

[164] This is the coefficient estimate for the variable MFN*Post Period, where MFN is an indicator variable equal to one for the affected combination (treatment) and zero otherwise, and Post Period is a variable equal to one in the post-MFN period and zero otherwise. Based on the model specification, the coefficient represents the change in reimbursement rate for an "affected combination" relative to the control group in the post-MFN period, accounting for the effects of other variables included in his analysis. Dr. Leitzinger submitted a corrected version of Exhibit 8 after submitting his report.

[165] Leitzinger Deposition at 36:19-22 ("Q. Does your regression in any way analyze the product market for commercial health insurance? A. No. The regression analysis is not -- does not relate to prices for commercial health insurance."); 45:16-21 ("Q. … Does the regression that you've performed in this case, any of the 23, tell you anything about whether Blue Cross increased its market power in the market for commercial insurance? A. No.").

evidence that the third element of plaintiffs' theory of harm (i.e., reduced competition in an alleged downstream market) resulted from any of the alleged increases in reimbursement rates he attributes to the MFN provision at the twenty-three "affected combinations."

111. With respect to the first element (i.e., that BCBSM paid more), Dr. Leitzinger's DID analysis presents this alleged finding at only five of the thirteen hospitals considered in his analysis (see his Exhibit 8). However, upon closer inspection, according to Dr. Leitzinger's own findings, two of these five hospitals have estimated increases in reimbursement rates that are not statistically different from zero at levels of statistical significance commonly applied and generally accepted by the economics community (i.e., 10 percent, 5 percent, or 1 percent).[166] This finding is shown in Table 2. In Table 2, the first column of results presents Dr. Leitzinger's DID estimates with accompanying asterisks that indicate the level of their statistical significance based on the p-values obtained from his supporting documentation. The table shows that his DID estimates for BCBSM are not statistically different from zero at the 10 percent level at either Beaumont Hospital – Royal Oak PPO or Beaumont Hospital – Troy PPO. In addition, his DID estimate for the remaining BCBSM Beaumont affected combination, Beaumont Hospital – Gross Pointe PPO, appears implausibly high. According to Dr. Leitzinger, the average reimbursement of BCBSM paid to Beaumont Hospital – Gross Pointe was 32.5 percent before the MFN and 39 percent after the MFN.[167] Based on his DID estimate (which attempts to compare changes in reimbursement rates at the allegedly affected combination to changes in control group rates), he concludes that the reimbursement rate would be lower by 15.8 percentage points. In other words, the reimbursement rate in his but-for world would have been roughly 23.2 percent, or roughly 9

[166] Significance levels of ten percent are sometimes considered only marginally significant.

[167] Leitzinger Report, Exhibit 6.

percentage points lower than the average reimbursement rate in the pre-MFN period. Dr. Leitzinger offers no explanation or logic for why BCBSM's rate to Beaumont Hospital – Gross Pointe would have been expected to decrease so much. Effectively, the reimbursement would have fallen to levels not seen since before the 2006 PHA, which was designed to raise reimbursement, not lower it.

112. Taking another approach to the plausibility of his DID estimate for Beaumont Hospital – Gross Pointe, I calculated the reduction in hospital payments to the hospital during the alleged overcharge period for the BCBSM PPO product that he considered. Since Dr. Leitzinger's overcharge analysis is applied to inpatients for this affected combination, my analysis focuses on inpatient-related payments as well.

113. I then examine what Dr. Leitzinger's alleged overcharges imply about the hospital's financial condition but for the MFN. As shown in Table 3, applying his but-for rate to the total allowed amount associated with BCBSM-related inpatient claims for this product during the alleged overcharge period lowers hospital payments by over $36 million. During that same period, Beaumont Hospital – Gross Pointe's operating income from patient services was negative $12.7 million. Thus, Dr. Leitzinger's estimate would imply a threefold increase in the hospital's operating income losses. The hospital's actual net operating margin (defined as net patient income divided by net patient revenues) was -2.65 percent. Using Dr. Leitzinger's but-for reimbursement rate in the BCBSM PPO agreement, the hospital's but-for net operating margin would decline to approximately -11 percent.[168]

[168] Further taking into account reduced payments for this hospital from the two other "affected combinations" involving this hospital and HAP lowers the but-for operating margin to -11.56 percent. Table 3 also shows the same calculations for the other Beaumont hospital combinations.

[redacted]

The steep cut in the reimbursement rate Dr. Leitzinger's but-for analysis predicts for payments under BCBSM's PPO agreement with Beaumont Hospital – Grosse Point would essentially negate much of the progress Beaumont made during this period. Dr. Leitzinger admitted during his deposition that his DID method does not consider the financial implications of his findings on the affected hospitals.[170] Clearly, the feasibility of these reductions and their financial impact on Beaumont Hospital – Grosse Point should be analyzed. Extending this to other hospitals would require individualized analysis of each hospital.

115. Other information in the record also calls into question the reductions in the reimbursement rate Dr. Leitzinger predicts would take place at Beaumont hospitals absent the MFNs. [redacted]

[redacted]

[redacted] In contrast, according to Dr. Leitzinger, Beaumont's two largest facilities (Royal Oak and Troy) were paid BCBSM reimbursement rates that were too high (under its non-HMO agreement) beginning in February of 2006.

116. For the remaining two hospitals for which Dr. Leitzinger claims to show a positive DID effect for BCBSM, St. John and Providence Park, none of his DID models shows that a competitor paid more. Thus, the second element of plaintiffs' theory of harm is not shown. Summarizing the above in a different way, for the three hospitals for which he shows post-MFN increases (relative to his control group) for both BCBSM and a competitor, the claimed BCBSM rate increase is either (1) not statistically different from zero or (2) implausibly high.

117. So far I have discussed the implications of DID analysis using the results that are derived from Dr. Leitzinger's own regression models. However, Dr. Leitzinger's proposed use of the DID framework in this setting raises another important implementation issue that he fails to discuss. Recall that the DID method that he proposes attempts to estimate the impact of the MFN provision on the reimbursement rate of the "affected combination" relative to a specified control group. In implementing this approach, he uses quarterly (three month) data on average reimbursement rates both before and after the MFN. In a footnote to his report, he states: "MFN compliance is on an annual basis. However, I performed this analysis using quarterly-level reimbursement rates to ensure a sufficient sample size."[172] However, in his report, he does not discuss the possibility that autocorrelation in the quarterly rates might bias estimates of standard errors derived from commonly-used estimation procedures (such as ordinary least squares) and

[172] Leitzinger Report at ¶ 53, footnote 115.

that alternative procedures have been recommended to address this issue. When standard errors are biased downward, one might conclude that claimed effects are statistically different from zero when they are not.[173] Failure to consider this issue has been an important criticism of the DID approach in applications involving repeated observation on the outcome variable in the before and after periods.

118. While there are a number of potential approaches for dealing with this issue, Dr. Leitzinger omits a discussion of this topic in his report. However, based on a review of the statistical software programs he provided as backup to his report, it appears that Dr. Leitzinger used one of the several alternative approaches to address this issue. To examine the sensitivity of his findings with respect to his particular chosen method, I re-estimated Dr. Leitzinger's regression models using another recommended method for dealing with this issue. In particular, I collapsed (aggregated) the quarterly data into averages within the pre-MFN and post-MFN periods. These results are shown in Table 2 under the column heading labeled "Alternative Model 1." I found that these results differed from the findings reported by Dr. Leitzinger. The asterisks indicate that only five of the twenty-three DID estimates are statistically different from zero, even at the 10 percent level.

119. In Alternative Model 2, I conducted another sensitivity analysis. In particular, I follow the same approach but examine the 2-year period before and after the start of Dr. Leitzinger's post-period. Focusing on a more immediate period around the event, I find many of the DID effects are smaller in magnitude and again most are not statistically different from zero

[173] See Marianne Bertrand, Esther Duflo, and Sendhil Mullainathan, (2004) "How Much Should We Trust Differences-In-Differences Estimates?" *Quarterly Journal of Economics*, Vol. 119, No. 1. Dr. Leitzinger provided both the statistical programs he used and model coefficients and associated p-values in his working papers. Throughout, when I refer to Dr. Leitzinger's methodology, I mean the specific statistical computer code that he provided.

at professionally-accepted levels. Thus, Dr. Leitzinger's results appear quite sensitive to how one handles known statistical issues that are unaddressed in Dr. Leitzinger's report and whether one uses quarterly data. Dr. Leitzinger opined in his deposition that "the role of quarterly information would be to allow the model to perhaps potentially get a better fix on the role of some of the other factors in the regression model in terms of reimbursement."[174] However, all but one of his "factors" do not vary quarterly. The only factor that does is "Billed Amount … which controls for differences in the change in the influence of a specific insurer-network combination at a hospital overtime."[175] However, such influence wouldn't generally be reflected in rates until contracts are renegotiated, which certainly does not occur quarterly. I conclude from Table 2 that this approach to dealing with autocorrelation leads to results that are quite different from those of Dr. Leitzinger. In this sense, Dr. Leitzinger's results are not robust.

120. Despite plaintiffs' claim that BCBSM paid hospitals more to enact MFNs, Dr. Leitzinger curiously omits any analysis of BCBSM's prices at hospitals at the Peer Group 5 hospitals where Priority or Aetna were allegedly harmed. In Table 4, I explore this issue by applying his DID framework to calculate the purported MFN effects on BCBSM rates at the seven Peer Group 5 hospitals involving Priority and Aetna "affected" PPO agreements."[176] I find that Dr. Leitzinger's approach has an odd implication. As shown in the table, the DID estimates of the "MFN effect" for BCBSM are negative and statistically significant at the five percent level in four cases, significant at the 10 percent level in one case, and not statistically significant in two cases. By Dr. Leitzinger's logic, this implies that the MFNs may have made BCBSM into a

[174] Leitzinger Deposition at 128:9-13.

[175] Leitzinger Report at ¶ 55.

[176] In applying Dr. Leitzinger's methodology, I followed the same procedure he used to identify control group hospitals for the affected combinations that he considered.

lower cost competitor in insurance markets, thus resulting in pro-competitive effects, not anticompetitive effects.

121. With respect to the "affected agreements" involving Peer Group 1-4 hospitals, I previously discussed issues related to the five agreements involving BCBSM, i.e., two DID results are not statistically significant, one appears implausibly large, and in the case of the agreement involving Providence Park and St. John, no competitor of BCBSM was shown—or even alleged—to have paid a higher rate post-MFN. The remaining Peer Group 1-4 hospitals in his "affected agreements" involve HAP. I previously have shown that many of these "affected agreements" have DID effects that are not statistically different from zero at the 10 percent level when aggregated data are utilized to account for the possibility that repeated times series observations at the same hospital are not statistically independent. However, closer scrutiny of his HAP DID model also highlights the sensitivity of Dr. Leitzinger's approach with respect to the choice of control group hospitals.

122. For example, Dr. Leitzinger's DID analysis of HAP's PHP plans at Beaumont Hospital – Gross Pointe and Beaumont Hospital – Troy include seven control group hospitals. In both analyses, his control group includes Lakeland Regional Medical Center – St. Joseph and McLaren Bay Regional. These two hospitals are located considerable distances from the two allegedly affected Beaumont hospitals.[177] Although Dr. Leitzinger asserts that hospital locations are largely irrelevant,[178] it is at least plausible that closer hospitals better represent the local supply and demand factors near the affected hospitals than more distant ones. To investigate the

[177] See Leitzinger Report, Figures 1 and 2.

[178] Leitzinger Deposition at 39:11-17 ("Q. Do you think the location of the control hospitals are important? A. Not for the -- except, again, for the accounting I made of location in or out of the Detroit area, no, I didn't see other -- the need -- I didn't see that other locational effects were important.").

sensitivity of his model with respect to the inclusion of these two distant hospitals, I ran two alternative regressions for each of the two HAP PHP "affected combinations," removing one of the two distant control group hospitals (see Table 5). When I did so, the magnitude of his alleged "MFN effects" dropped markedly and, in all cases, the effects were no longer statistically significant, even at the 10 percent level. That is, I find that his results are very sensitive to adding or dropping a single more distant hospital from his control group.

123. Another way of examining the reliability of Dr. Leitzinger's proposed application of the DID methodology is to consider whether it would find an "MFN effect" at a control group hospital, none of which have MFNs. To explore this issue, I examined the Beaumont Hospital – Royal Oak agreement with HAP HMO. This agreement accounts for over twenty percent of Dr. Leitzinger's claimed aggregate class-wide overcharges. Dr. Leitzinger's DID analysis for this "affected combination" is based on a comparison of rates at this hospital to the rates at twelve control group hospitals that did not have MFNs. I applied his approach to investigate whether it would reveal any statistically significant "MFN effects" at the control group hospital. Specifically, following his DID approach, I considered one of the control group hospitals to be "affected" and compared it to the other eleven hospitals in the control group. In implementing this test, I used the same post-period as used by Dr. Leitzinger in his evaluation of the effected combination. In these examples, I find several statistically significant "MFN effects" (both rate increasing and rate reducing) (see Table 6). This illustrates that some control group hospitals were affected by factors other those included his model during the post-MFN period (implying that Dr. Leitzinger's procedure can "find" MFN effects even when there are none), which casts some doubt on the reliability of the findings.

124. This doubt over the reliability of Dr. Leitzinger's results is due in great part to his confusing correlation with causation. His methodology alleges some instances of higher growth in average rates at some hospitals with MFNs than at other "control" hospitals without MFNs. Even if one were to accept that average rates increased, this does not reliably indicate any causal relationship between MFNs and the higher rates for several reasons. First, as I previously discussed, BCBSM alleged that MFNs were sometimes incorporated intro contracts where hospitals negotiated higher rates. This would imply that we would see higher rates accompanying MFNs, precisely at the insurer contract dates, but the causality would run in the reverse direction. Second, Dr. Leitzinger does not examine whether his measured "effects" flow from MFNs or from idiosyncratic (and unexamined) factors affecting reimbursement rates. This is illustrated by my analyses showing significant "MFN effects" at control group hospitals without MFNs and significant changes to alleged "MFN effects" based on the omission of a single distant control hospital. Third, Dr. Leitzinger does not attempt to disentangle MFNs from other contemporaneous changes at hospitals, including other contract provisions and whatever factors served as the impetus for a hospital opening negotiations in the first place.

4. Dr. Leitzinger's procedure fails to adequately isolate the effects of MFNs on rates from other factors. To do so requires individualized analysis.

125. Dr. Leitzinger's DID analysis based on comparisons of average rates ignores the record evidence of the many individualized aspects of each negotiation.[179] He states, "I don't think the negotiating documents bear on the economic evidence that I have presented."[180]

[179] Dr. Leitzinger stated that he did not consider any of the record evidence about the specific negotiations and that his "analysis does not rest upon that or incorporate that kind of review." Leitzinger Deposition at 78:24-79:7.

[180] Leitzinger Deposition at 79:25-80:1.

126. Dr. Leitzinger argues that his "control group" hospitals, along with several additional variables in the regression, control "for factors that may also have changed across the time periods in question other than the event of interest."[181] Dr. Leitzinger appears to conclude that his DID effects capture the independent effects of the MFNs, net of all other influences. This requires, at a minimum, that the control group hospitals be very similar to affected hospitals, apart from having MFNs. Even if that were true, and putting aside statistical issues, there is another difficulty with Dr. Leitzinger's argument.

127. In particular, there is a strong pattern in the data that neither plaintiffs' theory of harm nor Dr. Leitzinger's analysis can address. In Figures 1 and 5, Three Rivers and Mercy Health Partners raised the affected insurers' rate up to the BCBSM level, consistent with plaintiffs' theory (though also consistent with BCBSM's explanation for MFNs). However, Figures 2, 3 and 4, exhibit a very different pattern. From the beginning of their respective MFN effective periods, Charlevoix Area Hospital ("Charlevoix"), Paul Oliver Memorial Hospital ("Paul Oliver"), and Kalkaska Memorial Health Center ("Kalkaska") raised the affected insurer's rates well above those of BCBSM. This was certainly not required by the MFNs in effect at those hospitals. In addition, in all five cases over time, the "affected" insurer's rate remained well above that of BCBSM. These figures imply that some factors are at work that do not appear in either the plaintiffs' theory of harm or in Dr. Leitzinger's analysis and that differ from hospital to hospital. They are likely explained by differences in hospital bargaining strategies and motivations.

[181] Leitzinger Report at ¶ 51.

128. In the following paragraphs, I review some of the individualized issues in the rate-setting process of each "affected combination" and conclude that individualized issues call into question the use of class-wide analysis. Indeed, Dr. Leitzinger appears to concede this point in his deposition:

> Q. And how if at all does that economic evidence relating to Priority at Allegan affect your conclusion whether or not Aetna was affected at Three Rivers Hospital?
> A. It doesn't.
> …
> Q. How if at all does the economic evidence used to find impact to Priority at Charlevoix Hospital affect the ability to find impact to Aetna at Bronson LakeView?
> A. It doesn't … the finding as to each combination will ultimately reflect the underlying data and the impact of the MFN scheme on that combination.[182]

129. Thus, Dr. Leitzinger concedes that a finding of an "MFN effect" for one payer at one hospital does not provide any insight into whether there is any antitrust impact of any other MFN at any other hospital for any other payer. There may be unique circumstances in some hospital-insurer negotiations that lead to an outcome that cannot be predicted using evidence common to the class. Failing to account for any unique circumstances by using a model that simply glosses over them is not evidence of "class-wide effects." It is evidence of a one-sided analytical approach.

130. [redacted]

[182] Leitzinger Deposition at 59:2-60:22.

[redacted]

131. St. John Hospital and Medical Center and Providence Park Hospital. St. John and Providence Park are part of the Ascension-Michigan system. [redacted]

[redacted] eposition of Suzanne Hall, 11/15/12 at 136:7-137:3.

[184] This was also acknowledged by BCBSM. Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 53 ("We knew we had a great discount at Beaumont…" [redacted]

[185] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 46.

[186] Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 53.

[187] [redacted] and Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 76:9-13.

Ascension-Michigan hospitals were regarded by insurers as very desirable providers.[188] These hospitals believed that BCBSM was paying too little to Michigan hospitals, in general.[189] Mr. Patrick McGuire explained, "the problem we were trying to solve was that Blue Cross was negotiating rates lower than what we thought should be paid."[190]

132. The reimbursement rates for both hospitals were determined as part of the negotiations for the Ascension-Michigan system. Dr. Leitzinger's analysis ignores this important fact. The Ascension-Michigan system includes hospitals that, as explained by Mr. McGuire the system believed insurers "really need to have … within their product offering to be competitive."[191] Mr. McGuire regarded departicipation—the non-renewal of contracts with payers—as a valid and valuable negotiating tool:[192]

> Departicipation is where you would effectively not renew your contract with Blue Cross, and so you would be deemed a nonparticipating facility for Blue Cross patients. Anyone that has Blue Cross insurance would not be able to use our facilities without incurring substantial beneficiary costs to do so.[193]

133. In its 2008 negotiation with BCBSM, Ascension-Michigan implemented a multi-hospital departicipation strategy. It notified BCBSM that one of its constituent hospitals, Borgess Medical Center ("Borgess"), would no longer contract with BCBSM unless BCBSM agreed to

[188] Deposition of Laura Eory, 11/12/12, at 146:1-147:25.

[189] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 78.

[190] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 204:10-12.

[191] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 69:1-4, 70:23-25.

[192] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 94-96 (explaining the departicipation strategy and stating that it provides "leverage" over Blue Cross); also at 194 (calling negotiations with BCBSM "aggressive" and "contentious").

[193] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 94:3-8.

steep price increases across Ascension-Michigan's hospitals.[194] It was made clear to BCBSM that other hospitals could soon follow[195] and a prioritized list of hospitals that would also departicipate if needed was devised.[196] The carefully chosen list of hospitals was based on three criteria.

134. First and foremost, the departicipation of a particular hospital had to be significantly harmful to Blue Cross. For example, Borgess, the hospital at the top of the list, was in a "2 hospital town" in which the "other hospital has no capacity."[197] The implication here is that if Borgess departicipated, BCBSM would find it difficult to send its members to another nearby hospital. Genesys Hospital was added to the list in part because of its importance to BCBSM client General Motors and its retirees. The departicipation of Genesys would, therefore, "…be painful to Blue Cross."[198]

135. Second, the departicipation of a hospital had to be credible. Borgess had actually sent BCBSM a departicipation letter in the past, "…so we believed that a threat that Borgess would departicipate would be the most credible threat of any of our organizations; therefore, that's why they were chosen number 1."[199]

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[194] BLUECROSSMI-99-02025158; Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 195:6-15.

[195] See Deposition of Patrick McGuire at 195:17-19.

[196] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 95:10-23.

[197] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 96:4-5.

[198] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 100:14-21.

[199] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 96:12-16; also see 97:7-9 ("Borgess had the strongest track record that they would actually do it.").

136. Third, the departicipation should "mitigate the negative impact" on Ascension-Michigan.[200] For example, Ascension-Michigan examined whether or not the BCBSM business lost by a departicipating hospital could be recaptured by another hospital in its system.[201]

137. The coordinated negotiating campaign was broadened to include the threatened departicipation of multiple hospitals in the Ascension-Michigan system.[202]

> If a system like Ascension Health or St. John Providence were to departicipate, the feeling is that that would harm Blue Cross in their sales effort to sell their product; therefore, it is leverage to essentially walk away from that, from that business.[203]

138. Thus, St. John and Providence Park, through Ascension-Michigan benefitted from the weight of a large hospital system that sought to orchestrate price concessions for each member hospital. No doubt, Ascension-Michigan received less than it hoped to get. However, this strategy was, in McGuire's view, a success: "…we ultimately got as high rates as we were going to get without actually departicipating from Blue Cross."[204]

139. The intricate and well-orchestrated bargaining strategy adopted by Ascension-Michigan shows that individualized analysis is essential to understanding the price-setting process at its member hospitals, invalidating the one-size-fits-all DID regression approach of Dr. Leitzinger. According to his DID analysis, the alleged MFN effect for St. John for the BCBSM

[200] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 100:8-10.

[201] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 100:2-7.

[202] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 195:2-196:21.

[203] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 94:19-23.

[204] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 185:10-12.

PPO agreement is 2.9 percentage points [205] and is 13.6 percentage points for the BCBSM PPO agreement at Providence Park Hospital.[206] However, it is also important to note that, in the view of Mr. McGuire "the MFN was relatively ineffective."[207] It was both sufficiently vague and prescribed prices for rival insurers that Ascension-Michigan would have enacted anyway as they were in its "business interest."[208] [redacted]

140. This fact illustrates how Dr. Leitzinger's attempt to show impact by common proof fails. He assumes that his entire estimated overcharge is attributable to the MFN without separating any effect of the MFN from the record evidence of the effects of the broad negotiating strategy used by Ascension. To arrive at a defensible analysis of impact on these hospitals, Dr. Leitzinger would have had to consider the unique aspects of the bargaining process and the power implied by the system's strategy.

141. Further, Dr. Leitzinger again ignores the interdependencies between hospitals in the same system. Dr. Leitzinger's analysis treats St. John and Providence Park Hospital as if they set prices independently, despite the fact that Ascension-Michigan negotiated collectively for all these hospitals and that these negotiations resulted in prices that were governed by the same

[205] Leitzinger Report, Corrected Exhibit 9.

[206] Leitzinger Report , Corrected Exhibit 9.

[207] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 81.

[208] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 81:3-6 (stating that the MFN prevented rates to rival insurers which in his view were "not in our best business interest to give to any other payer anyway"; 162:10-15 (suggesting scenarios where lower prices to rivals would, in his view, not violate the MFN).

[redacted]

PHA and reimbursement mechanism.[210] Dr. Leitzinger obtains implausibly different overcharges of 34.2 percent for one hospital and only 7.6 percent for the other.

[redacted]

[210] Leitzinger Report Exhibit 9 (corrected). See also BLUECROSSMI-98-000551-00561.

[redacted]

analysis of the facts specific to Allegan's bargaining strategy could deduce what prices it would have been able to negotiate absent an MFN given its strategy of seeking higher prices independent of any MFN agreement.

144. The Allegan experience highlights another issue with Dr. Leitzinger's analysis. Allegan sought an MFN as part of its specific bargaining strategy to obtain higher prices. A similarly-situated hospital without a similar strategy may not have been seeking higher prices and thus may not have sought an MFN. Comparing the two hospitals as Dr. Leitzinger does, one would see higher prices associated with an MFN, but have the causality entirely backwards. Allegan may have obtained an MFN because it was seeking higher prices from Priority and United, rather than seeking higher prices because it was bound by an MFN.

145. Three Rivers Health. Three Rivers would have sought more reimbursement from the affected insurer, Aetna, even without an MFN because Three Rivers was experiencing significant financial difficulty.[216] The CFO of Three Rivers Health stated that the hospital's financial condition was the "number one factor" in its negotiations with Aetna,[217] but that *both* the hospital's financial condition and the MFN were relevant to its negotiating a higher rate: "I want to clarify that renegotiating with these payers is not solely a result of what Blue Cross is doing but … obviously the Blue Cross agreement accelerated that process …"[218]

146. The extent of the rate increase Three Rivers would have obtained absent the MFN is uncertain. Over time, Aetna's rates at Three Rivers diverged from those of BCBSM and significantly exceeded the rates required by the MFN. For Aetna's PPO agreement with Three

[216] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 66:13-20; 85:6-12.

[217] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 87:14-16.

[218] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 66:17-22.

Rivers, Figure 1 shows that Aetna's rate exceeded that of BCBSM by more than 10 percentage points. This suggests that at least part, if not all, of the obtained price increases would have been obtained with or without an MFN. Careful, individualized analysis of the negotiation between Three Rivers and Aetna would be required to deduce how much of the increase is attributable to the MFN.

147. Because of the unique circumstances surrounding each of these negotiations, the results of such an analysis would not allow one to conclude anything about the impact of an MFN at other hospitals. For example, Ascension-Michigan knew that the potential departicipation of "a system like Ascension Health or St. John Providence… would harm Blue Cross" and thus wielded significant "leverage" and considerable bargaining power over BCBSM.[219] Conversely, Three Rivers generally saw itself as in a poor bargaining position with respect to BCBSM.[220] Departicipation "didn't seem like a viable option."[221] [redacted]

Reflecting a very different bargaining strategy, the Three Rivers representative considered the MFN helpful to negotiations with Aetna. Hence, finding that the MFN caused the Aetna rate to

[219] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 94:19-23.

[220] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 48:4-49:13.

[221] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 50:13-22.

[redacted] and Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 75:22-76:13.

go up by some given amount at Three Rivers is uninformative about the role played by the MFN at Ascension-Michigan or Beaumont, and vice versa.

148. Charlevoix Area Hospital. Although the Charlevoix representative, Mr. William Jackson, was intent on raising revenues with or without an MFN, the MFN agreement was an important consideration in his negotiations with Priority.[224] It is significant that in its Charlevoix Priority PPO agreement, the data used by Dr. Leitzinger show Priority's rate was twenty points above the BCBSM rate by 2010 and thus significantly exceeded the requirements of the MFN (see Figure 2). Since the Charlevoix agreement involved an equal-to-MFN provision, this discrepancy cannot reasonably be attributed to the MFN, but is at least partly the result of Charlevoix's own bargaining power and strategy with Priority. There is nothing in Dr. Leitzinger's analysis that can explain why an MFN would lead to such disparity in rates. As with other Peer Group 5 "affected" hospitals, Charlevoix might well have been able to negotiate rates without an MFN equal to or just below those it obtained with an MFN. The likely result of each hospital's negotiations in a world without MFN agreements would require individualized analysis.

149. Paul Oliver Memorial Hospital and Kalkaska Memorial Health Center. Munson HealthCare owns Paul Oliver and manages Kalkaska, each of which is part of an allegedly affected combination. Munson HealthCare had been negotiating for higher rates from Priority prior to the MFN, though the MFN agreement "helped us get there."[225]

[224] Deposition of William Jackson (Charlevoix), 3/2/2012, at 119:19-24; 93:8-12, 79:7-80:6. However, the MFN was not specifically raised as an issue with Priority. Deposition of William Jackson (Charlevoix), 3/2/2012, at 126:2-8.

[225] Deposition of Steven Leach (Munson HealthCare), 3/15/2012, at 63:11-65:22; also see at 69:17-24 ("Q. How would you say the MFN clause with Blue Cross that Paul Oliver and Kalkaska had impacted the hospital's reimbursement from Priority Health? A. I'm going to say that it had an influence but it was not a direct relationship.

150. Munson HealthCare also owns the much larger Munson Medical Center, the system's "mother ship,"[226] to which Paul Oliver and Kalkaska act as feeder hospitals. When Munson HealthCare increased Priority's rates at Paul Oliver and Kalkaska to be in compliance with the MFN, it also decreased Priority's rate at Munson Medical Center. "In other words, to get them [Priority] to - - to improve their reimbursement [at Paul Oliver and Kalkaska], we would take a nick on Munson. So there was like, if you will, an offset there." [227]

151. The unusual features in this arrangement provide additional perspectives on the shortcomings the Dr. Leitzinger's proposed statistical analysis. Figures 3 and 4 show the reimbursement rates for BCBSM and Priority at the "affected agreements" involving the Paul Oliver and Kalkaska hospitals. At both hospitals, there is a clear rise in Priority's reimbursement rates at the time the MFN became effective. For a short period of time after the effective dates, Priority's rate is slightly below that of BCBSM, but for nearly all of the damage period claimed by Dr. Leitzinger, Priority's rate is well above that of BCBSM. As with several other affected combinations, Munson HealthCare's hospitals had ample scope to lower Priority's rate but clearly chose not to do so.

152. Dr. Leitzinger again ignores the interrelated negotiations that occur among hospitals in the same system. Here, he overlooks the fact that when Munson HealthCare raised Priority's rates at Paul Oliver and Kalkaska (which are "affected combinations"), it simultaneously lowered the Priority rate at the much larger Munson Medical Center, which is

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As I mentioned earlier, we were pursuing improved reimbursement from Priority for some time, and it was not - - it wasn't a new issue at all.").

[226] Deposition of Steven Leach (Munson HealthCare), 3/15/2012, at 52:18-19.

[227] Deposition of Steven Leach (Munson HealthCare), 3/15/2012, at 99:13-16.

absent from the analysis. The stated goal of these offsetting rate changes was to comply with the MFNs at the two Peer Group 5 hospitals while leaving Priority revenue-neutral over all three hospitals.[228]

> There really isn't a financial implication to it. It's a neutral position. I would say that it made us more comfortable with the equitability of the two hospitals against Blue Cross/Priority, and Blue Cross being more equitable. And it didn't -- it didn't cost us anything, you know, system wide.[229]

153. Hence, Priority was not affected overall, if the term "affected" is to have any relationship to antitrust impact and economic logic. Dr. Leitzinger creates the appearance that Priority was harmed due to the MFNs by focusing on the rate increases at Paul Oliver and Kalkaska while ignoring the discount at Munson Medical Center. Any analysis that fails to account for the inextricably intertwined actions at all three hospitals cannot speak to antitrust harm in any sense meaningful to an economist.

154. Dr. Leitzinger's artificial focus on only half of a revenue-neutral adjustment in prices has a second implication for class certification. Individual insured patients are also members of the proposed class. Because Munson Medical Center is the only tertiary care facility in its area, it draws patients—especially those with more serious conditions—from a fair distance away.[230] Specifically, patients admitted to Paul Oliver and Kalkaska with serious medical conditions will often be moved to a larger hospital such as Munson Medical Center. Such

[228] Deposition of Steven Leach (Munson HealthCare), 3/15/2012, at 100:13-14 (stating that the net effect on Priority, in dollar terms, "was equitable, break even, close to break even")

[229] Deposition of Steven Leach (Munson HealthCare), 3/15/2012, at 102:3-8; also see at 101:12-13 (stating that the overall change was "neutral to" Munson HealthCare, leaving them "indifferent").

[230] Deposition of Steven Leach (Munson HealthCare), 3/15/2012, at 45:2-46:2.

patients are affected by MFNs in contradictory ways. A Priority insured who is moved from Paul Oliver to Munson Medical Center but pays a co-insurance that varies with the allowed amount at each institution can be harmed at one and benefitted at the other. Depending on individualized analysis into the mix of care at the two hospitals, this patient can be better off or worse off in the aggregate. If one such member is better off, then he or she is differently situated than a Priority member who is admitted only to Paul Oliver and thus pays allegedly higher rates.

155. Mercy Health Partners – Lakeshore. As with other affected agreements, the one between Priority and Mercy Health Partners, Lakeshore Campus resulted in a reimbursement rate for nearly all of the claimed damage period that is well in excess of what would constitute compliance with the MFN. Figure 5 compares Priority's and BCBSM's rate for the PPO product at Mercy Health Partners, Lakeshore Campus. Following Dr. Leitzinger's "effective date" of the MFN, the Priority rate was roughly equal to the BCBSM rate for only about the first year. In early 2010, the BCBSM and Priority rates quickly diverge, with Priority's rate between 5 and 30 points higher. This suggests that the MFN was not instrumental in maintaining Priority's rate and raises the possibility that the hospital could have obtained similar (or perhaps even the same) rates from Priority without the MFN. Dr. Leitzinger's analysis does not offer any explanation for these rate patterns, and only individualized analysis can allow a conclusion as to whether (and when) the MFN had an effect or not.

156. A second complication is that Mercy Health Partners, Lakeshore Campus is owned by the Trinity Health System which appears to have given Priority a compensating discount at another Trinity hospital.[231] Much like his omission in the case of Munson

[231] Deposition of Pramod Sahney (Trinity), 8/17/2012, at 210:25-212:2.

HealthCare, which negotiated compensating price decreases for Priority, Dr. Leitzinger does not examine these system-wide effects. This challenges the potential for class certification for two reasons. First, it is possible that Priority actually suffered no injury at all if its higher rates at Mercy Health Partners, Lakeshore Campus were fully offset by lower rates at another hospital. Specific analysis of the nature and value of any such offsetting discount would be needed, but would clearly not be informed by class-wide evidence. Second, Priority members may have been treated at both Mercy, Lakeshore and the other hospital, paying higher prices at one and lower prices at the other. If so, these patients, like those at Paul Oliver and Kalkaska, may or may not have paid higher prices, in aggregate. Only a careful analysis of the specific services provided, and billing involved could sort patients that are better off from those that are worse off.

157. Bronson LakeView Hospital ("Bronson"). As noted above, Dr. Leitzinger's DID approach simply compares reimbursement rates before and after some moment in time but fails to consider other contemporaneous events. The negotiations between Bronson LakeView and its insurers illustrates this problem as well. Dr. Leitzinger alleges that Aetna was negatively affected by an MFN as of January 1, 2008.[232] [redacted] The transition in ownership brought a new negotiating team, which renegotiated the existing agreement with Aetna. Under the new agreement, effective January 1, 2008, Aetna was to pay the renamed Bronson LakeView Hospital the higher rate contained in the Aetna's agreement with Bronson Methodist Hospital,

[232] Leitzinger Report Table 1.

[redacted]

which had no MFN.[234] [redacted]

158. Dr. Leitzinger's DID analysis ignores these crucial facts entirely. As a result, his analysis is divorced from the events that actually took place at this hospital. The fact that his data show some change in prices implies nothing about the actual causation at this particular affected combination.

159. Sparrow Ionia Hospital. In the late 2000s, Sparrow Ionia was "losing …more than a million dollars a year."[236] Like many other peer group 5 hospitals, Sparrow Ionia wanted insurers to pay higher prices, and a main bargaining tool appears to have been the fact that Ionia was not viable absent new sources of revenue:

> When we met with them, I was quite clear in that the -- a rate that Priority was paying us was way too low compared to our cost and the market and that if we were going to survive as a viable provider in that community, that they would have to pay us a fair rate, and that was the focus of our argument with them.[237]

[redacted]

[236] Deposition of William Roeser (Sparrow Ionia), 8/8/2012, at 115:13-14; 51:25-52:1, 145:9-11.

[237] Deposition of William Roeser (Sparrow Ionia), 8/8/2012, at 88:17-23.

160. Although the MFN was mentioned in its negotiations, the Sparrow Ionia representative, Mr. William Roeser, stated that financial viability and not the MFN was the main issue raised with Priority.[238] In his estimation, the hospital's financial jeopardy would have resulted in higher rates from Priority even without the MFN.[239] Again, Dr. Leitzinger's analysis does not separate any potential role of the MFN from the higher prices that would have prevailed anyway. Without individualized analysis, it would be impossible to ascertain the role played by the MFN in achieving the increase in the Priority rate. Further, any conclusion drawn from the Priority/Sparrow Ionia experience would not generalize to other affected combinations because the relative significance of the MFN versus other factors varies from hospital to hospital.

161. From my review of the record, including depositions of hospital representatives, I conclude that alleged effects of MFNs, if any, would coincide with a significant and varied collection of other factors that drive impact reimbursement rates. I find that individual negotiations were predominantly governed by specific, idiosyncratic circumstances and strategies of each payer and hospital and therefore impossible to analyze without individualized investigation of each negotiation.

[238] Deposition of William Roeser (Sparrow Ionia), 8/8/2012, at 51:24-52:6, 64:22-65:1.

[239] Deposition of William Roeser (Sparrow Ionia), 8/8/2012, at 88:12-89-15 ("It really didn't have anything to do with the most favored nation clause at that point, even though we did refer to that. It was because we were really being underpaid."). Note that the CFO of the Sparrow system stated that the MFNs had no impact on rates. Deposition of Paula Reichle (Sparrow Health), 8/8/2012, 158:1-158:24.

D. Dr. Leitzinger's supposed proof of impact by common evidence fails

1. Dr. Leitzinger's approach to showing impact by common proof

162. Given his DID analysis of average reimbursement effects, Dr. Leitzinger's final step is to relate those overcharges to prices paid at hospitals by class members. He does this by considering the three most popular methods of reimbursing hospitals: DRG-based reimbursement, percent of charge reimbursement, and flat rates. DRG-based reimbursement is used by BCBSM and, at times, by Priority. HAP uses all three at different hospitals and at different times. Dr. Leitzinger argues that these hospital pricing methods all spread average reimbursement to each hospital function or service, and hence aggregate overcharges imply that all payments by class members are inflated. To Dr. Leitzinger, this is common evidence that shows impact.

163. Dr. Leitzinger's proof fails for several reasons. To start with, it relies on his DID estimates and inherits their faults. I have described above the problems associated with his proposed approach. In addition, his approach, if applied to BCBSM rates, in some cases implies a rate-reducing MFN effect for BCBSM, meaning that in the but-for world, there are gainers and losers relative to the actual world even though Dr. Leitzinger only deals with the latter. It also ignores the possibility that the affected hospitals may have been unusually motivated to increase reimbursement rates with or without MFN. Likely some would have achieved without MFNs what they actually achieved with them, due to hospital bargaining or some other idiosyncratic factor. Some outpatient service rates may be determined by competition, and not amenable to overcharges. Only individualized analysis can untangle the separate effects of these disparate factors. Dr. Leitzinger does not deal with these issues. Hence, Dr. Leitzinger has not shown impact by common evidence.

164. Apart from this, Dr. Leitzinger assumes that impact on a class member is given entirely by the prices supposedly paid by that class member. However, there are other factors that determine impact and which also imply the impossibility of proving impact by common evidence in this matter. This is the subject of the next sections.

2. The effects of quality, access, and program variety at hospitals

165. A main theme in policy debates over American healthcare is that there is a tradeoff between cost and quality of care. It is quite peculiar then, that Dr. Leitzinger adopts a singular focus on reimbursement rates, simply ignoring quality of care and its large, attendant literature. As he admitted in his deposition:

> Q. Did you do any analysis for any of the alleged overpayments at any of the affected hospitals for how those payments may have affected the quality delivered at those hospitals?
> A. No. [240]

166. A number of studies have found a relationship between reduction in hospital reimbursement and several quality-related outcomes, including the increased discharge of patients in unstable condition, increased short-term mortality, decreased compliance with standards of patient safety, and significantly worse patient outcomes.[241] As the authors of one study concluded:

> [W]e find evidence that as hospital profit margins decline, adverse patient safety events increase within a hospital for both nursing and surgical events. These results suggest that financial pressures limit

[240] Leitzinger Deposition at 173:25-174:3.

[241] See, for example, Yu-Chu Shen (2003), "The Effect of Financial Pressure on the Quality of Care in Hospitals," *Journal of Health Economics* 22, at 243–269 (concludes "that the adverse effect of financial pressure on health outcomes of AMI [acute myocardial infraction] patients is not trivial." at 266).

> a hospital's ability to make costly investments in patient safety improvements, and lead to a safety culture problem across the hospital.[242]

167. The general finding from this body of research is that better financial performance allows hospitals to provide a higher quality of care. Despite Dr. Leitzinger's assertion that antitrust impact in this case depends solely on price,[243] a hospital's quality of care is inseparable from its financial health. For example, a notable link exists between a hospital's finances and its ability to subsidize unprofitable hospital services, including burn units, substance abuse services, severe trauma units, and inpatient psychiatric services.[244] As hospitals sometimes lose money on the provision of these services, their provision is understandably dependent on a hospital's financial health. One study of hospitals across nine states concludes "that as financial resources become strained, hospitals may limit service capacity and access to care for these [unprofitable] services."[245] Notably, while these services are unprofitable mostly due to their utilization by

[242] William E. Encinosa and Didem M. Bernard (2005), "Hospital Finances and Patient Safety Outcomes," *Inquiry* 42(1), 60-72, at 68. The authors generally find a relationship between lower hospital operating margins and increased risk of safety lapses.

[243] Leitzinger Deposition at 173:25-174:12 ("Q. Did you do any analysis for any of the alleged overpayments at any of the affected hospitals for how those payments may have affected the quality delivered at those hospitals? A. No. Q. …Why not? A. The claim by the plaintiffs in this case is that the MFNs caused class members to pay additional amounts for hospital services. And from the standpoint of that theory of impact, it's testing for that impact that I was doing in connection with my analysis.").

[244] Jill R. Horwitz (2005), "Making Profits and Providing Care: Comparing Nonprofit, For-profit, and Government Hospitals," *Health Affairs* 24(3), 790-801.

[245] Hsueh-Fen Chen, Gloria J. Bazzoli, and Hui-Min Hsieh (2009), "Hospital Financial Conditions and the Provision of Unprofitable Services," *Atlantic Economic Journal* 37(3), at 273.

indigent, uninsured patients, cuts to or elimination of these services impact insured patients, as well.[246]

168. Service and quality cutbacks in response to financial challenges are rarely uniform, instead negatively impacting only some treatments and diagnoses.[247] In fact, as a hospital cuts back on some areas of service, other services may actually improve due to the increased focus they may receive.[248] Therefore, the effect of financial distress on a hospital is not the same across its patients. For example, increased hospital reimbursements that result in construction of a trauma or burn unit will likely benefit patients in need of these services, but their costs will be subsidized by all patients, regardless of diagnosis.

169. Any class-wide damages will necessarily reward some winners of improved services along with the patients who did not avail themselves of these services. Further, even within a common diagnostic code, "the effect that such changes in service provision may have on patient outcomes will depend on the illness severity."[249] More broadly, even if the cost of a given service improvement does not vary across patients, their value of the service improvement (and thus a determination of whether the value is worth the increased cost) does. As patients vary in their medical needs and tradeoffs between price and service quality, determining the net impact

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[246] Hsueh-Fen Chen, Gloria J. Bazzoli, and Hui-Min Hsieh (2009), "Hospital Financial Conditions and the Provision of Unprofitable Services," *Atlantic Economic Journal* 37(3), 259-277 ("The results indicate that not-for-profit hospitals with strong financial performance provide more unprofitable services for the insured and uninsured than do not-for-profit hospitals with weaker condition." at 259).

[247] Richard C. Lindrooth, Gloria J. Bazzoli, and Jan Clement (2007), "The Effect of Reimbursement on the Intensity of Hospital Services," *Southern Economic Journal* 73(3), 575-587.

[248] Yu-Chu Shen (2003), "The Effect of Financial Pressure on the Quality of Care in Hospitals," *Journal of Health Economics* 22, at 266 ("The financial pressure might have an adverse effect only on certain diseases, and lead to improvements in other aspects of hospital quality.").

[249] Meena Seshamani, Jingsan Zhu, and Kevin G. Volpp (2006), "Did Postoperative Mortality Increase After the Implementation of the Medicare Balanced Budget Act?" *Medical Care* 44(6), at 527.

on any given patient requires individual analysis. Further, as hospitals vary in their priorities and competitive situations, these decisions of which services to expand and curtail will, of course, vary from hospital to hospital.[250] On this point, Dr. Leitzinger agrees:

> … if one were looking to see whether there was a benefit in the nature or quality of care associated with increased reimbursement, it seems to me the answer to that question would necessarily involve a look at what happened at each of the affected hospitals.[251]

170. The record evidence in this matter is in line with the conclusions of the economics literature in recognizing revenues as a driver of hospital quality. [redacted]

[250] Meena Seshamani, Jingsan Zhu, and Kevin G. Volpp (2006), "Did Postoperative Mortality Increase After the Implementation of the Medicare Balanced Budget Act?" *Medical Care* 44(6), at 527. ("The response of a hospital to financial stress will likely depend not only on the size of the shock, but also on the baseline financial health of the hospital.").

[251] Leitzinger Deposition, at 175:12-17.

[252] [redacted] See also the deposition of Timothy J. Johnson (Eaton Rapids Medical Center), 5/7/2012, at 242: 17-19: [redacted]

[253] [redacted] also Deposition of Timothy Johnson (Eaton Rapids Medical Center), 5/7/2012, at 242:16-243:13 [redacted]

[redacted]

A similar point is made by Steve Andrews, of Three Rivers:

[redacted]

Q. And do you agree with me that as those means are reduced, its ability to provide certain services are also reduced?
A. That's correct.[258]

[redacted]

172. As the above shows, higher hospital revenues have three distinct effects that benefit class members: service quality is improved, additional programs can be offered, and possible hospital closure avoided. It is important to note that these benefits are likely to vary across class members. Some class members will place more value on these benefits than will others. There is no reason to suppose that such benefits are valued uniformly across the proposed class.

173. The impact of the alleged rate increases attributed to the MFNs on a given class member will depend on the net effect of possibly paying more for either healthcare services or health insurance set against the quality and access improvements made possible by these rate increases. However, since the relative valuations of these benefits vary across class members in a non-formulaic matter, the quality-adjusted impact of the rate increases at issue must also vary across class members. For those who do not value quality effects highly, the quality-adjusted

[258] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 203:18-21.

[redacted]

impact of the alleged rate increases is negative. However, for others it may well be less and even positive. Hence, impact cannot be determined without individualized analysis.

3. Dr. Leitzinger overlooks potential benefits of MFNs at affected hospitals to supposedly unaffected insurers

174. According to plaintiffs' theory of harm, MFNs "serve to increase the costs incurred by its rival insurance providers," [261] leading to "reduced competition in the provision of health insurance and higher health care costs" and raising the price of health insurance.[262] However, Dr. Leitzinger stated in his deposition that he has no opinion on whether Priority, Aetna, HAP, or any other insurer was competitively disadvantaged by the MFN and provides no analysis on whether competition was hurt at all.[263] The "raising rival costs" theory is not a panacea for plaintiffs but requires first and foremost a demonstration of antitrust harm. As explained by a former FTC Commissioner:

> One concern about the "raising rivals' costs" theory is that harm to competitors does not always result in harm to competition itself, that is, it may not adversely affect consumer welfare. … Thus, in any of these theories, a showing of likely consumer injury should be required … that is, a likely increase in quality-adjusted price or likely decrease in output ...[264]

[261] Leitzinger Report at ¶ 79.

[262] Leitzinger Report at ¶ 77.

[263] Leitzinger Deposition at 57:1-58:2; 92:24-93:2 ("Q What opinion do you have that MFNs generally impacted competition? A I haven't given any opinions about that in my work today.").

[264] Christine A. Varney, FTC Commissioner, "New Directions at the FTC: Efficiency Justifications in Hospital Mergers and Vertical Integration Concerns," Remarks before the Healthcare Antitrust Forum, Chicago, May 2, 1995, available at http://www ftc.gov/speeches/varney/varht.htm.

175. However, Dr. Leitzinger's empirical analysis almost entirely ignores measures of health insurance competition, quality of care, and effects on output. I have described the important links between quality and reimbursement. In contrast, he focuses solely on selective evidence of higher costs, ignoring these factors. Dr. Leitzinger analyzes only "affected combinations" of payers and hospitals where his claims his results indicate rate-increasing effects on the "affected" insurers while ignoring that all insurer plaintiffs at an affected hospital may be impacted by the MFN at that hospital.

176. From an economist's perspective, one should not simply add up purported negative consequences of MFNs while ignoring any potential positive effects, yet Dr. Leitzinger does exactly this. A consequence of Dr. Leitzinger limiting his analysis to the affected provider agreements is that he does not address whether *any* market—upstream or downstream—actually experienced antitrust harm. In fact, he explicitly admits that his report *does not* examine market-wide impacts of MFNs[265] and further admits that he has not presented a framework by which to do so:

> Q. Does your model in any way answer the question whether or not any MFN in any Michigan hospital that's not part of an affected combination that you analyzed affected the competitiveness of any Blue Cross competitor?
> A. No, it does not.
> Q. Do you propose a model in your report that answers that question, that is, whether a Blue Cross MFN affected the competitiveness of any Blue Cross competitor?
> A. No, I did not propose a model that -- for that purpose in my report.[266]

[265] Leitzinger Deposition at 38:14-21.

[266] Leitzinger Deposition at 153:3-14.

177. In economic terms, other insurer plaintiffs are affected at the very "affected" hospitals where Dr. Leitzinger alleges harm, even though he does not consider them as "affected combinations." From an economic standpoint, accepting the results of Dr. Leitzinger's regressions, one cannot demonstrate that a plaintiff was worse off overall, let alone show anticompetitive harm to an antitrust market, by adding up negative consequences while simply ignoring any potentially contrary evidence. For example, I showed earlier that Dr. Leitzinger's own methodology suggests that BCBSM's rates declined relative to a control group at several hospitals where Dr. Leitzinger claims another insurer's rates increased. Dr. Leitzinger makes no effort to investigate, much less balance, these increases and decreases. As a matter of economics, antitrust harm first requires demonstrating that a market, as a whole, and not just one competitor, was harmed.[267] Therefore, Dr. Leitzinger's focus on "affected combinations" does not, and cannot, allow for a determination whether any relevant market was negatively affected.

178. Furthermore, from an economic standpoint, one cannot say even that a single competitor is harmed until one accounts for all the effects of the MFN, including looking beyond the selected "affected combinations." Dr. Leitzinger does not do so. Some of the plaintiffs may stand to benefit at hospitals where they are not an "affected combination." First, they gain from any quality, service, and access improvements at a hospital that may accompany the higher payments that plaintiffs allege are the result of MFNs. Second, if higher payments place a hospital on surer footing, this can improve other payers' bargaining position with respect to the

[267] See, for example, William J. Lynk (2000), "Some Basics about Most Favored Nation Contracts in Health Care Markets," *Antitrust Bulletin* 45, at 509 ("… it is the net effect on average price, *aggregated over all of the affected purchasers*, that is the ultimate economic test of consumer injury or benefit." *emphasis added*).

hospital, perhaps negotiating lower rates than they otherwise would. This, of course, requires individualized analysis of the bargaining situation at each hospital and with each payer.

179. Additionally, Dr. Leitzinger argues that even when a payer does not receive lower prices or higher quality service due to the MFN, it can still benefit if it receives a *relative* price improvement in the market. The logic of plaintiffs' theory—that BCBSM willingly accepted higher rates for MFNs but still benefitted due to even higher rates for rivals—implies that presumably "unaffected" class members also benefitted from the higher rates paid by the "affected combinations."[268]

180. Although Dr. Leitzinger's analysis ignores the effect of MFNs on insurers when they are not part of "affected combinations," the above logic indicates that plaintiffs can easily be affected by MFNs in countervailing ways. To determine whether or not a plaintiff is harmed, one would need to enumerate the hospitals where each plaintiff is harmed and the hospitals where it is benefitted. Next one would have to calculate the net impact of these countervailing forces and translate that into competitive harm downstream. Dr. Leitzinger's approach does not address this issue.

181. At the end of his report, Dr. Leitzinger briefly discusses potential justifications and competitive benefits of MFNs. He considers one such benefit: "For instance, BCSM has argued here that MFNs allow it to secure the best prices available for their customers and help

[268] Leitzinger Report at ¶¶ 77, 79; CAC at ¶ 4 ("BCBSM benefitted from this scheme, even though this scheme resulted in BCBSM's costs going up, because it raised its rival insurers' costs even more, affording BCBSM a cost advantage vis-à-vis its competitors.").

control costs."[269] For this particular benefit, Dr. Leitzinger argues that it raises common issues and would not raise individualized evidentiary issues.

182. However, the economic literature on MFNs summarized above, points to another potential benefit to MFNs: reduced transaction and negotiating costs. This type of analysis does require individualized analysis and evidentiary burdens. As I previously noted, a number of hospitals that had an MFN agreement had negative net operating margins prior to the adoption of new agreements with BCBSM. In at least some cases, these hospitals may have successfully negotiated higher reimbursement rates with payers with or without an MFN agreement. For hospitals that would have eventually negotiated higher rates with or without MFNs, the existence of MFNs has two effects.

[redacted] These very real benefits must be weighed against any potential alleged anticompetitive harm. The costs of renegotiating a contract can be quite large.[272] In several ways, MFNs can reduce the costs of negotiation. For example, sometimes hospitals may desire MFNs

[269] Leitzinger Report at ¶ 111.

[270] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 66:17-22 ("I want to clarify that renegotiating with these payors is not solely a result of what Blue Cross is doing but is basically - - we try to do this periodically, so I will say that in this case obviously the Blue Cross agreement accelerated that process …"), and at 270:18-22 ("…we would have went through that process regardless, yes. I can say that, going back to my initial comment, that obviously the Letter of Agreement [MFN] accelerated that process, it did."). [redacted]

[271] With these assurances and the reduction in risk and uncertainty, "the buyer is more willing to enter into a mutually beneficial long-term contract with the seller." William J. Lynk (2000), "Some basics about most favored nation contracts in health care markets," *Antitrust Bulletin* 45 at 519.

[272] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 243:22 (On brinkmanship: "It wastes resources. It takes time.").

to ease negotiations with non-BCBSM insurers. MFN agreements with BCBSM may allow the hospital to conclude these negotiations more quickly than they otherwise would, thereby hastening the non-price benefits to class members that I described above, such as solving the free-rider problem.

[redacted]

V. ANTITRUST INJURY AND DAMAGES

185. Dr. Leitzinger devotes two paragraphs of his report to a methodology for calculating damages at each of the 23 "affected combinations." To obtain these estimates, he multiplies the alleged "MFN effect" derived from his DID analysis by what he believes to be the total allowed charges. Dr. Leitzinger's analysis is limited to calculating aggregate alleged overcharges in the market for hospital services. By his own admission, Dr. Leitzinger does not attempt to estimate damages in any market for commercial health insurance and does not attempt to disaggregate his overcharges to determine the level of damages for any specific class member.

186. Since Dr. Leitzinger's methodology for estimating damages relies on the same DID analysis he performs to show impact, I view his calculation of total overcharges with the

[redacted]

same reservations as I discussed above. Thus, Dr. Leitzinger's proposed methodology cannot be relied upon to produce even aggregate damage estimates. Further, as I explain throughout my report, some of these issues are significantly individualized and are therefore unlikely to be amenable to any formulaic class-wide method.

187. Aside from the unreliability of Dr. Leitzinger's methodology to ascertain aggregate damages, Dr. Leitzinger does not propose any methodology for allocating those damages to individual class members. Thus, he fails to address complex data issues that would arise in doing so. For example, plaintiffs propose to exclude from the class insureds whose only payments were "deductible payments where the hospital charge was larger than the deductible payment."[274] Their apparent goal is to exclude insureds whose payments would have been the same whether or not the hospital charged an allegedly "inflated" amount or the proper amount. However, during his deposition, Dr. Leitzinger stated that the determination would be made as to *each claim* associated with an insured.[275] In certain cases, such a determination would incorrectly allocate damages across individual class members (i.e., insured versus insurer).

188. To illustrate, consider two examples. In both, assume the deductible limit on the insured's policy during the coverage period is $1,000 and the alleged overcharge is 10 percent of hospital charges. In the first example, an insured visits the hospital once during her coverage period. Hospital charges in the claim equal $2,000 and the deductible payment equals $1,000. In

[274] Plaintiffs' Motion at 5.

[275] Leitzinger Deposition at 191:9-14 ("Q. And those two [class exclusion] conditions that you just walked through, that's a determination that needs to be made for each insured, correct? A. It would be a determination that would be made *as to each claim* associated with an insured, yes." *emphasis added*); 191:4-7 (the exclusion criteria would determine "whether the patient paid a deductible amount, and if so, did it pay a deductible in connection with a claim that was greater in total than the deductible."); 189:11-19 (stating that a person who exceeds her deductible in a specific claim is not excluded from the class, but only that claim is excluded).

this case, the claim would be excluded from the class because her payment for hospital services did not change as a result of the alleged overcharge. The alleged overcharge of $200 ($2,000 x 0.10) would have been incurred by the insurer and the insured would not receive damages.

189. Now consider a second example in which the insured had the exact same total charges and payments, but they were spread over two separate visits to the hospital during her coverage period. Hospital charges in her first visit equaled $900 and her deductible payment was $900; hospital charges in her second visit equaled $1,100 and her deductible payment was $100 (exhausting the $1,000 deductible limit). If the determination for class exclusion was implemented on a claim-by-claim basis, the insured would be assigned alleged damages of $90 on her first visit ($900 x 0.10) but no damages would be assigned on her second because hospital charges on that visit exceeded the deductible payment. Instead, the insurer would be assigned damages of $110 ($1,100 x 0.10). Notice, however, that during the coverage period, the insured's total payment of $1,000 would be the same whether or not the hospital charged an allegedly "inflated" amount or the proper amount. Her deductible payment would have been $90 less on the first claim but $90 more on the second claim. Thus, in this example, a determination for class exclusion implemented on a claim-by-claim basis incorrectly allocates the alleged overcharge across the incurred and insurer.

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David S. Sibley
Executed on February 3, 2014

APPENDIX I

CURRICULUM VITAE OF DAVID S. SIBLEY

DAVID S. SIBLEY

Professor, Department of Economics
University of Texas at Austin
Austin, TX 78712
Phone: (512) 475-8545

Education:

1969 B. A. in Economics, Stanford University
1973 Ph.D. in Economics, Yale University

Teaching Fields:

Graduate and undergraduate courses in industrial organization, including topics covering antitrust law and economics.

Research Fields:

Vertical restrictions, including bundling and tying; vertical and horizontal mergers; public utility pricing and regulatory policy; equilibrium constraints on tests of single firm conduct under Section 2 of the Sherman Act.

Professional Experience:

January, 2009 – June, 2009: Visiting Professor of Law and Economics, Boston University School of Law.

May 2003 – October 2004: Deputy Assistant Attorney General for Economic Analysis, U.S. Department of Justice, Washington, D.C.

March, 1992 – Present: John Michael Stuart Centennial Professor of Economics, University of Texas at Austin.

August, 1991 – March, 1992: Edward Everett Hale Centennial Professor of Economics, University of Texas at Austin.

September, 1983 – August, 1991: Research Manager, Bell Communications Research, Morristown, NJ. Head of Economics Research Group.

September 1981 – September 1983: Member of Technical Staff, Bell Laboratories, Murray Hill, NJ.

September 1980 – September 1981: Adviser to the Chairman of the Civil Aeronautics Board.

January 1980 – September 1980: Consultant, Civil Aeronautics Board, Washington, D.C.

September 1978 – January 1980: Senior Staff Economist, Council of Economic Advisers, Executive Office of the President, Washington, D.C.

October 1973 – September 1978: Member of Technical Staff, Bell Laboratories, Holmdel, NJ.

Teaching:

September 1991 – Present: Introductory Microeconomics, undergraduate and graduate Industrial Organization, business strategy and antitrust law.

Fall 1989: Visiting Lecturer, Woodrow Wilson School of Public and International Affairs, Princeton University. Graduate course in regulation and public choice.

September 1983 – December 1983: Adjunct Lecturer in Economics, University of Pennsylvania. Graduate course on regulation.

Publications:

A. Journal Articles:

"A Note on the Concavity of the Mean-Variance Problem," *Review of Economic Studies*, July 1975.

"Permanent and Transitory Income Effects in a Model of Optimal Consumption with Wage Income Uncertainty," *Journal of Economic Theory*, August 1975.

"Optimal Foreign Borrowing with Export Revenue Uncertainty," (with J. L. McCabe), *International Economic Review*, October 1976.

"The Demand for Labor in a Dynamic Model of the Firm," *Journal of Economic Theory*, October 1977.

"Optimal Decisions with Estimation Risk," (with L. C. Rafsky, R. W. Klein and R. D. Willig), *Econometrica*, November 1977.

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"Regulating Without Cost Information: The Incremental Surplus Subsidy Scheme," (with D. M. Sappington), *International Economic Review*, May 1989.

"Asymmetric Information, Incentives and Price Cap Regulation," *Rand Journal of Economics*, Fall 1989.

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"Regulating Without Cost Information: Some Further Thoughts," (with D. M. Sappington), *International Economic Review*, November 1990.

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"Regulatory Incentive Policies and Abuse," (with D. M. Sappington), *Journal of Regulatory Economics*, June 1993.

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B. Reports and Articles in Conference Volumes, and Other Publications

"The Dynamics of Price Adjustment in Regulated Industries," (with E. E. Bailey), in *Proceedings of IEEE Conference on Systems Control*, 1974.

"Optimal Non-Uniform Pricing for Electricity: Some Illustrative Examples," (with R. W. Koenker), in Sichel (ed.) *Public Utility Ratemaking in an Energy-Conscious Environment*, Praeger, 1979.

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C. Books:

The Theory of Public Utility Pricing, (with S. J. Brown), Cambridge University Press, 1986. Second printing 1986. Third printing 1989.

Co-editor of *Telecommunications Demand Analysis*: *An Integrated View*, North-Holland, 1989.

Editorial Duties:

Associate Editor of the *Journal of Regulatory Economics*.

Guest Editor of "Bundling Rebates: The Quest for an Antitrust Theory," *Antitrust Bulletin* 50(3), Fall 2005.

Editorial Board of *Review of Industrial Organization* 2005-present.

Unpublished Manuscripts and Revisions:

"Tying and Bundled Discounts: Equilibrium Analysis of Section 2 Liability Tests," with Matthew Sibley. Under Revision for *Antitrust Law Journal.*

"Network Congestion and the Unilateral Effects Analysis of Mergers", with Brijesh P. Pinto. Submitted to *International Journal of Industrial Organization.*

Other Professional Activities:

Consultant to the Governor of New Jersey's Task Force on Market-Based Pricing of Electricity.

Referee for National Science Foundation and numerous professional journals.

Consulting for Bell operating companies on a variety of pricing and public policy issues.

Memberships: American Economic Association, American Bar Association; listed in *Who's Who in the East* 1990.

Prior Reports and Expert Testimony within Past Four Years:

UNITED STATES DISTRICT COURT, DISTRICT OF DELAWARE
ZF Meritor LLC and Meritor Transmission Corporation v. Eaton Corporation
Expert Report (2013)

UNITED STATES DISTRICT COURT, MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

In re: Photochromic Lens Antitrust Litigation
Expert report and deposition testimony (2012 - 2013)

DISTRICT COURT OF HARRIS COUNTY, TEXAS, 80TH JUDICIAL DISTRICT
Rx.com, Inc and Joe S. Rosson v. John M. O'Quinn & Associates, PLLC d/b/a The O'Quinn Law Firm, *et al.*
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APPENDIX II

LIST OF DOCUMENTS CONSIDERED

COURT DOCUMENTS

Complaint, Civil Action No. 2:10-cv-14155-DPH-MKM (10/18/2010).
Class Action Complaint, Civil Action No. 2:11-cv-10375-DPH-VMM (1/28/2011).
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Defendant's Motion for Summary Judgment with Exhibits, Civil Action No. 11-cv-15346-DPH-MKM (10/25/2013)
Memorandum Opinion and Order, in re: Evanston Northwestern Corporation Antitrust Litigation, Civil Action No. 07-cv-04446, 2013 WL 6490152 (N.D.Ill.) (12/10/2013).
Plaintiffs' Motion for Class Certification and Appointment of Class Counsel (with exhibits), Civil Action No. 2:10-cv-14360-DPH-MKM (10/21/2013).

EXPERT REPORT OF DR. LEITZINGER

Expert Report of Jeffrey Leitzinger, Ph.D. in Support of Plaintiff's Motion for Class Certification (with exhibits and supporting material, including computer programs, input data files, and associated documentation), Civil Action No. 2:10-cv-14360-DPH-MKM (10/21/2013).

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Expert Report of David T. Scheffman, Ph.D. (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (4/17/2013).
Expert Report of Dr. Christopher A. Vellturo (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (6/07/2013).
Expert Report of Dr. David Dranove Supporting Motion for Class Certification (redacted version for public file), Master Docket No. 07-CV-4446 (2/18/2009).
Rebuttal Expert Report of Dr. Christopher A. Vellturo (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (6/7/2013).
Reply Report of Dr. David Dranove Supporting Motion for Class Certification (redacted version for public file), Master Docket No. 07-CV-4446 (12/8/2009).

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Deposition of Amy Ruedisueli (1/10/2012)
Deposition of Anne Patrice Noah (1/09/2014)
Deposition of Bill Berenson (10/11/2012)
Deposition of Brian Rodgers (12/07/2012)
Deposition of Christopher Vellturo (9/17/2013 & 9/18/2013)
Deposition of Chuck Nelson (9/19/2012)
Deposition of Dan Babcock (1/13/2012)
Deposition of David Brown (10/02/2012)
Deposition of David T. Scheffman (9/26/2013 & 10/27/2013)
Deposition of Donald Whitford (11/20/2012)
Deposition of Douglas Darland (11/14-15/2012)
Deposition of Eric Kropfreiter (9/18/2012)
Deposition of Gerald Messana (3/20/2012)
Deposition of Gerald Noxon (10/04/2012)
Deposition of Gretchen Kline (11/15/2012)
Deposition of Helen M. Hughes (8/21/2012)

Deposition of Jason Anderson (3/16/2012)
Deposition of Jeffrey Connolly (8/27/2012)
Deposition of Jeffrey Leitzinger (12/10/2013)
Deposition of Jeffrey Longbrake (8/29/2012)
Deposition of Jill Wehner (1/11/2012)
Deposition of Joan Budden (11/05/2012)
Deposition of Joan Janks (1/17/2014)
Deposition of John Dunn (10/12/2012)
Deposition of Joseph Fifer (8/23/2012)
Deposition of Karmon Bjella (12/13/2011)
Deposition of Kelly Wright (10/19/2012)
Deposition of Kenneth Matzick (11/13/2012)
Deposition of Kevin J. Cawley (4/19/2012)
Deposition of Kim Capps (3/29/2012)
Deposition of Kim Sorget (10/16/2012 & 10/17/2012)
Deposition of Kimberly Horn (11/12/2012)
Deposition of Kirk Rosin (11/27/2012)
Deposition of Laura Eory (11/12/2012)
Deposition of Mark Bertolini (12/03/2012)
Deposition of Mark Gross (11/15/2012)
Deposition of Mark Hall (11/14/2012)
Deposition of Mark Johnson (10/30/2012)
Deposition of Michael Falatko (12/16/2011 & 1/11/2012)
Deposition of Michael Grisdela (10/24/2012)
Deposition of Michael Koziara (11/19/2012)
Deposition of Nickolas Vitale (11/12/2012)
Deposition of Patrick McGuire (8/14/2012)
Deposition of Paula Reichle (8/08/2012)
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Deposition of Pramod Sahney (8/17/2012)
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Deposition of Richard Harning (11/07/2011)
Deposition of Robert Milewski (10/11/2012)
Deposition of Robert Smith (11/14/2012)
Deposition of Ronald Crofoot (11/29/2012)
Deposition of Scott Wilkerson (10/31/2012)
Deposition of Steve Andrews (11/02/2011)
Deposition of Steven Leach (3/15/2012)
Deposition of Susan Baynard (1/13/2014)
Deposition of Suzanne Hall (11/15/2012)
Deposition of Terrence Burke (9/18/2012)
Deposition of Terry Lutz (1/12/2012)
Deposition of Thomas Sargent (12/14/2012)
Deposition of Timothy J. Johnson (5/07/2012)
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WEBSITES

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HAP-DOJ-003072
HAP-DOJ-003099
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WBH-61282

HCRIS DATA

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HCRIS_DataModel.pdf
HCRIS_FACILITY_NUMBERING.csv
HCRIS_STATE_CODES.csv
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HCRIS 2552-10:
HCRIS_DataDictionary.csv
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HOSP2010_README_UPDATE.txt
HOSP2010_Worksheet Codes.pdf

PERSONAL CONVERSATIONS

John Dunn
Gerald Noxon
Kim Sorget

APPENDIX III

TABLES AND FIGURES

TABLE 1
NET OPERATING MARGINS FOR "AFFECTED" HOSPITALS

Hospital Name & Measure[3]	2005	2006	2007	2008	2009	2010	2011	2012
Allegan General Hospital								
Net Patient Income ($)	-2,509,307	509,934	-511,670	409,019	39,592	1,556,226	-629	-391,293
Net Operating Margin (%)	-8.24	1.46	-1.34	1.02	0.11	3.62	0.00	-0.91
Beaumont Hospital - Grosse Pointe[4, 5]								
Net Patient Income ($)	-26,835,628	-27,817,602	-20,327,551	-16,968,545	-9,170,364	-5,739,597	2,250,686	9,970,740
Net Operating Margin (%)	-19.07	-19.14	-14.09	-11.40	-5.89	-3.70	1.35	5.65
Beaumont Hospital - Royal Oak								
Net Patient Income ($)	-12,120,662	-15,354,234	-5,501,000	1,914,912	19,785,554	37,043,959	30,513,722	43,593,812
Net Operating Margin (%)	-1.16	-1.43	-0.49	0.16	1.64	3.13	2.57	3.62
Beaumont Hospital - Troy								
Net Patient Income ($)	22,448,513	15,395,446	20,695,187	15,341,131	21,788,411	22,607,894	30,395,774	39,675,127
Net Operating Margin (%)	6.10	3.80	4.58	3.24	4.44	4.42	5.95	7.33
Bronson LakeView Hospital[4]								
Net Patient Income ($)	418,102	709,645	-3,706,974	412,685	-132,433	-1,083,091	1,482,246	-1,810,973
Net Operating Margin (%)	1.19	1.99	-9.40	0.92	-0.24	-1.92	2.45	-3.59

TABLE 1
NET OPERATING MARGINS FOR "AFFECTED" HOSPITALS
(CONTINUED)

Hospital Name & Measure[3]	2005	2006	2007	2008	2009	2010	2011	2012
Charlevoix Area Hospital[4]								
Net Patient Income ($)	630,633	-690,022	-722,252	-1,197,927	-1,736,332	-933,418	-3,659,690	-1,845,693
Net Operating Margin (%)	2.32	-2.49	-2.39	-3.80	-5.57	-2.83	-11.66	-5.18
Kalkaska Memorial Health Center[2, 4]								
Net Patient Income ($)	125,272	662,814	1,411,892	1,727,006	1,294,092	798,142	-8,071	-358,334
Net Operating Margin (%)	0.75	3.56	6.92	7.61	5.23	3.04	-0.03	-2.74
Mercy Health Partners, Lakeshore Campus[2, 4]								
Net Patient Income ($)	938,305	1,013,784	1,523,886	1,421,068	484,799	45,134	806,305	866,995
Net Operating Margin (%)	8.85	8.97	12.79	10.27	2.97	0.23	3.49	7.10
Paul Oliver Memorial Hospital[2, 4]								
Net Patient Income ($)	224,286	358,922	457,081	417,009	512,502	709,611	871,481	480,921
Net Operating Margin (%)	1.98	2.92	3.46	3.01	3.58	4.71	5.35	5.64
Providence Park Hospital[1, 2, 4]								
Net Patient Income ($)	11,015,864	23,384,537	19,138,256	-4,109,910	-20,750,569	-16,241,371	1,566,871	6,588,052
Net Operating Margin (%)	2.21	4.47	3.55	-0.72	-3.46	-2.67	0.26	2.15

TABLE 1
NET OPERATING MARGINS FOR "AFFECTED" HOSPITALS
(CONTINUED)

Hospital Name & Measure[/3]	2005	2006	2007	2008	2009	2010	2011	2012
Sparrow Ionia Hospital[/4]								
Net Patient Income ($)	-1,114,418	-1,689,274	-2,170,361	-1,915,442	-1,758,236	-580,255	-130,028	710,588
Net Operating Margin (%)	-6.20	-8.88	-10.58	-8.11	-6.69	-2.19	-0.48	2.39
St. John Hospital and Medical Center[/2, 4]								
Net Patient Income ($)	3,137,475	-352,795	-10,275,728	-8,950,707	619,304	-4,936,016	-14,239,860	-7,895,046
Net Operating Margin (%)	0.59	-0.06	-1.74	-1.42	0.10	-0.74	-2.05	-2.27
Three Rivers Health								
Net Patient Income ($)	-156,930	-90,585	-3,153,440	-6,315,514	-4,618,446	-4,510,730	-4,562,655	-1,219,151
Net Operating Margin (%)	-0.36	-0.19	-6.35	-13.30	-9.96	-9.19	-10.39	-2.60

Source: HCRIS FY2004-2012.
Notes:
/1 Reports jointly with Providence Hospital.
/2 Partial calendar year data for 2012.
/3 Net Patient Income equals Net Patient Revenues less Total Operating Expenses. Net Operating Margin equals Net Patient Income divided by Net Patient Revenues. Net Patient Revenues include revenue from inpatient and outpatient services.
/4 Financial measures adjusted to calendar year basis.
/5 Beaumont Hospitals acquired Bon Secours Hospital on October 1, 2007 and renamed the facility Beaumont Hospital – Grosse Pointe. See Beaumont Health System website, <https://www.beaumont.edu/press/news-stories/2007/10/beaumont-hospitals-acquires-bon-secours/> (January 17, 2014).

TABLE 2
SUMMARY OF ALTERNATIVE DID ANALYSES

Hospital Name	Insurer	Network	DID (MFN*Post Period)/1		
			Leitzinger Report/2 Quarterly	Alternative Model 1/3 Aggregated	Alternative Model 2/4 Aggregated
Beaumont Hospital - Grosse Pointe	BCBSM	PPO	0.158***	0.212*	0.194*
Beaumont Hospital - Royal Oak	BCBSM	PPO	0.009	0.009	0.014
Beaumont Hospital - Troy	BCBSM	PPO	0.028	0.032	-0.003
Providence Park Hospital	BCBSM	PPO	0.136**	0.200**	0.177*
St. John Hospital and Medical Center	BCBSM	PPO	0.029**	0.030	0.030
Allegan General Hospital	Priority	HMO	0.213***	0.181	0.105
Allegan General Hospital	Priority	PPO	0.246***	0.221	0.144
Charlevoix Area Hospital	Priority	PPO	0.289***	0.282	0.202
Kalkaska Memorial Health Center	Priority	PPO	0.446***	0.808	0.810**
Mercy Health Partners, Lakeshore Campus	Priority	HMO	0.433***	0.431**	0.381**
Mercy Health Partners, Lakeshore Campus	Priority	PPO	0.354***	0.350	0.270
Paul Oliver Memorial Hospital	Priority	HMO	0.333***	-0.440	0.642
Paul Oliver Memorial Hospital	Priority	PPO	0.403***	1.377	1.308
Sparrow Ionia Hospital	Priority	HMO	0.217***	0.211	0.178
Beaumont Hospital - Grosse Pointe	HAP	AHL	0.208***	0.207	0.153
Beaumont Hospital - Grosse Pointe	HAP	PHP	0.080***	0.173	-0.211
Beaumont Hospital - Royal Oak	HAP	AHL	0.103***	0.125	0.045
Beaumont Hospital - Royal Oak	HAP	HMO	0.115***	0.118	0.045
Beaumont Hospital - Royal Oak	HAP	PHP	0.086***	0.093	0.055
Beaumont Hospital - Troy	HAP	AHL	0.102**	0.127**	-0.044
Beaumont Hospital - Troy	HAP	PHP	0.090***	0.247	0.100
Bronson LakeView Hospital	Aetna	PPO	0.178***	0.301	0.266**
Three Rivers Health	Aetna	PPO	0.321***	0.313**	0.316**

Notes:
/1 Regression analysis using data used in Dr. Leitzinger's regression analysis. Symbols ***, **, and * denote statistical significance at the 1%, 5%, and 10% levels respectively.
/2 Coefficients reported in Leitzinger Report Exhibit 8 (corrected). Statistical significance is determined using p-values reported in Leitzinger Report Exhibit 8 (corrected).
/3 DID analysis is performed using a two-period dataset constructed by taking the averages of the dependent and independent variables in Dr. Leitzinger's pre and post periods. Statistical significance is determined using OLS standard errors.
/4 DID analysis is performed using a two-period dataset constructed by taking the averages of the dependent and independent variables in the following two periods: (1) the eight quarters preceding Dr. Leitzinger's first post-period quarter and (2) the first eight quarters in Dr. Leitzinger's post period. Statistical significance is determined using OLS standard errors.

TABLE 3
PLAUSIBILITY OF REDUCTION IN PAYMENTS FOR BEAUMONT HOSPITAL COMBINATIONS

Hospital Name	Insurer	Network	Reduction in Payments ($)	Net Patient Income[/1, 4] ($)	Actual Net Operating Margin[/5] (%)	But-For Net Operating Margin[/6] (%)
Beaumont Hospital - Grosse Pointe[/2]	BCBSM	PPO	36,017,576	-12,659,275	-2.65	-11.56[/7]
	HAP	AHL	1,158,977			
	HAP	PHP	907,994			
		Total	*38,084,547*			
Beaumont Hospital - Royal Oak[/3]	BCBSM	PPO	27,405,839	69,959,370	1.02	-0.06
	HAP	AHL	6,078,438			
	HAP	HMO	27,399,650			
	HAP	PHP	13,217,302			
		Total	*74,101,228*			
Beaumont Hospital - Troy[/3]	BCBSM	PPO	33,621,329	124,663,209	4.45	2.91
	HAP	AHL	3,574,952			
	HAP	PHP	7,053,896			
		Total	*44,250,176*			

Notes:
/1 Financial data from HCRIS.
/2 Financial data for 12-month reporting periods ending December 31 of 2009, 2010, and 2011. MFN effective January 1, 2009 through January 1, 2012.
/3 Financial data for 12-month reporting periods ending December 31 of 2006, 2007, 2008, 2009, 2010, 2011, and 2012. MFN effective February 7, 2006 through January 1, 2012. Financial data for 2006 adjusted to MFN effective period by multiplying financial measures by the ratio of number of days for which MFN is effective (328) to number of days in the year (365).
/4 Equals Net Patient Revenues less Total Operating Expenses.
/5 Equals Net Patient Income divided by Net Patient Revenues.
/6 Equals Net Patient Income less Reduction in Payments divided by Net Patient Revenues less Reduction in Payments.
/7 But-For Net Operating Margin for reduction in BCBSM PPO payments only is -11.04%.

TABLE 4
DID RESULTS FOR BCBSM AT AETNA AND PRIORITY "AFFECTED" HOSPITALS

Hospital Name	MFN Type	Insurer	Network	Hospital Peer Group	Control Peer Group	DID (MFN*Post Period)/1	p-value/1
Allegan General Hospital	Equal-to-MFN	BCBSM	PPO	5	4	0.5%	0.836
Bronson LakeView Hospital	Equal-to-MFN	BCBSM	PPO	5	4	1.1%	0.805
Charlevoix Area Hospital	Equal-to-MFN	BCBSM	PPO	5	4	-12.7%	0.000
Kalkaska Memorial Health Center	Equal-to-MFN	BCBSM	PPO	5	4	-21.4%	0.000
Mercy Health Partners, Lakeshore Campus	Equal-to-MFN	BCBSM	PPO	5	4	-13.9%	0.002
Paul Oliver Memorial Hospital	Equal-to-MFN	BCBSM	PPO	5	4	-12.4%	0.082
Three Rivers Health	Equal-to-MFN	BCBSM	PPO	5	4	-8.2%	0.000

Note:
/1 Regression using insurer claims data obtained from Dr. Leitzinger's backup material and SAS regression code. The post period is based on hospital MFN effective dates provided in Dr. Leitzinger's backup material. Control group selection is based on Dr. Leitzinger's methodology.

TABLE 5
DID RESULTS FOR HAP PHP "AFFECTED" COMBINATIONS WITH EXCLUDED CONTROL HOSPITALS

Hospital Name	Excluded Control Hospital	Hospital Peer Group	Control Peer Group	DID (MFN*Post Period)/1	p-value/1
Beaumont Hospital - Grosse Pointe	Lakeland Regional Medical Center-St. Joseph	2	2	3.18%	0.157
Beaumont Hospital - Grosse Pointe	McLaren Bay Regional	2	2	1.94%	0.427
Beaumont Hospital - Troy	Lakeland Regional Medical Center-St. Joseph	2	2	0.08%	0.970
Beaumont Hospital - Troy	McLaren Bay Regional	2	2	2.97%	0.172

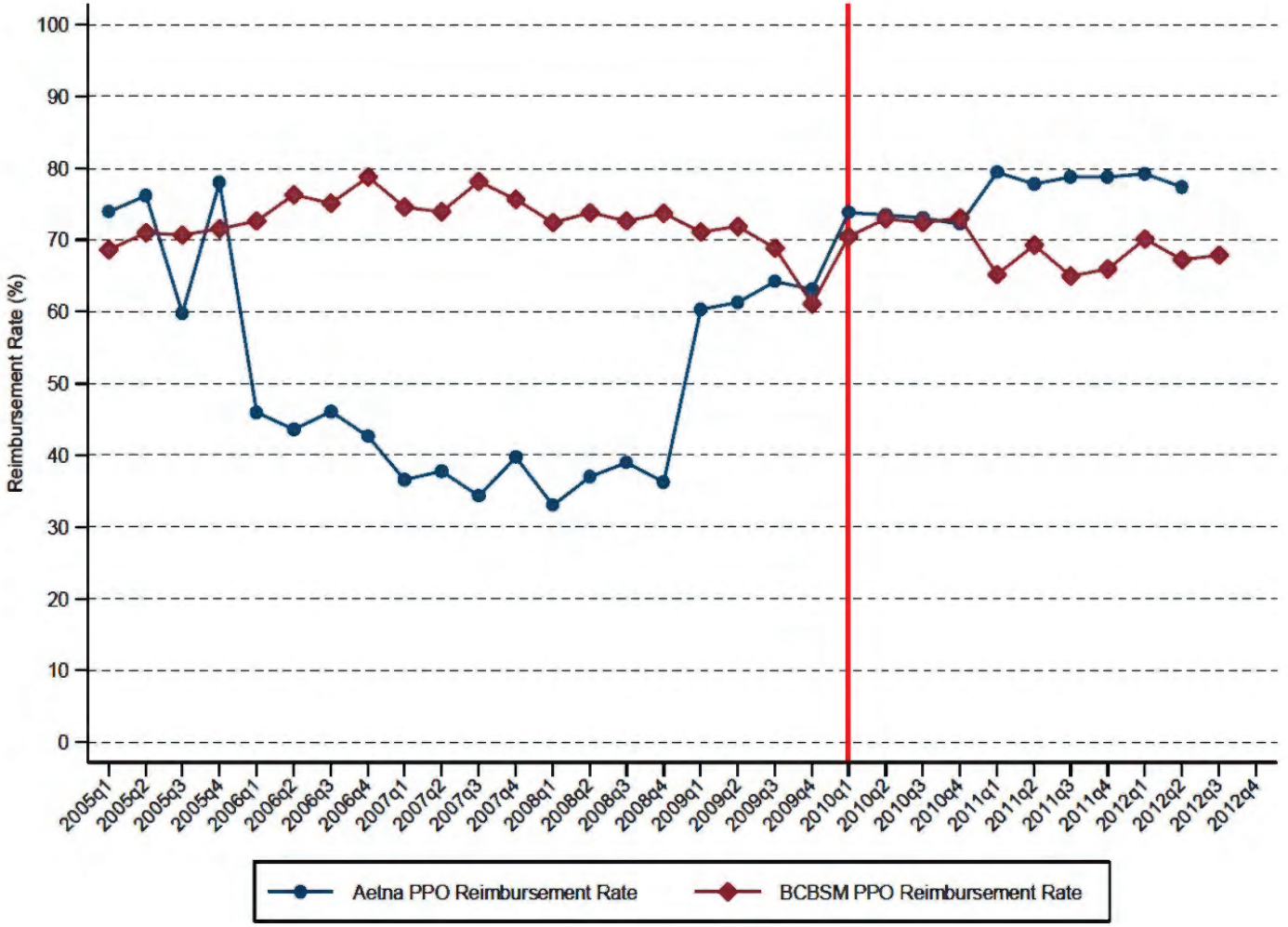
Note:
/1 Regression using insurer claims data obtained from Dr. Leitzinger's backup material and SAS regression code.

TABLE 6
DID RESULTS AT CONTROL GROUP HOSPITALS
"AFFECTED" COMBINATION: BEAUMONT HOSPITAL – ROYAL OAK HAP HMO

Control Hospital Considered Affected	Insurer	Network	DID (MFN*Post Period)/1	p-value/1
Detroit Receiving Hospital/University Health Center	HAP	HMO	8.79%	0.000
Doctors' Hospital of Michigan	HAP	HMO	14.41%	0.000
Garden City Hospital	HAP	HMO	-20.22%	0.000
Harper University Hospital / Hutzel Women's Hospital	HAP	HMO	-0.70%	0.849
Henry Ford Hospital	HAP	HMO	-1.79%	0.561
McLaren Flint	HAP	HMO	8.82%	0.000
McLaren Macomb	HAP	HMO	-9.56%	0.000
McLaren Oakland	HAP	HMO	-5.30%	0.078
Oakwood Hospital & Medical Center-Dearborn	HAP	HMO	7.67%	0.001
Sinai-Grace Hospital	HAP	HMO	-6.50%	0.002
St. Joseph Mercy Oakland	HAP	HMO	13.83%	0.029
University of Michigan Hospitals and Health Centers	HAP	HMO	-13.22%	0.000

Note:
/1 Regression using insurer claims data obtained from Dr. Leitzinger's backup material and SAS regression code. Regression analysis based on post period used in Dr. Leitzinger's DID regression for the "affected" combination Beaumont Hospital - Royal Oak HAP HMO.

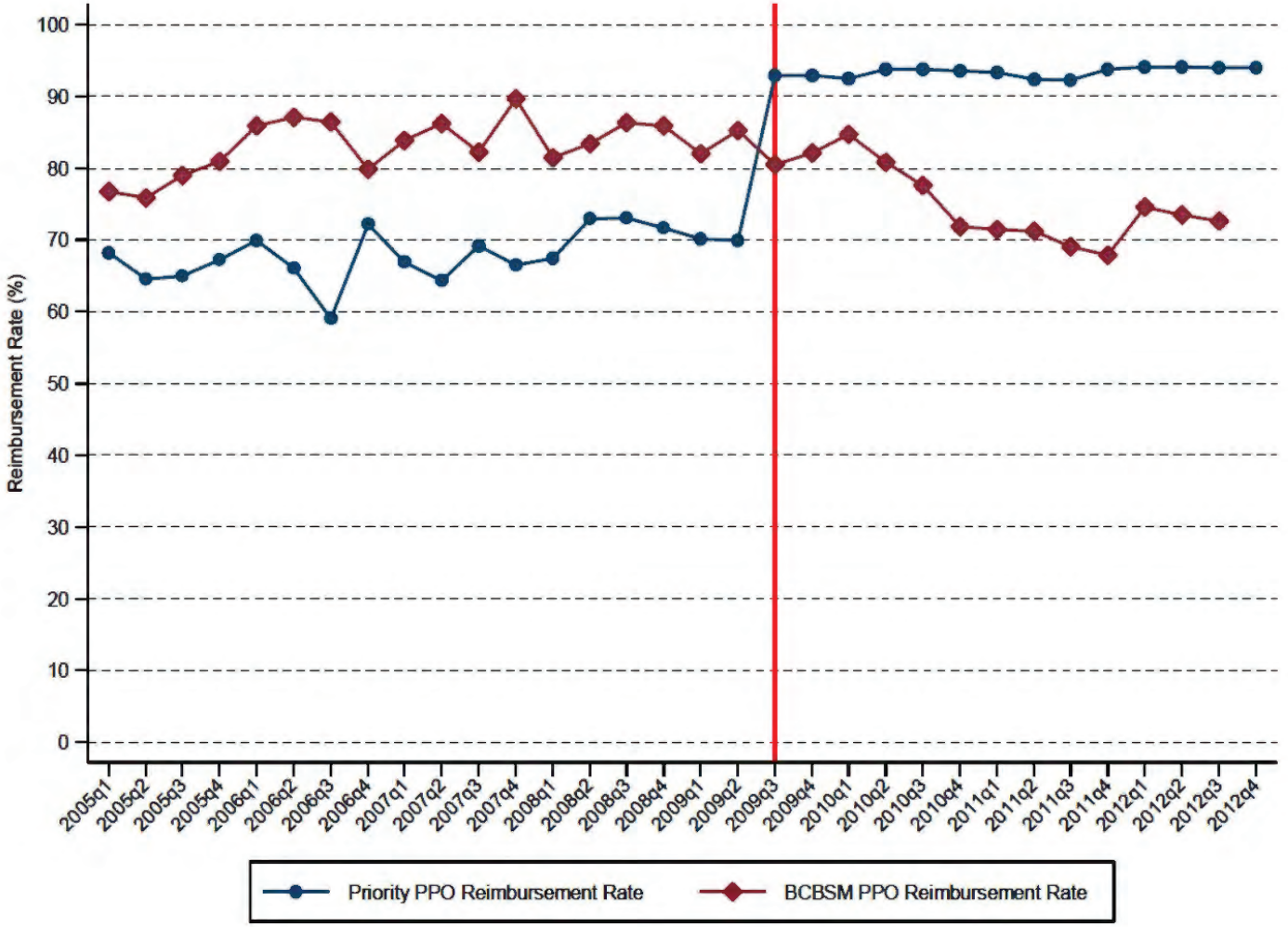
FIGURE 1
AETNA PPO & BCBSM PPO - THREE RIVERS HEALTH - REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

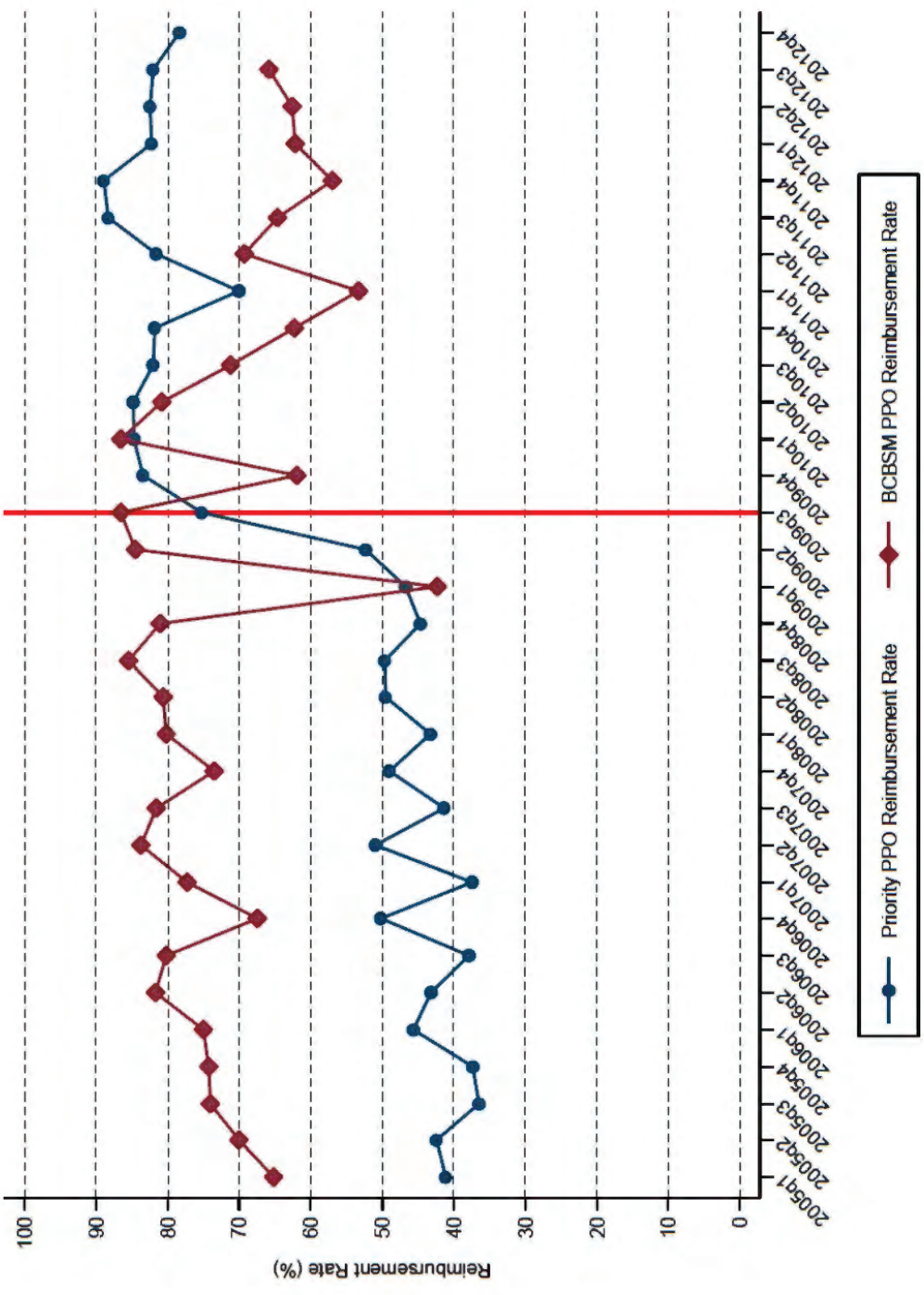
FIGURE 2

PRIORITY PPO & BCBSM PPO - CHARLEVOIX AREA HOSPITAL - REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

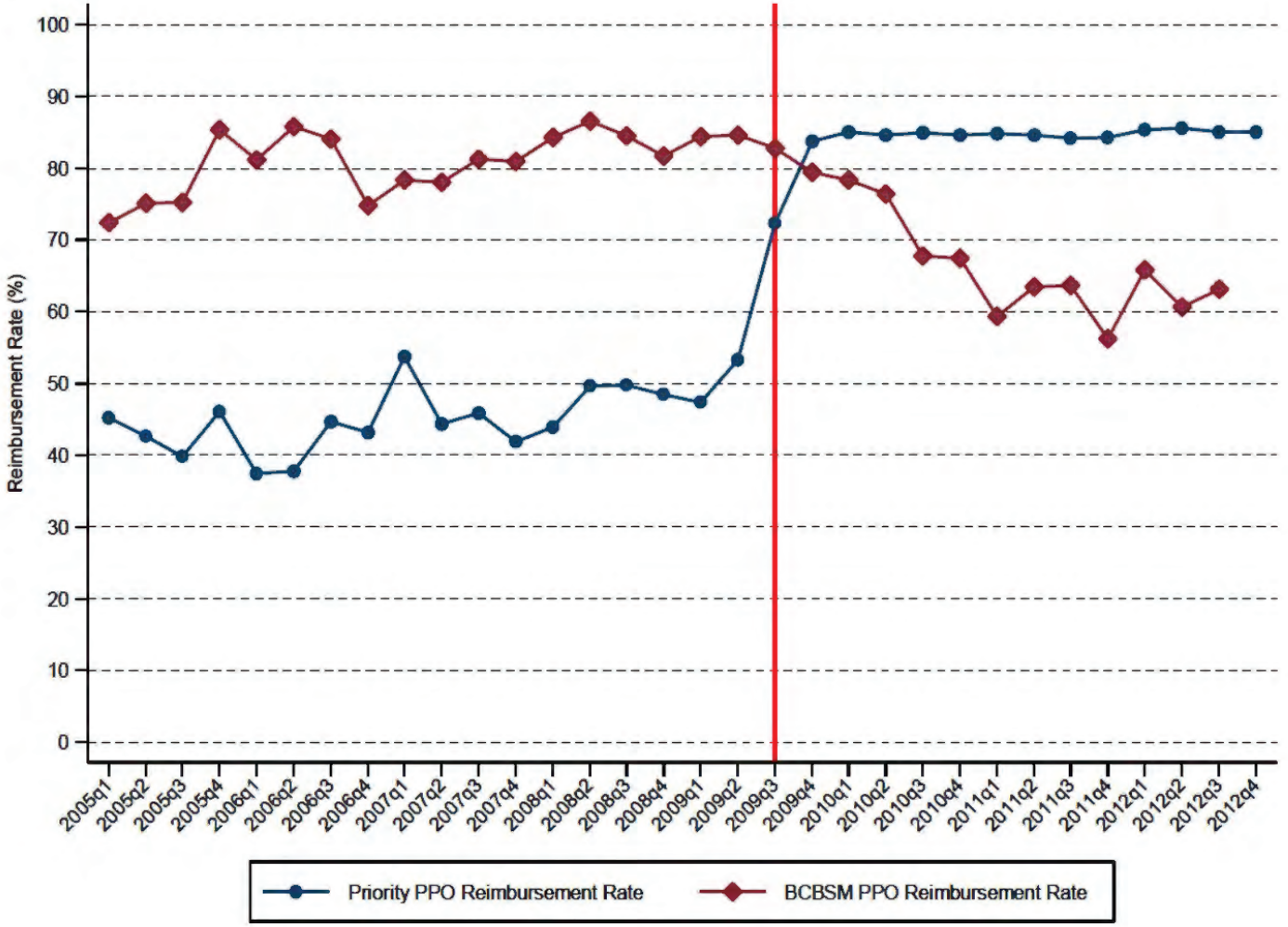
FIGURE 3
PRIORITY PPO & BCBSM PPO - PAUL OLIVER MEMORIAL HOSPITAL - REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

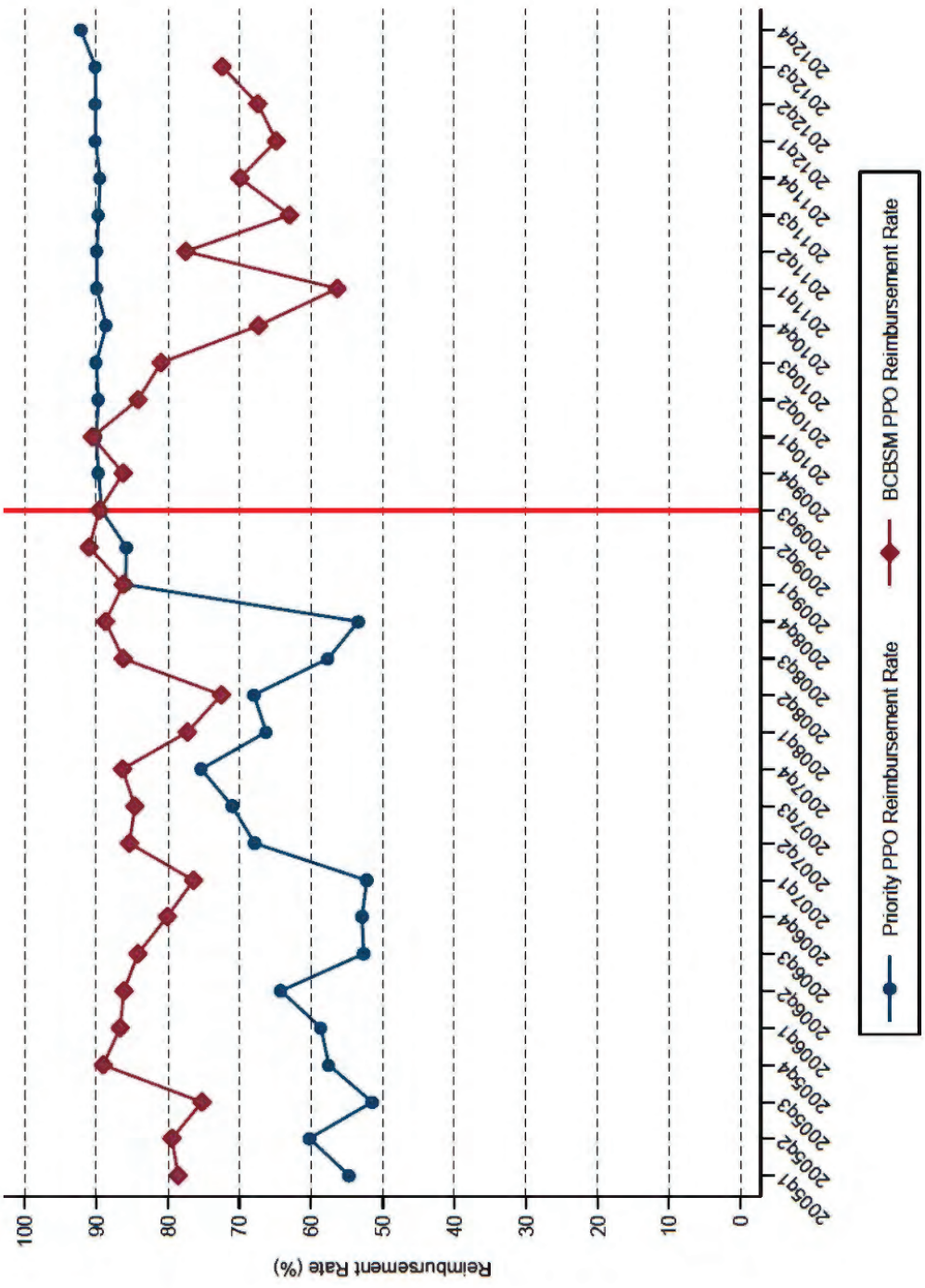
FIGURE 4

PRIORITY PPO & BCBSM PPO - KALKASKA MEMORIAL HEALTH CENTER - REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

FIGURE 5
PRIORITY PPO & BCBSM PPO - MERCY HEALTH PARTNERS, LAKESHORE CAMPUS- REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

EXHIBIT 1
Part 2 of 2

APPENDIX 14

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action no.: 2:10-cv-14155-DPH-MKM Judge Denise Page Hood Magistrate Judge Mona K. Majzoub

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

AETNA INC., Plaintiff, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No. 2:11-cv-15346-DPH-MKM

Kalamazoo, Michigan

Wednesday, August 29, 2012

Highly Confidential Video Deposition of:

RICHARD L. FELBINGER,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Miller Canfield, 277 South Rose Street, Kalamazoo, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:06 a.m., when were present on behalf of the respective parties:

Q And have Blue Cross negotiators conveyed that sentiment to you? **15:07:31**

A Yes.

Q And, hypothetically -- we were talking about Medicare and Medicaid -- if Congress passed a law tomorrow that said effective immediately Medicare will pay cost plus 5 percent, and Michigan Ascension **15:07:48** facilities started getting a 5 percent margin on its Medicare business, what would that do to Blue Cross's leverage at Michigan Ascension hospitals --

MR. LIPTON: Object to the form.

MR. JOYCE: Object -- **15:08:04**

BY MR. STENERSON:

Q -- in your view?

A Their leverage wouldn't change because they're still a dominant player in Michigan. What might change was the need for the Michigan Ascension Health hospitals **15:08:21** to push Blue Cross into significantly higher rates, because we would have received them from the Federal Government at that point in time.

For us, it really is trying to hit an overall operating margin given the constraints that we **15:08:36** have. Medicare and Medicaid, we cannot negotiate those rates. For others we can easier than Blue Cross. But Blue Cross is such a big payer, we have to talk with

them to help us meet our goals so that we can stay in business. **15:08:57**

The last thing Blue Cross would need -- would like is for Borgess Health to shut down and have a one-hospital town. Wouldn't be able to deal with all the business and they would be at a total negotiating disadvantage at that point in time. So it's in **15:09:10** everybody's best interest to make sure that everybody kind of pays their fair share. In the absence of that, we have no alternative.

Q Right. It's not in Blue Cross's business to force your rates down so low that you can't operate; **15:09:20** correct?

A That's correct.

Q So let's talk about that. Let's talk about that a little bit in the negotiation of trying to find that right price. I think you mentioned that Blue **15:09:30** Cross's leverage wouldn't change if Medicare started paying cost plus 5 percent, but the hospital could approach negotiations in a different manner; correct?

MR. LIPTON: Object to the form.

THE WITNESS: That's correct. **15:09:49**

BY MR. STENERSON:

Q So is it true that negotiations depend on both sides of the table?

MR. LIPTON: Object to the form.

THE WITNESS: Could you rephrase that question? **15:09:55**

BY MR. STENERSON:

Q Sure. When you entered into the negotiations that resulted in Plaintiff's 9, the LOU with the effective date of July 1, 2008, did you tell Blue Cross Blue Shield of Michigan negotiators what your bottom line price was? **15:10:07**

A Yes.

Q Did the negotiation ultimately reach that price? **15:10:25**

A No.

Q Well, then, was it really your bottom line?

A Yes.

Q Can you explain?

A As I indicated before in one of the other exhibits where I made that quote at the end, you know, "Great deal," we were overruled. And, therefore, we had to accept what -- you know, what we received. That was not our goal. We did not achieve a 5 percent operating margin. We did not spend the capital that we needed to spend. So it's -- you know, sometimes you win in the game, sometimes you lose. **15:10:31** **15:10:51**

Our goal and our bottom line was to hit a

5 percent operating margin, and we needed to get certain rates from Blue Cross in that negotiation, amongst doing all kinds of other things with other payers and other costs, to get to where we need to go. 15:11:06

Q In your view, is there a difference in your mind between your goal amount and your bottom line in a negotiation? 15:11:20

A No. I happened to be overruled by someone higher than me.

Q Well, somebody within Ascension Health accepted an amount lower than what you personally would have accepted? 15:11:32

A That is correct. I still have to try to get my 5 percent operating margin some other way, though.

Q At the time the negotiations that resulted in Plaintiff's 9 began, do you recall what, converted to a percent of charge, the Blue Cross reimbursement rate was at Borgess Medical? 15:11:53

A I believe it was 37 to 39 percent of charges.

Q And do you know what it is under the -- well, strike that.

Is Plaintiff's 9 still in effect? 15:12:12

A It is until 2013, yes.

Q Do you know what Blue Cross's rate is today at Borgess Medical?

APPENDIX 15

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD

OF MICHIGAN,

Defendant.

_____

The Videotaped Deposition of DAVID MARCELLINO,

Taken at 28050 Grand River Avenue,

Farmington Hills, Michigan,

Commencing at 9:25 a.m.,

Thursday, September 6, 2012,

Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

A. I am -- you know, I do remember, you know -- we must have had -- I don't remember the meeting specifically.
Q. Do you know if at or around the time of March, 2007, Botsford was looking for a, a rate increase to support cost plus 3%?
A. Yeah, that's based upon the Blue Cross model.
Q. Okay, and do you know in this approximate timeframe what Blue Cross's position was as to what reimbursement rate they were willing to provide to Botsford?
MR. STENERSON: Object to the form.
A. Well, because we were negotiating, it was obvious that it was their recognition of what our cost was, and they felt -- they came up with a different number than what we did. So it was part of the negotiation, was to try to get to the point, and that really relates back to the rebasing discussion in terms of what your starting point for cost.
BY MR. TORZILLI:
Q. Okay, and at this point in time, how -- could you describe how close Botsford and Blue Cross were to a final agreement?
A. I think we were getting fairly close, if I remember the meeting correctly. I think it was -- when Kim Sorget got involved, I think we were getting close to

APPENDIX 16

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UNITED STATES OF AMERICA, et al,
Plaintiffs,
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BLUE CROSS BLUE SHIELD
OF MICHIGAN,
Defendant.
_____

The Confidential Videotaped Deposition of
MARK GRONDA,
Taken at 4960 Towne Centre Road,
Saginaw, Michigan,
Commencing at 10:08 a.m.,
Thursday, December 13, 2012,
Before Rebecca L. Russo, CSR-2759, RMR, CRR.

Medicare and Medicaid losses trended?
A. Well, the volumes have gone up, both Medicare and Medicaid, and the losses have gotten more significant with Medicaid, because we're either getting no price increases, or in a couple cases we actually had takeaways, as the states manage their budget problems.
Q. So, if I understand correctly, in the past five years at Covenant, the Medicare and Medicaid shortfalls have increased both in terms of increased volume of patients and downward trending rates?
A. Rates that have not kept up with inflation, and with the example with Medicaid, I think they're actually downward, you know, less reimbursement, let alone inflation.
Q. Have Medicare rates in the past five years kept pace with inflation?
A. No.
Q. So in the past five years, Medicare rates at Covenant, as compared to inflation, have been trending downward?
A. They've eroded.
Q. And what are Covenant's options to make up for those sins of Medicare and Medicaid?
MR. ALLEN: Objection, form.
A. The only option we have is to look to the commercial payers, including Blue Cross.

A. I do.
Q. Why did you think it important to tell Blue Cross that even after a rate increase, they would have a reimbursement advantage of at least 13 percentage points?
A. It's a negotiating position, just to reinforce what a large advantage they had.
Q. Did anyone from Blue Cross express to you in the past the concern that because of Blue Cross' size, that hospitals might seek a larger portion of government shortfalls from Blue Cross?
A. Could you repeat that?
Q. Sure. Did anyone from Blue Cross express to you in the past that because of Blue Cross' size, hospitals like Covenant might seek to only seek increases from Blue Cross and not other commercial payers?
A. No.
Q. In the -- do you know whose handwriting is on this document?
A. Yeah, it's mine.
Q. I'd like to direct your attention to the handwriting on the top of page 2. Could you read that for us?
A. High 'caid/uncompensated care, services, economy.
Q. Do you know what you were writing a note about there?
A. Just some of the factors that we felt compelled us to

need higher reimbursement from Blue Cross because of the high Medicaid uncompensated care, and the fact that we were just going into a recession at that point.

Q. I was going to say, I know the economy has been less than ideal recently, but do you recall at this time, in or around November of '08, what the economic conditions in and around Saginaw were like?

A. Not specifically, but we've been in a downturn for two decades because of the downsizing of GM before this most recent recession, so it's -- we've had higher unemployment rates than the state and in the nation, as a rule. I couldn't tell you the exact unemployment rate unless I said it here. I don't see it.

Q. If you could go to page 3, in the paragraph that starts C, it says:

We believe that other hospitals in our area are benefitting from higher Blue Cross rates due to their having higher costs, not due to any superiority in terms of efficiency or quality.

Do you see that?

A. I do.

Q. It says:

As you are aware, one of the largest factors affecting operating costs is wages, yet the

APPENDIX 17

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

989.583.0000 Tel

COVENANT HealthCare

November 17, 2008

Mr. Doug Darland
Director, Hospital Contracting & Policy
Blue Cross Blue Shield of Michigan
27000 W. Eleven Mile Road
Mail Code B772
Southfield, MI 48034

Re: Reimbursement Changes

Dear Doug,

Recently, Blue Cross provided information to Covenant Medical Center concerning the market pricing initiative where outpatient pass through factors for certain services, such as radiology and lab, would match the fee screens for free standing facilities. This change is intended to be made in a budget neutral manner with a corresponding increase in our inpatient reimbursement rates. As part of this initiative, you provided us draft calculations of the new inpatient rates. We reviewed that information not only in the context of the budget neutrality principle, but more broadly in terms of the overall adequacy of Blue Cross payment. As discussed in more detail below, we believe an adjustment to our rates is merited and are hopeful that, working together, we can accomplish a change effective January 1st, the proposed effective date of the market pricing initiative.

Background

Covenant HealthCare is the largest provider of health care services in the mid-Michigan area, serving the communities of Saginaw, Midland and Bay City. We operate two acute care inpatient facilities and numerous outpatient centers. The hospital is the sole provider of obstetric and pediatric services in Saginaw, and we operate both a pediatric ICU and neonatal ICU. For Blue Cross, more than half of our top ten admissions are related to maternal and infant health.

Like other Michigan hospitals, the past years have been particularly challenging as the economy has worsened and more individuals are losing group health coverage. The local economy of Saginaw has been particularly affected by the downturn in automobile manufacturing. Over the past several years, our uncompensated care has more than doubled, from $14.8 million in fiscal 2004 to more than $33.7 million in fiscal 2008. In addition, Medicaid enrollment has increased considerably, and the impact to

Covenant is more pronounced due to the fact that we are the sole Saginaw provider of obstetric and pediatric care. In fiscal 2008, more than two-thirds of hospital charges related to Medicare (48.1%), Medicaid (16.1%) and uncompensated care (3.3%).

We have undertaken numerous efforts to control the rate of growth in costs. The most recent information from Blue Cross shows that the hospital's standardized cost per case ($6,242) is substantially below the statewide average ($6,797). In addition, the hospital's cost growth has been less than the growth in revenue. Notwithstanding our exceptional efforts to operate efficiently, the erosion in our payor mix adversely affects our financial results. In fiscal 2008, we had a negative patient margin and our total operating margin was only one-half of one percent, well below what is needed to fund operations and make needed capital investments.

In addition to our changing payor mix and worsening financial position, we note that due to changes in technology, more and more services are being performed on an outpatient basis. The shift from inpatient to outpatient among Blue Cross members is significant: from 2004 to 2008, the number of inpatient admissions has declined from 7124 to 6238, more than 12%. The continuing shift causes us concern that the market pricing implementation will not be budget neutral over time and will result in further loss of reimbursement.

Adjustment in Blue Cross Rates

We have reviewed our Blue Cross rates in light of our costs, service mix, payor mix and market position, and we request that Blue Cross increase our payment rates by 8%. Blue Cross currently enjoys the most significant discount of any commercial payor, and we estimate that, even with the requested increase, Blue Cross will have a reimbursement advantage of at least 13% percentage points. The rationale for our request is described more fully below.

1. *Below Market Rates.* Our Blue Cross payments are well below what Blue Cross pays other hospitals in the region. Our DRG rate, even after including the add-ons for capital and graduate medical education, was approximately $8,700 in fiscal 2007. This is considerably below what other hospitals of similar scale and teaching programs receive.

   a. Part of the reason for the lower rates is our cost structure. The most recent data shows that our standardized cost per case in 2006 ($6,242) was more than $500 below the statewide average ($6,797). This differential alone amounts to more than $3.0 million in 2006 ($500 * 5661 cases *1.0764 case mix). Over the past three years (2006-2008), the impact is more than $9.0 million.

   b. As part of Blue Cross' transparency efforts, it recently shared with us comparative payment data for 41 common procedures. The data was region specific, covering the Saginaw-Bay-Midland metropolitan

statistical area. In each case, the payments to Covenant are far below the market averages. For example, in the case of C-section and vaginal deliveries, Covenant's rates are $2600 and $2000 below the market averages, respectively. The degree of underpayment is even worse when one considers the fact that our low rates are in the "market average," and we are the sole provider of obstetric services in Saginaw.

c. We believe that other hospitals in our area are benefitting from higher Blue Cross rates due to their having higher costs, not due any superiority in terms of efficiency or quality. As you are aware, one of the largest factors affecting operating costs is wages, yet the Medicare wage index varies widely among the hospitals in the Saginaw-Bay-Midland area even though we are all competing for the same staff. For example, in fiscal 2009, St. Mary's Medicare wage index is 1.0769, yet our wage index is only .90. Bay Medical and MidMichigan have a .9410 wage index. The favorable wage index of our competitors results in more Medicare reimbursement. This, in turn, can lead to higher wages, thus increasing their Blue Cross cost base and reimbursement. For example, the average hourly wage for the past three years for St. Mary's was $30.47, more than 10% higher than the three year average hourly wage at Covenant $26.87. We do not expect Blue Cross to remedy Medicare wage index variations, but we hope that you can appreciate the challenge it poses for Covenant. The differences in Medicare reimbursement for two hospitals in the same town and the differences in service mix (contributing to larger Medicaid case loads) underscore why it is so important that we achieve appropriate reimbursement from Blue Cross and other commercial payors.

2. *Cost Exclusions.* The Blue Cross model for Peer Group 1 through 4 hospitals excludes certain costs. In fiscal 2004, the base year for the development of rates, non-reimbursable costs were $38.8 million, more than 10% of our cost base. Blue Cross only recognized $2.96 million or 7.6%. This is considerably below the share that Blue Cross recognized of other costs (around 20%). We note that, even if Blue Cross were to recognize its share of the non-reimbursable costs, the hospital would still have a standardized cost per case below the statewide average. This supports the conclusion that the hospital is efficiently operated even if Blue Cross recognizes its full share of non-reimbursable costs.

a. Some of the costs that were excluded result from our unique service mix. We must employ various physicians given our obstetric and pediatric services. For example, the hospital employs pediatric intensivists, hospitalists and pediatric surgeons. These employment arrangements result in losses which Blue Cross did not take into account in the development of our rates.

b. We also believe that the manner for allocating costs to Blue Cross members results in some aberrations, particularly as respects obstetrics services. The costs associated with this service are higher than the average costs of "adults and pediatrics general routine care," yet for cost allocation purposes, the average cost was used. As noted earlier, more than half of our top ten admissions for Blue Cross members relate to maternity care.

c. While the cost exclusions may have been consistent with the model, it had a disproportionate effect on Covenant. Not only did the exclusion result in lower rates, it results in even more costs having to be shifted to other commercial payors. The commercial payors are already picking up an extraordinary cost shift due to the fact that Blue Cross does not recognize the cost of Medicaid underfunding.

3. *BCN Margin.* In 2004, the hospital agreed to convert its BCN rates to the equivalent of TRUST rates. This resulted in a significant reduction in the hospital's BCN reimbursement since BCN rates were more on par with what the hospital had established with other commercial payors, such as HealthPlus. Simply put, the margin on the BCN business far exceeded the Blue Cross target margin (4%). When the change was made, it was handled on a budget neutral basis so that the reduction in BCN reimbursement was offset by an increase in Blue Cross reimbursement. Hence the hospital protected the BCN margin. Under the new PHA model, BCN reimbursement is set at the TRUST level and reimbursement is subject to the same margin assignment (4% in our case). This has resulted in lower reimbursement over time to the hospital. Both the original deal and the 2004 conversion to TRUST "protected" the BCN margin; the current arrangement does not.

4. *Uncompensated Care Growth.* The hospital's uncompensated care expense has more than doubled since fiscal 2004. For fiscal 2008, it was over $33.7 million. While we understand that the standard model rebases uncompensated care annually, there is a three year lag. This lag is creating significant hardship for the hospital given the exceptional high growth in this cost.

5. *Shift to Outpatient.* As noted earlier, the hospital has experienced a consistent decline in admissions each year since 2004. In addition, some services, such as PTCA, are now performed on an outpatient basis, yet were previously handled on an inpatient basis. This change alone has had a material impact since the difference in PTCA reimbursement is around $2,800. During the nine month period of October 1, 2007 through June 30, 2008, we had 41 procedures, resulting in a loss of reimbursement exceeding $110,000. Our request for additional reimbursement is supported by this and other expected shifts that will arise as technology continues to improve. We also raise this issue in relation to market pricing. The market pricing implementation does not protect against this or other

PHA Advisory Comm ? Spence

2007 is base year

shifts from inpatient to outpatient. We believe that this shift should be estimated and taken into account in developing rates under the market pricing initiative.

For the reasons discussed above, we believe our request for an adjustment to our rates is warranted. We would like the opportunity to meet to discuss this request in detail and provide you with supporting documentation. I will contact your office in the near future to set up a time to meet.

As a final matter, we are aware that Blue Cross is interested in establishing a Medicare Advantage PPO product. We have some concerns relative to the proposed contract and reimbursement terms, and we may be willing to participate if those concerns can be adequately addressed. Our intention is to complete our negotiations concerning this matter first before addressing the Medicare Advantage PPO product.

In the event that you have any questions or comments concerning the matters addressed in this letter, please contact me.

Very truly yours,

Mark Gronda
Vice President and Chief Financial Officer

MG/ms

cc: Mr. Spencer Maidlow

APPENDIX 18

From: Milewski, Robert <RMilewski@bcbsm.com>
Sent: Saturday, October 6, 2007 12:01 AM
To: Parris, Bernadette <BParris@bcbsm.com>
Subject: FW: Meeting

Bernie, FYI

From: Connolly, Jeffrey
Sent: Fri 10/5/2007 8:28 AM
To: Milewski, Robert; Sorget, Kim; Darland, Doug; Noxon, Gerald
Subject: Re: Meeting

Melissa, can you set up a meeting through Bob's office on this. I would like Ken D there as well.

Thanks

----- Original Message -----
From: Milewski, Robert
To: Connolly, Jeffrey; Sorget, Kim; Darland, Doug; Noxon, Gerald
Sent: Fri Oct 05 08:25:54 2007
Subject: Re: Meeting

I agree that we should meet and have a strategy session.

We need to sort out why we are receiving these current requests. From the input I have received from Kim, Doug and Jerry, we have always received some of these requests.

Some requests could be related to our heightened commitment to relationship and service. Some CEO may falsely read our kindness as weakness or oppotunity.

We need to use objective data to assess each request and see how the requests line up with strategies which will benefit the Blues. We need to look for measurable win-win situations if we are going to make exceptions to the standard PHA. The business leaking into Wisconsin in the UP may be an example.

Bob

----- Original Message -----
From: Connolly, Jeffrey

To: Sorget, Kim; Crofoot, Ron; Milewski, Robert
Cc: Darland, Doug
Sent: Fri Oct 05 07:54:47 2007
Subject: Re: Meeting

I agree. At some point I believe we need to have a high level discussion about other hospitals and their perceived needs. We seem to be getting some requests for support (ie northern michigan hospital, metropolitan,etc). What is our position on this? Not sure how we have addressed historically or if this is new given the economy. Both Ken and Mark Bartlett have commented on this recently as well.

Thanks

----- Original Message -----
From: Sorget, Kim
To: Connolly, Jeffrey; Crofoot, Ron
Cc: 'IMCEAMAILTO-RMilewski+40bcbsm+2Ecom@dchs.org' <IMCEAMAILTO-RMilewski+40bcbsm+2Ecom@dchs.org>; Darland, Doug
Sent: Thu Oct 04 21:21:09 2007
Subject: Re: Meeting

Ron can you set up the meeting. I think we should see the proposal before we come up with any solution on the product shift.

----- Original Message -----
From: John Schon <John.Schon@dchs.org>
To: Sorget, Kim; Connolly, Jeffrey; Crofoot, Ron
Cc: Milewski, Robert <IMCEAMAILTO-RMilewski+40bcbsm+2Ecom@dchs.org>
Sent: Thu Oct 04 18:37:27 2007
Subject: RE:Meeting

Hi Everyone,

As we discussed at our last UP Blue Steering Committee meeting, we were going to set up a meeting to discuss my/DCHS's proposal to Blue Cross to help our Healthcare System financially to strengthen our ability to retain more market share in Dickinson County/the UP. In that regard, I have been working with my staff to layout the current status of our market share data by MDC/specialty as well as identify those physician specialties that we need to recruit/retain in our community.

Hopefully, we can determine the cost/benefit to allow Blue Cross to reimburse DCHS and our physicians better and allow our hospital the ability to recruit new physicians to our community and, as well, retain those physicians currently on our medical staff that are threatening to relocate their practices across our boarder into Wisconsin. If we are successful, the result will be that we retain more market share for DCHS and lower claims cost for our local employers and Blue Cross.

One additional item that hopefully can be addressed is the fact that the promotion of Blue Cross/UP Blue is starting to negatively impact our hospital financially. Through August or eight months into our fiscal year, our Blue Cross patient revenues are $2,635,000

higher than anticipated and our Commercial Insurance revenues are $2,422,000 lower than anticipated. This shift has cost out hospital approximately $900,000 to $1 Million dollars so far this year due the 40 to 45% decrease in reimbursement that we receive when an employer switches their coverage from a Commercial Insurance carrier to Blue Cross. Hopefully we can address this issue; otherwise the potential increase in our hospitals' Blue Cross patient utilization (created through the sale of the UP Blue product) will never offset this 40 to 45% reduction in our reimbursement.

Let me know potential dates that we can meet to discuss these issues in more detail and hopefully come to a resolution that is beneficial to both parties.

Thanks,

John

From: Milewski, Robert [mailto:RMilewski@bcbsm.com]
Sent: Monday, September 17, 2007 12:12 PM
To: John Schon
Cc: Sorget, Kim; Connolly, Jeffrey; Crofoot, Ron
Subject: Follow Up from UP Council Meeting

John,

I enjoyed speaking with you after the Council meeting last week. I look forward to working with you on the challenges you face in delivering high quality healthcare to your community of Iron Mountain. Please follow up with Ron Crofoot on some of the ideas we discussed. Developing solutions to keep Michigan healthcare business in Michigan hospitals is in all of our best interest. My contact information is below. I look forward to our ongoing dialogue.

God Bless,

Bob

Robert Milewski

Senior Vice President, Contracting and Hospital Relations

Blue Cross Blue Shield of Michigan

27300 W. 11 Mile Road, B792

Southfield, MI 48034-6147

Bernie Parris, Executive Assistant

Phone: 248-448-6903

APPENDIX 19

Discussions With BCBSM

DCH SYSTEM

Participants From BCBSM:
- Ron Crowfoot
- Doug Darland

Participants From DCHS:
- John Schon, Administrator and CEO
- John Lee, CFO
- Deb Hanson, Reimbursement Coordinator

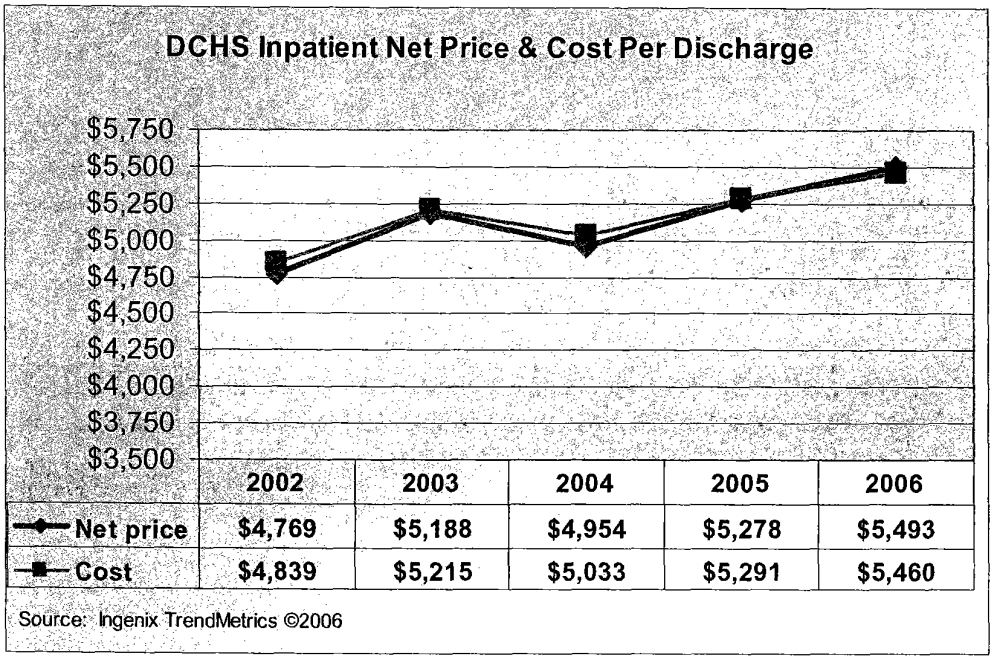
DCHS Proposal to Partner with BCBSM

- Decrease out-migration of BCBSM members to Wisconsin providers by supporting and enhancing programs at DCHS that meet member needs.
- Jointly approach area businesses to promote affordable healthcare insurance solutions that assist with these goals.
- Increase DCHS reimbursement rates to fund strategic initiatives in support of these goals.
  - Offset lost revenue from other private plans with higher reimbursement rates from BCBSM.
  - Reduce competitive disadvantage compared to both Wisconsin providers and neighboring, smaller Peer Group 5 hospitals.
  - Create a Peer Group 4 ½ for DCHS to achieve these goals.

DCHS Financial Challenges

- The following slides present current and historical information since 1997, the first full year in our present hospital facility.
- Because of the decline in charge based payers and overall changes and decreases in patient volumes there are increased financial pressures.
- DCHS has maintained effective control on variable costs, while the fixed costs related to the new facility have been covered despite the volume decline.
- At the same time, DCHS has been proactive in physician recruiting both on our own and jointly with MGHS and BellinHealth. DCHS has also been successful in nurturing cooperation and partnership with tertiary providers both to the North and to the South.
- DCHS' ongoing efforts and initiatives include development of a hospitalist program using existing and potential Internal Medicine candidates.
- DCHS' initiatives do address out migration of BCBSM members and restoring and improving overall market share by working with present physicians and recruiting specialist where needed.

DCHS Operates on a Thin Margin



	2002	2003	2004	2005	2006
Net price	$4,769	$5,188	$4,954	$5,278	$5,493
Cost	$4,839	$5,215	$5,033	$5,291	$5,460

Source: Ingenix TrendMetrics ©2006

- Thin margin with high gross prices, relatively low BCBSM reimbursement.
- Costs are well-controlled, but there is a high level of fixed costs.

DCHS Payer Mix and Revenue Composition

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997* *First full year in new facility
Present and historical Payer Mix:						
Medicare	43%	42%	43%	43%	43%	44%
Michigan Medicaid	9%	8%	8%	8%	6%	6%
BCBSM	24%	23%	23%	26%	22%	16%
Other	19%	21%	21%	20%	25%	29%
Self pay	5%	5%	5%	5%	5%	5%
Total	100%	100%	100%	100%	100%	100%
Based on total Healthcare System gross charges.						
Gross revenue in $000's:						
Inpatient	$ 33,689	$ 32,397	$ 46,945	$ 45,342	$ 36,605	$ 29,651
Hospital outpatient	71,767	66,089	100,208	76,199	53,794	31,444
Sub-total - Hospital	105,456	98,486	147,153	121,541	90,399	61,095
Physician services	4,367	3,337	5,207	4,476	4,030	3,368
Total	$ 109,823	$ 101,823	$ 152,360	$ 126,017	$ 94,429	$ 64,463
% change in total revenue -						
Eight-month period comparison	7.9%					
Three-year Inervals			20.9%	33.5%	46.5%	
Inpatient Hospital Revenue %	31.9%	32.9%	31.9%	37.3%	40.5%	48.5%

- Inpatient volumes and revenue have decreased dramatically.
- Payer mix has shifted causing an adverse effect on net revenue.
- BCBSM now 24% of gross charges, up in 10 years from 16%.
- Other (charge based payers) now 19% of gross charges, down in 10 years from 29%.

DCHS
Net Revenue, Allowances and Bad Debts

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997*
Net revenue and allowances in $000s:						
Gross revenue	$ 109,823	$ 101,823	$ 152,360	$ 126,017	$ 94,429	$ 64,463
Allowances (excludes bad debt provisions)	(63,711)	(57,457)	(82,373)	(64,651)	(48,845)	(23,210)
Net revenue	$ 46,112	$ 44,366	$ 69,987	$ 61,366	$ 45,584	$ 41,253
Net revenue percentage of gross revenue	42.0%	43.6%	45.9%	48.7%	48.3%	64.0%
Provision for doubtful accounts	$ 3,102	$ 2,405	$ 3,865	$ 3,151	$ 2,399	$ 1,717
Provision as percentage of gross revenue	2.8%	2.4%	2.5%	2.5%	2.5%	2.7%

*Special note: 1997net revenue includes $750,000 one-time net reimbursement effect of the sale of the old hospital facility. When adjusted, net revenue would have been 62.8% of gross without that one-time net reimbursement.

- From ten years ago, net revenue declined to 42% of gross revenue compared to 63% in 1997, the first full year in the new facility.
- As a result of increased deductibles and coinsurance and an increase in the uninsured, bad debts have increased in 2007.

DCHS
Change in 2007 Payer Mix

Estimated Net Revenue Impact - Projected 2007 Payer Mix change from 2006 Actual			
	Gross Revenue	**Payment Rate**	**Net Revenue Impact**
BCBSM	$ 2,109,487	40.0%	$ 843,795
Other Private Plans	$ (2,109,487)	89.1%	$ (1,879,553)
Net Impact			$ (1,035,758)

The decrease in gross charges from other private plans could be attributable to both a switch by employers from other plans to BCBSM and to a loss in market share from other plans coinciding with increased market share from BCBSM Members.

- DCHS has continuously conducted community education and has communicated directly with the general public and community leaders about our service lines, programs and capabilities.
- We intend to continue our communications and other efforts to keep and grow our market share.
- Controlling our prices to charge-based payers now that, generally speaking, deductibles are higher is also an important strategy.

DCHS
Effective, Efficient, Viable

- The following slides show financial information and benchmark comparisons of DCHS prices and costs.
- DCHS continues to operate efficiently and controls costs to justify its role as a viable partner with BCBSM to provide care in Michigan and decrease out migration of its members to Wisconsin providers.

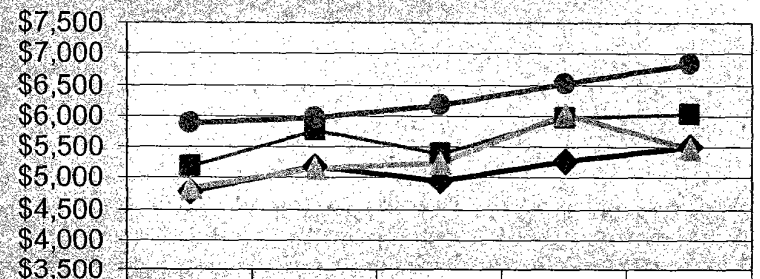
DCHS
Productivity and Staffing

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997*
Productivity and efficiency:						
Revenue per full-time equivalent employee	$115,844	$111,367	$111,275	$100,655	$88,077	$77,135
Worked hours per adjusted discharge	90.7	92.3	89.5	91.4	107.1	NA
Salaries as percentage of total costs	44%	44%	45%	46%	46%	44%
Fringe benefits as percentage of salaries	28%	29%	30%	30%	21%	25%
Staffing level - total employment:						
Total paid full-time equivalent employees	632.3	627.3	629.0	615.6	580.2	545.5
Paid hours / adjusted discharge (IP discharges / ratio of IP revenue to Total)	104.33	107.98	107.64	108.56	110.18	117.94
% increase in employment:						
Eight month periods	1%					
Three-year intervals			2%	6%	6%	
% improvement: Staff level relative to patient volumes						
Eight month periods	3%					
Three-year intervals			1%	1%	7%	

- Staffing is controlled relative to patient volumes.
- DCHS is the largest employer in Dickinson County and has provided steady employment with good job growth.
- As a tactic, could leverage these facts in efforts to win support from community.

DCHS Price Comparison

Net Price Per Discharge Comparison
CHIPS Database Medians



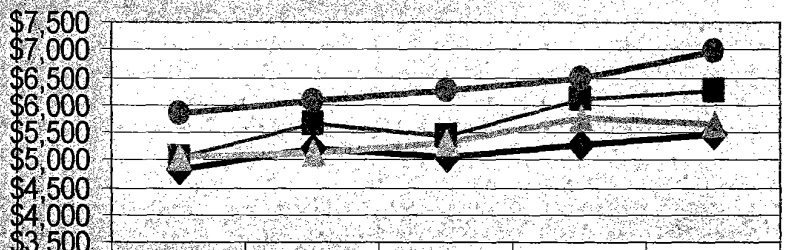
	2002	2003	2004	2005	2006
DCHS	$4,769	$5,188	$4,954	$5,278	$5,493
Michigan	$5,184	$5,774	$5,380	$5,968	$6,036
East North Central	$5,887	$5,964	$6,161	$6,525	$6,839
Rural E. No. Central <100 beds	$4,834	$5,149	$5,247	$6,034	$5,467

Source: Ingenix TrendMetrics ©2006

- Compares favorably except to small hospitals.
- BCBSM Peer 5 hospitals receive better reimbursement and can set prices lower.
- Wisconsin hospitals receive better reimbursement and can set prices lower.
- Unfavorable competitive situation.

DCHS Cost Comparison

Cost Per Discharge Comparison
CHIPS Database Medians

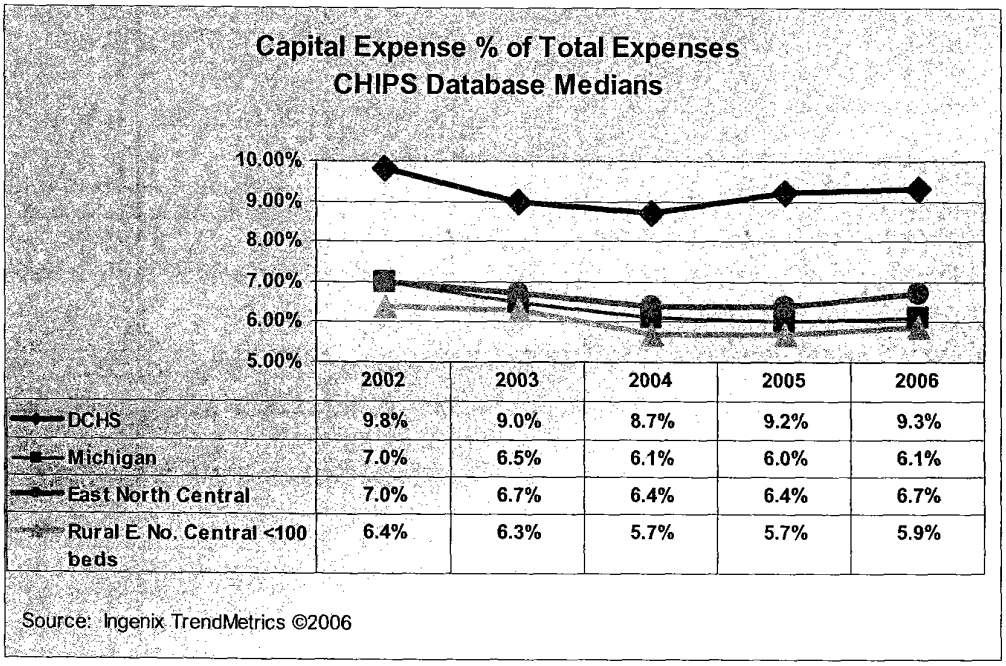


	2002	2003	2004	2005	2006
DCHS	$4,839	$5,215	$5,033	$5,291	$5,460
Michigan	$5,032	$5,649	$5,425	$6,112	$6,251
East North Central	$5,850	$6,052	$6,241	$6,494	$6,978
Rural E. No. Central <100 beds	$5,032	$5,136	$5,309	$5,761	$5,650

Source: Ingenix TrendMetrics ©2006

- Cost per discharge is low compared to other peer group medians.
- High capital costs (fixed) cause increase in cost/discharge when volumes decline.
- Inpatient census needs to be "steady" to cover fixed costs.

DCHS Capital Expense as % of Total Expenses



	2002	2003	2004	2005	2006
DCHS	9.8%	9.0%	8.7%	9.2%	9.3%
Michigan	7.0%	6.5%	6.1%	6.0%	6.1%
East North Central	7.0%	6.7%	6.4%	6.4%	6.7%
Rural E. No. Central <100 beds	6.4%	6.3%	5.7%	5.7%	5.9%

Source: Ingenix TrendMetrics ©2006

- Relatively new facility occupied in November 1996.
- Additional debt beginning in 2005 for building addition, new MRI.
- Hospital facility and attached medical office building serves to attract physicians to area.

DCHS
Physician Strategies

- The following slides show our current losses on physician practices and information on our proactive recruiting efforts and other strategies.
- We have identified direct relationships between our historic periodic shortage in orthopedic coverage of the emergency department and historic losses in market share for surgeries (not just orthopedic).
- We are working with present orthopedists to increase efforts to increase market share in order to justify an additional orthopedic surgeon.
- Existing orthopedists do knee and hip procedures, but not spines. We would recruit a new orthopod with ability to do spinal surgeries when additional volumes would justify it.
- We have identified an increase of transfers of emergency cases to other hospitals because of lack of coverage to treat cases medically and other reasons.
- A Hospitalist program that provides coverage to treat medically the surgical cases, including emergency cases, is a key component of our strategy. A proposal from BellinHealth to hospitalists at a cost of $950,000 is being considered.

DCHS

Physician Recruiting Information – Potential Benefit and Cost by Specialty

Specialty	Average Revenue Generated	Average Starting Salary*
Cardiology *(invasive)*	$2,662,600	$342,000
Orthopedic Surgery	$2,312,168	$370,000
Cardiology *(non-invasive)*	$2,240,286	$342,000
Neurosurgery	$2,100,000	$489,000
Internal Medicine	$1,987,253	$162,000
General Surgery	$1,947,934	$272,000
Hematology/Oncology	$1,624,246	$275,000
Family Practice	$1,615,828	$145,000
Obstetrics & Gynecology	$1,413,426	$234,000
Gastroenterology	$1,336,133	$315,000
Pulmonology	$1,332,534	$248,000
Urology	$1,272,563	$320,000
Psychiatry	$888,911	$174,000
Nephrology	$865,214	$225,000
Pediatrics	$697,516	$151,000
Ophthalmology	$584,310	N/A
Neurology	$557,916	$210,000

**2006 Merritt, Hawkins & Associates' Recruitment Incentives Survey.*

DCHS
Physician Practice Losses & Recruiting Activity

Practice specialty	YTD: 9/30/2007	FYE: 12/31/2006
Orthopedics	$ (130,000)	$ (238,000)
Pediatrics	$ (89,000)	$ (229,000)
Internist	$ (214,000)	$ (326,000)
Obstetrics	$ (18,000)	N/A
Overall, including outlying clinics	$ (1,032,000)	$ (1,498,000)

Special note: The hospitalist program is projected to add $250,000 to $400,000 to annual losses.

Physician Recruiting Activities:

- Current recruiting report shows active status of candidates, including internal medicine, pulmonology and obstetrics.
- Recruiting successes include 2 pediatricians and an ENT.
- Present Internist/Nephrologists plus recruiting candidates in Internal Medicine and Pulmonology could also form the core for a Hospitalist Program.
- Planning discussions with present general surgeons about recruiting a gastroenterologist are ongoing.

APPENDIX 20

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No.: 2:10-cv-14155-DPH-MKM Judge Denise Page Hood Magistrate Judge Mona K. Majzoub

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

AETNA INC., Plaintiff, v. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No.: 2:11-cv-15346-DPH-MKM

Marquette, Michigan

Thursday, December 6, 2012

Confidential Video Deposition of:

Jerry L. Worden,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Marquette General Hospital, Wallace Building, 420 Magnetic Street, Marquette, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:36 a.m., when were present on behalf of the respective parties:

THE WITNESS: Would you repeat that.
BY MR. SANDBERG: 13:32:34
Q I posited 60 percent.
A You started at 60 percent.
Q So, therefore, a 40 percent discount?
A Yes.
MR. SANDBERG: Okay. Thank you very 13:32:42
much.
MR. GRINGER: Scott, Mr. Warheit,
anything?
MR. WARHEIT: I have no questions for
him. 13:32:48
MR. GRINGER: Mr. Stenerson.
MR. STENERSON: One second, please.
EXAMINATION
BY MR. STENERSON:
Q Good afternoon. Mr. Worden. My name is Todd13:33:05
Stenerson. I represent Blue Cross.
When you joined Marquette General in the
spring of 2008, what was the hospital's financial
condition?
A They were just about to report a $10 million 13:33:18
operating loss. They had had Wellspring, which was a
nationally known turn-around firm, that was here. They
had just gone through an early retirement program. They

had gone through some management reorganization, and they were extremely financial -- financially distressed. And their day's cash I believe was just a little bit over 50 days cash, and they were about to default on several bond covenants.

Q Do you know how close Marquette was in defaulting on their bond covenants? 13:33:53

A We did default on it.

Q You did default?

A We did.

Q Do you know how many covenants were defaulted?

A Three. I know it very well. 13:34:00

Q And this is in the spring of 2008?

A It actually -- our fiscal year ends June 30, and so when we issued the financial statements in September, we would have had to issue default notices on the covenants that we defaulted on. 13:34:15

Q And while the agreement that's reflected in Worden Number 3 had yet to be signed when you joined, did you understand why -- or, strike that.

Did you come to learn why Marquette General was seeking additional reimbursements from Blue Cross that ultimately resulted in the agreement that's Worden Number 3? 13:34:34

A Yes.

APPENDIX 21

Darland, Doug

From: Seitz, Kevin
Sent: Tuesday, May 22, 2007 5:41 PM
To: Sorget, Kim; Milewski, Robert; Connolly, Jeffrey
Cc: Darland, Doug; Noxon, Gerald; Crofoot, Ron; Carlson, Jeanne; Klobucar, Kevin
Subject: RE: Marquette General Hospital

agree with your option 3. We can also offer to split upside risk on the HMO(not necessarily 50/50).

Please keep in mind Kevin Klobucar's advice. BCN would like to go into the U.P., but BCBSM should not sacrifice for this to happen.

would like to bring this to closure quickly. Can we give them a deal/no deal deadline of June 30th? I also want to understand our final proposal so that Bob and I can brief the BCBSM Board chair. Thanks.

From: Sorget, Kim
Sent: Thursday, May 17, 2007 10:38 AM
To: Seitz, Kevin; Milewski, Robert; Connolly, Jeffrey
Cc: Darland, Doug; Noxon, Gerald; Crofoot, Ron
Subject: Marquette General Hospital

Doug, Ron, and I had a face to face meeting with Nemacheck, his CFO, and Reimbursement Director yesterday to understand their issues with the new model and what it would take for them to participate in the BCN product.

Although not totally surprising at least it was very disappointing what MGH desires is modifying their existing LOU to provide the following enhancements:

1) Expand their P4P to include outpatient, as the new model prescribes
2) Take advantage of the new model update methodology
3) Utilize the new model methodology to set their inpatient prices
4) Recognize their funding needs for their Ortho program when they know them (probably in July)

In essence they want to keep their current deal and want all the advantages of the new model contract. Most current data approximates they are over the model by nearly [redacted] of a $50 million BCBSM payments per year, which is primarily driven by their outpatient deal where we are paying nearly [redacted] of charges. The net effect of their request (points 1-3 above) approximates $5 million or an overall increase of roughly 10%.

The basis of their argument for these needed changes is to support programs where they see us as partner to launch their Ortho program as well as other not yet fully defined strategic programs they intend to launch over the next couple of years. They see this added cash as seed money and ongoing costs to manage their initiatives.

I explained to them that providing them all the added values of the new PHA without making other new model adjustments was very problematic and our goal is to [redacted] I knew this would be a non starter for them, but wanted to get it on the table and then suggested we were open to considering some extension of their current deal without the positive new model features they sought. Their position was that they needed the reimbursement enhancements to fund these strategic "partnering" initiatives. We pressed for what they believed were the funding requirements for the initiatives and were advised it was in the area of [redacted] million a year. I think once they know the value of what they actually requested their need will raise to the [redacted] number.

We advised them that we were definitely interested in partnering in programs where ROI's could be achieved, but would be looking at it as some form of risk arrangement, which they were not much supportive. Their primary concern was over measurements.

We closed the meeting on the note that what they requested in terms of LOU enhancements was going to be a problem for us as presented, but we would consider other ways that might provide for some funding for their "partnering" initiatives and would get back to them in a couple of weeks.

Following this Bill wanted to know if BCBSM would be willing to grant a 4 year loan to them to cover a pension shortfall they

have this year. According to Bill they need about $5 million in cash to meet their bond holder requirements for cash on hand. The thing that was a little bothersome is that they want the money for four years, but they don't want to start repayments until year three. This prompted us to ask about their financial status in which they indicated they lost $6 million last year on operations, but did not comment on investment income. I let him know I would check into it, but I was not aware of any such arrangements we had done in the past.

Doug, Ron and I met following the meeting and came up with what we believe our options are in responding to MGH, which are as follows:

1) [redacted]

Other sweeteners to consider with the desired option above:

a) [redacted]

Our group tended to want to develop something along the lines of Option 3 and consider one or more of the sweeteners. Before we spend a great deal of time on proposing something we seek your input to these ideas or any others you might have. Thanks, KIM

- extend current 3 year
- [redacted]
- May consider funding opportunity when your plans are ready to be shared "support partnership" etc.

- BCN open to gain/sharing
- Separate gain share program w/ BC

5/24/2007

APPENDIX 22

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,
Plaintiffs,
vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD
OF MICHIGAN,
Defendant.
_____

The Confidential Videotaped Deposition of
TIMOTHY SUSTERICH,
Taken at 5900 Byron Center Avenue,
Wyoming, Michigan,
Commencing at 9:17 a.m.,
Tuesday, November 20, 2012,
Before Rebecca L. Russo, CSR-2759, RMR, CRR.

Q. And how has that mix changed, if at all, say in the past five years?
A. I wouldn't say it's changed significantly.
Q. Been fairly constant?
A. Yeah, pretty much.
Q. Do the government payers cover cost of providing service to government patients?
A. They do not.
Q. Do you know why not?
A. No, I don't.
Q. Do you -- why don't you go and negotiate a higher rate with Medicare?
A. It's a government program.
Q. They don't let you negotiate?
A. No, we do not negotiate with the government.
Q. Why don't you go negotiate higher rates with Medicaid?
A. It's a government agency, as well.
Q. So Medicaid won't negotiate with you?
A. No.
Q. Do you know approximately, in the current year, how much money in government underpayment -- well, strike that.

We can give a little background for folks who aren't in the hospital industry. When you say that government payers don't pay costs, how does that

affect Metro Health's financial position?
A. Well, obviously, it's a burden that we have to bear.
Q. So do you know, in rough estimates, what percentage of cost Medicare reimburses Metro Health for services provided to Medicare patients?
A. I don't know exactly.
Q. Do you have a combined number for Medicare and Medicaid as to how much under cost those programs reimburse Metro Health for providing care to their patients?
A. We calculate it annually. I just don't remember the exact number.
Q. Do you know the dollar range of the -- well, strike that.

So do I understand correctly that if the hospital provides service to a patient and it costs a hundred dollars to provide the service, and it's only reimbursed, say, $80, it has a $20 loss on that service?
A. That'd be accurate.
Q. And if you add those individual patient losses up over the course of the year, is there a label that you give that bucket of money?
A. Community benefit.
Q. And when you use the phrase community benefit, what is

MARKED FOR IDENTIFICATION:
BLUE CROSS EXHIBIT 1057
10:35 a.m.

A. It is.

BY MR. STENERSON:

Q. Thank you. Let me hand you what I'm marking as Blue Cross 1058 --

MARKED FOR IDENTIFICATION:
BLUE CROSS EXHIBIT 1058
10:35 a.m.

BY MR. STENERSON:

Q. -- and ask you to review it.

A. Okay.

Q. Is 1058, Blue Cross 1058 an email correspondence you had with Mr. Darland at Blue Cross?

A. Apparently, yes.

Q. Does this document refresh your memory about any of the discussions you had with Blue Cross in or around 2008?

A. I'm aware that we were negotiating, yes.

Q. And is this document in or around the time when you, on behalf of Metro Health, had approached Blue Cross to seek an increase in reimbursement rate?

A. It would have been, yes.

Q. Do you know how -- do you recall how long the --

excuse me. Do you recall how long the negotiations lasted?

A. I do not recall.

Q. Is it -- suffice it to say you had more than one conversation regarding the request for an increased rate?

A. Yes.

Q. Now, Mr. Darland's email is asking, in the first bullet, how do our rates come to the rates Priority pays to your hospital.

Do you see that?

A. I do.

Q. And to other commercial payers, do you see that?

A. I do.

Q. Do you recall earlier today when you mentioned that you thought it was a relevant fact for Metro Health to understand what its competitors were being paid by Blue Cross?

A. I do.

Q. Did you find anything wrong with the fact that Mr. Darland was concerned with where Priority's rates were?

MS. BHAT: Objection to form.

A. I was.

BY MR. STENERSON:

Q. I'm sorry?
A. I was.
Q. You were what?
A. I was concerned with him asking that question.
Q. Okay. And did you respond to Mr. Darland's question?
A. That we had a confidentiality agreement in all of our contracts, that we don't discuss rates.
Q. And Mr. Darland, in his third bullet, asks whether or not Priority's been approached, do you see that?
A. I do.
Q. Do you recall if you responded to that?
A. I don't recall.
Q. At the time that Mr. Darland was asking this, do I understand correctly that you were already in discussions with Priority?
A. I don't know if we were already, but we did have discussions with Priority, yes.
Q. Let me ask it this way. Prior to Mr. Darland's email in Blue Cross 1058, had Metro Health already made the decision to approach Priority for an increase in rates?
A. We had.
Q. Am I correct in understanding that nothing that Mr. Darland asked you in this email caused you to seek additional reimbursement rates from Priority?

MS. BHAT: Objection to form.

A. No, we were already in -- we already made a decision that we needed to approach all payers -- not all payers, but the significant payers, relative to rates.

BY MR. STENERSON:

Q. In your discussions with Priority, did they seek to determine what your reimbursement rate was with Blue Cross?

A. Don't recall.

Q. In your negotiations with Blue Cross, did you seek to determine what Blue Cross' reimbursement rate was to other hospitals in Grand Rapids?

A. I did not.

Q. How did you learn what you believe to be the rates that Blue Cross was paying other hospitals in Grand Rapids?

A. Well, Blue Cross or Blue Care Network is our TPA for our employees, so we obviously have claims that are paid to the other institutions.

Q. So you were able to roughly reverse-engineer those issues?

A. Correct.

Q. Would you describe Mr. Darland as a hard negotiator?

A. I would.

MS. BHAT: Objection to form.

BY MR. STENERSON:
Q. And what do you mean by hard negotiator?
A. Unwilling to -- well, unwilling to get to where I would like it to be.
Q. Do you think Mr. Darland is in the practice of paying hospitals like Metro Health higher reimbursement than he needs to?
A. No.
MS. BHAT: Objection to form.
MR. MATHESON: Objection to form.
MS. BHAT: And foundation.
BY MR. STENERSON:
Q. At the same time, did you find that Mr. Darland would listen to your actual financial needs in determining whether or not to agree to an increase?
MR. MATHESON: Objection to the form and to the leading.
A. He was -- he did listen, yes.
BY MR. STENERSON:
Q. Let me ask it this way. In your negotiations with Mr. Darland, what did you find to be an effective way to get Mr. Darland to consider a potential increased reimbursement?
MR. MATHESON: Objection, based on earlier leading.

A. The cost structure of the organization had changed.

MR. STENERSON: That's a new one.

MR. MATHESON: It's worked before.

BY MR. STENERSON:

Q. Any other factors that you found -- what if any other factors did you find effective in negotiating for higher reimbursements with Mr. Darland?

A. That was the basis for going forward with it at that time.

Q. Let me show you what I'm gonna mark as Blue Cross 1059.

MARKED FOR IDENTIFICATION:

BLUE CROSS EXHIBIT 1059

10:42 a.m.

A. Just stick this here?

BY MR. STENERSON:

Q. Yes, sir. If you would take a moment and review Blue Cross 1059 --

A. The whole document?

Q. -- just to familiarize yourself with it.

A. I'm familiar with it.

Q. Do you recognize Blue Cross 1059?

A. I do.

Q. And what is it?

A. It's a letter of understanding between Blue Cross and

APPENDIX 23

From: Sorget, Kim
Sent: Friday, January 25, 2008 1:49 PM
To: Milewski, Robert; Connolly, Jeffrey
Cc: Dallafior, Ken; Darland, Doug
Subject: RE: Metro

We will do some research on this but it may take a month or more. Doug and team have some very tight timelines on the Market Based Outpatient Pricing Initiative with the hospital industry and the MHA, as well as the PG5 deployment in addition to us opening up negotiations with Marquette General. KIM

-----Original Message-----
From: Milewski, Robert
Sent: Wednesday, January 23, 2008 9:10 AM
To: Connolly, Jeffrey
Cc: Sorget, Kim; Dallafior, Ken
Subject: RE: Metro

I don't know how much work it is, but I am good with this being the next step, if Kim is OK. I suspected that we would receive a request from Metro eventually because of their new facility.
Bob

Robert Milewski
Senior Vice President, Contracting and Hospital Relations
Blue Cross Blue Shield of Michigan
27300 W. 11 Mile Road, B792
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant
Phone: 248-448-6903

-----Original Message-----
From: Connolly, Jeffrey
Sent: Wednesday, January 23, 2008 9:08 AM
To: Milewski, Robert; Sorget, Kim
Cc: Dallafior, Ken
Subject: Re: Metro

Very very well said...I completely agree with you. Tim Susterich (their CFO) expects a response. Is the next step to have Doug assess the dollars?

Thanks

----- Original Message -----
From: Milewski, Robert
To: Connolly, Jeffrey
Cc: Sorget, Kim
Sent: Wed Jan 23 09:00:29 2008
Subject: RE: Metro

I agree; it would be good to know the cost of what they are requesting. I suspect that they will be in some serious financial trouble for a while due to their new facility, but once they get over the hump the combination of the new facility and location will result in a very successful operation. It is certainly important to keep them as a friend, but I don't want them playing us against Priority. If we are going to help them, I would like to see some return in our investment relative to their loyalty (increased market share). Therefore, if we are going to help them, what is the TANGIBLE plan to support our growth?
Bob

Robert Milewski
Senior Vice President, Contracting and Hospital Relations
Blue Cross Blue Shield of Michigan
27300 W. 11 Mile Road, B792
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant
Phone: 248-448-6903

-----Original Message-----
From: Connolly, Jeffrey
Sent: Wednesday, January 23, 2008 8:54 AM
To: Milewski, Robert
Subject: Fw: Metro

Hi Bob....see below. Should we just initially have Doug look at what the cost would be to us to accelerate their rebasing formula (scheduled to be in 2010 per contract)?

Thanks

----- Original Message -----
From: Connolly, Jeffrey
To: Sorget, Kim
Sent: Wed Jan 23 08:51:28 2008
Subject: Re: Metro

They do have a contract with priority...not as competitive (from what I hear) as ours, but very important point to consider as we assess our contract.

Thanks

----- Original Message -----
From: Sorget, Kim
To: Milewski, Robert
Cc: Connolly, Jeffrey
Sent: Wed Jan 23 08:25:20 2008

Subject: RE: Metro

I think Metro has a contract with Priority, but would rely on Jeff to confirm. I know that Metro was in contract negotiations for months with Priority regarding their ASF, but understand they now have an agreement with Priority. KIM

-----Original Message-----
From: Milewski, Robert
Sent: Wednesday, January 23, 2008 8:21 AM
To: Sorget, Kim
Subject: RE: Metro

Does Metro accept Priority?

Robert Milewski
Senior Vice President, Contracting and Hospital Relations
Blue Cross Blue Shield of Michigan
27300 W. 11 Mile Road, B792
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant
Phone: 248-448-6903
-----Original Message-----
From: Sorget, Kim
Sent: Tuesday, January 22, 2008 7:45 AM
To: Connolly, Jeffrey; Darland, Doug
Cc: Seitz, Kevin; Milewski, Robert
Subject: RE: Metro

Jeff, we I don't see we have any contractual obligation to rebase them ahead of schedule, unless BCBSM believes we have a good business reason to do so. To my knowledge neither Kevin or Bob, or the facility for that matter has made such a request. Kevin, is this something you think that should pursued? KIM

-----Original Message-----
From: Connolly, Jeffrey
Sent: Monday, January 21, 2008 6:20 AM
To: Sorget, Kim; Darland, Doug
Subject: Metro

Kim and Doug,

Had a brief meeting with Tim Susterich (CFO) at Metro. They are requesting that we advance the "rebasing" of their costs this year as opposed to 2010 (per contract). Given the new facility, he feels that it would equate to more needed reimbursement for the hospital. Apparently, Ken Nyson met with Kevin Seitz and made the same request. What are your thoughts??

Jeff

APPENDIX 24

MidMichigan Health / Blue Cross Blue Shield Agreement
CONFIDENTIAL

On September 5, 2008 MidMichigan Health and Blue Cross Blue Shield of Michigan reached a verbal agreement on contract terms after nearly nine months of negotiations. The contract terms are summarized as follows:

- The initial contract term is 3 years (fiscal year 2009, 2010 and 2011) it then becomes evergreen (automatically renews each year) with either party able to open it for negotiations with 120 days notice.

- Initially and annually thereafter, rates will increase by the market basket (NIPI) plus 0.3% at Midland and Gratiot and by the market basket at Clare and Gladwin. After the initial year, rate increases will be capped by the Standard Model Participating Hospital Agreement rate increase. Under these terms, Midland receives approximately $5.5 million per year of enhanced payments relative to the standard Blue Cross agreement.

- Gratiot will be reimbursed 100% of the Blue Cross share of the new patient tower and ER capital cost. This enhances payment to Gratiot by over $1.2 million each year.

MHA

- Gladwin and Clare will continue to receive the lucrative "Peer Group 5" discount off charges reimbursement without implementation of any significant terms of the new Standard Peer Group 5 Participating Hospital Agreement. This continues to enhance annual payments to Gladwin by approximately $1.5 million and Clare by $1.1 million relative to other Peer Group 5 hospitals in Michigan. Successful past negotiation of Clare into Peer Group 5 (they qualify as a Peer Group 4 hospital) enhances their payment an additional $1.8 million, or $2.9 million per year relative to their peers.

- Blue Cross will increase overall payments by 0.4 points for each .75% increase in Blue Cross activity to compensate for migration from other commercial payors to Blue Cross.

- The Blue Cross Traditional Indemnity and PPO plan payments will be blended to a single budget neutral rate, eliminating the differential and negative impact of migration from indemnity to PPO plans.

- MidMichigan Health agrees to provide an 8% greater discount to Blue Cross than it does to any other independent commercial payor for hospitals in the aggregate excluding ConnectCare. There will not be any retrospective audit and simple attestation will be adequate documentation of the favored rates.

- RATE INCREASE AUDIT

ΔπEXHIBIT 19
Deponent GOVT Rodgers
Date 12-7-12 Rptr. [illegible]
WWW.DEPOBOOK.COM

1954

APPENDIX 25

Jerry Noxon

Dear Jerry:

I appreciate you and Kim Sorget spending time with me on the phone on December 13, 2007 to clarify your proposal letter dated November 28, 2007.

I understand BCBSM's desire to have all hospitals on the revised PHA payment methodology and am supportive of this concept. However, your proposed increase of 1.8% does not cover the BCBSM pro rata share of new capital and operating costs that Sparrow will incur as a result of opening our new West Wing next month not to mention just general cost inflation. After our discussion I rolled forward our costs from the last rebasing using our actual annual increases in our costs per adjusted discharge. That analysis suggested that our current BCBSM rates are about $2 million higher than the PHA methodology would support, not the $9 million you reference in your letter. The following proposal would move us to the standard PHA agreement in year 2 and provide Sparrow with slightly lower annual rate increases to offset this estimated $2 million difference.

- Year 1- Sparrow to receive an update of 2.6% for hospital inpatient and outpatient charge based services with an application of the incentive program to all services consistent with the standard PHA agreement. In addition, Sparrow will be allowed to retain the $560,000 "PHA signing bonus" to partially offset the incremental costs in 2008 associated with opening the new West Wing.

- Year 2- Sparrow to receive the full PHA update factor less 1% plus the application of all provisions of your standard PHA agreement.

- Year 3- Sparrow to receive the full PHA update factor.

You have indicated that since 2010 is the beginning of a new base year cycle that rebasing will occur using 2007 data. As noted earlier Sparrow is opening its new West Wing in 2008 and 2007 will not be totally reflective of the increased costs to serve BCBSM beneficiaries and members. We would propose that 2007 costs be adjusted to include the new capital and operating costs in the rebasing process.

Thank you for your time to review our counterproposal. We stand prepared to meet with you as soon as practicable to conclude these payment discussions.

APPENDIX 29

Largest Network

Our network is the largest in the state. Nearly 30,000 doctors and 158 hospitals work with Blue Cross Blue Shield of Michigan and Blue Care Network.

Our PPO network: As a Blue Cross Blue Shield of Michigan member, you have access to all of the hospitals and more than 95 percent of the doctors in Michigan.

Our HMO network: As a Blue Care Network member, you have access to more than 5,000 primary care physicians, including family doctors, internists and pediatricians. You also have access to more than 15,000 specialists and most of the state's leading hospitals.

PPO or HMO, members can use our online search to easily find:

- A doctor, hospital or health care professional
- A dentist
- A vision care professional

FIND A DOCTOR >

Our pharmacy network is also extensive. Members can use a walk-in pharmacy or conveniently mail order medications.

Worldwide coverage

When you leave Michigan, your benefits travel with you.

Your enrollee ID card gives you access to more than 80 percent of the doctors and 90 percent of the hospitals in the United States.

The Bluecard Worldwide program gives you access to a network of over 900 hospitals in more than 130 countries when you're living or traveling abroad.

Visit the Blue Cross Blue Shield Association website to find health care professionals outside Michigan.

Blue Distinction® Centers

The Blue Distinction Specialty Care Program is a Blue Cross and Blue Shield Association program that recognizes hospitals that meet strict quality and cost-efficiency standards.

Blue Distinction Centers are available for:

- Bariatric surgery
- Cardiac care
- Complex and rare cancers
- Knee and hip replacement
- Spine surgery
- Transplants

The program has two designations for hospitals: Blue Distinction Centers and Blue Distinction Centers+.

- Blue Distinction Centers are hospitals that meet the program's quality standards for specialty care.
- Blue Distinction Centers+ are hospitals that meet the program's quality and cost-efficiency standards for specialty care.

You can use the Blue Distinction Center Finder to look for a center near you.

Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please call the customer service number on the back of your Blue Cross Blue Shield of Michigan or Blue Care Network identification card; and call your provider before making an appointment, to verify the most current information on their network participation status. Neither the Blue Cross and Blue Shield Association nor any of its licensees, including Blue Cross Blue Shield of Michigan and Blue Care Network, are responsible for any damages, losses or noncovered charges that may result from using this website or receiving care from a provider listed on this website.

APPENDIX 30

SECOND AMENDED AND RESTATED

PARTICIPATING HOSPITAL AGREEMENT

Revised – July 1, 2007

Exhibit B

REIMBURSEMENT

I. Implementation

Unless otherwise indicated, the following inpatient and outpatient reimbursement methodologies will be effective with the start of Hospital's fiscal year beginning on or after July 1, 2006.

II. Peer Groups

Hospitals will be categorized into one of the following peer groups:

PEER GROUP	HOSPITAL CHARACTERISTICS
1	Meet two of the following: - 50 or more full time equivalent (FTE) interns and residents - 325 or more licensed beds
2	Meet one of the following criteria: - Fewer than 50 FTE interns and residents - 325 or more licensed beds
3	Meet one of the following two groups of criteria: - Group one - meet both criteria · Non-rural * hospital · Fewer than 325 licensed beds - Group two - meet both criteria · Rural* hospital · More than 150 licensed beds
4	Meet all of the following criteria: - Rural * hospital - 150 or fewer licensed beds - Not in Peer Group 5
5	Meet all of the following criteria: - Rural * hospital - 100 or fewer licensed beds - Total annual equivalent inpatient admissions of less than 6000** - Hospital is not a specialty or limited service hospital without emergency room services.

6	Meet one of the following criteria: - Licensed as a psychiatric hospital - Received psychiatric exempt unit status from Medicare
7	Meet the following criteria: - Received rehabilitation exempt hospital or unit status from Medicare

* United States Census Bureau definition of rural

** Total acute care, psychiatric and rehabilitation inpatient admissions plus outpatient admissions calculated as follows: Outpatient charges / (inpatient acute care charges per inpatient acute care admissions)

III. Model Reimbursement Methodology for Peer Group 1-4 Hospitals

A. Reimbursement Principles

Hospitals' inpatient and outpatient rates and the reimbursement policies that guide the development of these rates will be based on the following principles:

1. [redacted]

2. [redacted] (Exhibit B, Section III, G)

3. [redacted]

4. [redacted] (Exhibit B, Section IV).

5. Hospitals' reimbursement and cost levels will be assessed [redacted]

APPENDIX 31

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

CONFIDENTIAL-- TO BE FILED UNDER SEAL
SUBJECT TO PROTECTIVE ORDER

THE SHANE GROUP, INC., et al., **Plaintiffs, on behalf of themselves and all others similarly situated,** **v.** **BLUE CROSS BLUE SHIELD OF MICHIGAN,** **Defendant.**	**No. 2:10-cv-14360-DPH-MKM**

EXPERT REPORT OF JEFFREY LEITZINGER, PH.D.
IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

Econ ONE Research, Inc.

October 21, 2013

550 South Hope Street, Suite 800
Los Angeles, California 90071

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I. Experience and Qualifications

1. My name is Jeffrey J. Leitzinger. I am an economist and President of Econ One Research, Inc., an economic research and consulting firm with offices in Los Angeles, Sacramento, Houston, Washington D.C., and Philadelphia. I have masters and doctoral degrees in economics from the University of California at Los Angeles and a bachelor's degree in economics from Santa Clara University. My doctoral work concentrated on the field within economics known as industrial organization, which involves the study of markets, competition, antitrust, and other forms of regulation, among other things.

2. During the past 33 years of my professional career, industrial organization has remained the principal focus of much of my work. I have worked on numerous projects relating to antitrust economics, including analyzing issues involving market power, market definition, and the competitive effects of firm behavior. I also have frequently assessed damages resulting from alleged anticompetitive conduct and have substantial experience in the calculation of damages in Class action litigation. Additionally, I have significant experience with economic issues related to Class certification in antitrust contexts.

3. I have testified as an expert in state and federal courts, and before a number of regulatory commissions. A summary of my training, past experience, and prior testimony is set forth in Exhibit 1.

4. Econ One is being compensated for the time I spend on this matter at my normal and customary rate of $675 per hour. Econ One also is being compensated for time spent by research staff on this project at their normal and customary rates.

II. Introduction, Assignment, and Materials Reviewed

5. In 2010, the U.S. Department of Justice ("US DOJ" or "DOJ") and the State of Michigan filed a civil antitrust action against Blue Cross Blue Shield of Michigan (BCBSM) "to enjoin [BCBSM] from including 'most' favored nation' clauses ("MFNs") in its contracts with hospitals in Michigan, to enjoin the enforcement of

such clauses by BCBSM, and to remove those clauses from existing contracts."[1] The DOJ complaint contended that the MFN agreements[2] reduced competition in the sale of health insurance throughout Michigan "by inhibiting hospitals from negotiating competitive contracts with Blue Cross' competitors.[3] The result, they alleged, was to reduce rivals' ability to compete and thereby raise prices paid by BCBSM rival health insurance companies, self-insured employers and their employees for hospital services.[4]

6. The complaints in this matter were filed by The Shane Group, Inc., Bradley A. Veneberg, Michigan Regional Council of Carpenters Employee Benefits Fund, Abatement Workers National Health and Welfare Fund, Monroe Plumbers & Pipefitter Local 671 Welfare Fund, and Scott Steele ("Plaintiffs") on behalf of themselves and all others similarly situated (the "Class" or "Class Members"),[5] against BCBSM.[6] Plaintiffs are health insurance companies, self-insured employers and their employees, and individuals with fully-insured health insurance plans, either through their employers or as individuals.

7. Like the US DOJ and the State of Michigan, Plaintiffs allege that the MFN clauses BCBSM introduced into its agreements with hospitals were anticompetitive.

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[1] *United States of America and the State of Michigan v. Blue Cross Blue Shield of Michigan*, No. 2:10-cv-14155-DPH-MKM, Complaint, (E.D. MI Oct. 18, 2010). http://www.justice.gov/atr/cases/f263200/263235.htm ("DOJ Complaint") at p.1.

[2] In some cases, these MFN clauses provided that the hospital in question would require reimbursement by other insurance companies that was equal to (or above) the reimbursement agreed to by BCBSM ("("Equal-to MFNs"). In other cases, these clauses provided that the hospital in question would require reimbursement on the part of other insurance companies that exceeded BCBSM's reimbursement by a minimum percentage.

[3] DOJ Complaint at p. 1.

[4] DOJ Complaint at p. 4.

[5] The Class is fully defined below in ¶7.

[6] *The Shane Group, et. al. v. Blue Cross Blue Shield of Michigan,* No. 2:10-cv-14360-DPH-MKM, Consolidated Amended Complaint, (E.D. MI June 22, 2012). I understand that The Shane Group, Inc., Bradley A. Veneberg, Monroe Plumbers & Pipefitter Local 671 Welfare Fund, Abatement Workers National Health and Welfare Fund and Scott Steele have moved the Court to be dropped from the case. I understand also that Patrice Noah and Susan Baynard have moved the Court to be added as named plaintiffs, and if the Court grants the motions of Ms. Noah and Ms. Baynard, then Plaintiffs' request that the Court accept this report on their behalf.

Plaintiffs further allege that these agreements artificially inflated the amounts that members of the proposed Class paid for hospital services. Plaintiffs propose a Class that includes all persons and entities that directly paid "Affected Hospitals" in Michigan for hospital healthcare services under "Affected Provider Agreements"[7] for the time periods set forth in Table 1 below. An Affected Hospital, a health insurer and an Affected Provider Agreement for a particular network are considered together an "Affected combination." The Class includes health insurance companies, self-insured employers and their employees, and individuals with fully-insured health insurance plans, either through their employers or as individuals.

Table 1: Affected Provider Agreements, Hospitals and Purchase Dates

Provider Agreement	Hospital	Dates of Affected Purchases
Aetna PPO Agreement	Bronson LakeView Hospital Three Rivers Health	01/01/08 – 05/18/12 01/01/10 – 05/24/12
BCBSM Non-HMO Agreement (inpatient claims only)	Beaumont Hospital - Gross Pointe Beaumont Hospital - Royal Oak Beaumont Hospital - Troy Providence Park Hospital St. John Hospital and Medical Center	01/01/09 – 01/01/12 02/07/06 – 01/01/12 02/07/06 – 01/01/12 07/01/07 – 07/01/10 07/01/07 – 07/01/10
HAP HMO Agreement (inpatient claims only)	Beaumont Hospital - Royal Oak	07/15/06 – 01/18/13
HAP PPO Agreement	Beaumont Hospital - Gross Pointe Beaumont Hospital - Royal Oak Beaumont Hospital – Troy	01/01/10 – 01/09/13 05/01/08 – 02/01/13 05/01/08 – 01/15/13
Priority PPO Agreement	Allegan General Hospital Charlevoix Area Hospital Kalkaska Memorial Health Center Mercy Health Partners - Lakeshore Paul Oliver Memorial Hospital	01/01/09 – 10/04/12 01/01/09 – 10/07/12 07/01/09 – 10/05/12 01/01/09 – 10/02/12 07/01/09 – 10/04/12
Priority HMO Agreement	Allegan General Hospital Mercy Health Partners - Lakeshore Paul Oliver Memorial Hospital Sparrow Ionia Hospital	01/01/09 – 10/05/12 01/01/09 – 10/04/12 07/01/09 – 10/04/12 12/01/08 – 10/02/12

8. Excluded from the Class are(1) BCBSM, its officers and directors, and its present and former parents, predecessors, subsidiaries and affiliates, and (2) insureds' whose only

[7] Provider Agreement here includes "Hospital Agreement," "Hospital Services Agreement," "Medical Services Agreement," "Facility Participation Agreement," "Facility Agreement," or amendments thereof.

payments to a hospital were (a) co-payments that do not vary with the size of the allowed amount, and/or (b) deductible payments where the hospital charge was larger than the deductible payment.

9. My assignment was as follows:

- Analyze the impact of the MFN agreements on amounts paid for hospital services;
- Determine whether all (or virtually all) Class members likely paid at least some overcharge in connection with payments for hospital services as a result of the MFN agreements;
- Determine whether total overcharges incurred by the Class as a whole can be calculated on a Class-wide, formulaic basis; and
- Discuss whether economic issues associated with proof of the alleged antitrust violation will involve economic evidence that is common to the proposed Class members.

10. In completing this assignment, my staff and I have reviewed the Consolidated Amended Complaint, documents, information, and testimony provided in discovery, academic literature, publicly available data, and claims data produced by BCBSM and Priority Health. A list of the materials reviewed at Econ One in connection with this assignment is attached as Exhibit 2. Additional materials developed in the process of continuing discovery may lead me to revise or supplement my findings and conclusions.

III. Summary of Conclusions

11. I have concluded that:

- The antitrust injury sustained by Class members in this case is reflected in increased rates of hospital reimbursement—both those paid by BCBSM as consideration for hospitals' agreement to MFNs and those imposed upon other insurers by hospitals in compliance with their MFN agreements with BCBSM. For each "Affected combination" shown in Table 1 economic evidence shows that MFN agreements led to higher payments for hospital

services. This evidence involves analysis of rates of reimbursement for eligible claims over time at the Affected combinations, as well as statistical comparisons of reimbursement rates at the Affected combinations compared with other hospitals involving the same insurers and networks where there were no MFN agreements.

- The reimbursement mechanisms set forth in the Affected Provider Agreements operated such that inflated rates of overall reimbursement would accompany inflated payments for all or virtually all of the claims paid pursuant to those agreements. Inflated claim payments mean that Class members paid overcharges. In particular, Class members that are health insurance companies paid increased amounts to cover their reimbursement obligations under fully-insured plans. Employer Class members paid increased amounts to cover their obligations under self-insured plans implemented on behalf of their employees. Class members who were participants in these plans (the patients receiving hospital services) paid increased amounts for the services through deductibles and co-insurance payments. As a result, all (or virtually all) Class members were impacted by higher hospital reimbursement rates stemming from the MFNs.

- I have concluded that the aggregate overcharges incurred by the Class is susceptible to formulaic calculation in a class-wide manner. Individualized analysis on the part of Class members will not be necessary. In particular, using claims data provided by BCBSM and other insurers in this case, statistical analysis of reimbursement rates across hospitals in the State of Michigan with and without MFN agreements can be used to measure the impact of those agreements on reimbursement for hospital healthcare services. That impact can be used in turn to quantify the amount by which total reimbursements paid by the Class members as a whole were inflated by virtue of the MFN agreements.

- BCBSM sells health insurance. From that perspective, the potential anticompetitive purpose in MFN agreements would be to raise the costs of hospital services to its health insurance competitors, thereby increasing BCBSMs monopoly power as a health insurance seller. Plaintiffs allege that

the product market relevant to this claim is commercial health insurance. The economic evidence which bears on this question is common to members of the proposed Class as a whole.

- The relevant geographic market for this case will be determined by evidence regarding the geographic scope of BCBSMs commercial insurance business and the geographic reach of the conduct at issue. This will be the same evidence from the vantage point of (i.e. common to) each Class member.

- Assessment of the monopoly power effects conferred by BCBSM's MFN clauses also will involve economic evidence that is common to members of the proposed Class. In particular, it would involve the manner in which BCBSM's MFN clauses served to increase the costs incurred by BCBSM's rival insurance providers and the effects of those higher costs on competition among insurance providers. The answers to these questions will not depend upon the circumstances of individual Class members.

- Finally, the economic evaluation of pro-competitive justifications (if any) involves common questions from the standpoint of the Class. In essence, one would be looking to see whether the MFNs in question gave rise to efficiency benefits (a) sufficient to outweigh the artificially inflated reimbursement costs and (b) that could not have been achieved in less restrictive ways. These questions--and the economic evidence needed to resolve them--are common to the proposed Class members.

IV. Background

A. Michigan Health Care

12. Michigan is the eighth largest state in the country by population, just under ten million people. The largest share of Michigan's population is concentrated near Detroit in the southeast corner of the state.[8] Other highly populated areas include

[8] About 40 percent of the population live in Detroit-Warren-Livonia, MI Metro Area, Wayne, Macomb, and Oakland Counties and Ann Arbor, MI Metro Area, and Washtenaw County.

Grand Rapids along the western border,[9] Flint - northwest of Detroit,[10] Lansing in the south-central region,[11] and Kalamazoo in the southwest. Combined, these areas, all of which are in the "Lower Peninsula," comprise more than 60 percent of the Michigan population. In total, the Lower Peninsula is 97 percent of the population [12] The "Upper Peninsula" has about three percent of the population; Marquette, the largest city on the Upper Peninsula, has about 20,000 people.[13]

13. In 2006, 90 percent of Michigan residents had health insurance of which about 84 percent was privately-offered. Of private insurance, about 91 percent was employment-based. By 2011 the share of residents with health insurance had declined to about 87 percent; 50 percent was employment-based, five percent was purchased directly by individuals, and 32 percent was supplied by government sources. About 31 percent of Michigan's employers, accounting for about 61 percent of employees, were self-insured.

14. The American Hospital Association ("AHA") reports that in 2011 there were 174 hospitals in Michigan with about 28,356 total hospital beds. 130 hospitals provide general acute care, including medical and surgical inpatient and outpatient services.[14] The hospitals listed in Table 1 are acute care hospitals. Exhibit 3 presents descriptive

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[9] Grand Rapids-Wyoming, MI Metro - Kent County.

[10] Near Detroit Metro in Genesee County.

[11] Lansing-East Lansing MSA.

[12]Michigan has about 9.8 million people. The Upper Peninsula has about 300,000 people (*See, e.g.,* Cabell, Brian, "U.P. Loses Population in Census," March 22, 2011), thus about 9.5 million in the Lower Peninsula, or 97 percent.

[13] The UP has about 300,000 people. *See, e.g.,* Cabell, Brian, "U.P. Loses Population in Census," March 22, 2011. Marquette population available at http://www.city-data.com/city/Marquette-Michigan.html ("Population in 2012: 21,532").

[14] The Michigan Health & Hospital Association defines an acute care hospital as a "[f]acility offering inpatient, overnight care, and services for observation, diagnosis and active treatment of an individual with a medical, surgical, obstetric, chronic or rehabilitative condition requiring the daily direction or supervision of a physician." ("Glossary of Health Care Terms"). Between 2005 and 2011, the number of acute care hospitals varies between 130 and 134 (for a total of 136 hospitals overall.) *See* The American Hospital Association's *Annual Survey Database,* 2005 - 2011.

statistics about acute care hospitals, such as the number of beds, total admissions, geographic location information, BCBSM Peer Group[15] and MFN status.

15. Michigan acute care hospitals are located in 118 cities, with anywhere from one to six per city (in Detroit).[16] Most (106, or 78 percent) are located in 34 urban core-based statistical areas ("CBSA") which each have a population greater than 10,000.[17] Of these, 25 (24 percent) are located in micropolitan statistical areas, or urban areas with between 10,000 and 50,000 people, and 81 (76 percent) are in metropolitan statistical areas (MSA) with a population greater than 50,000. 40 acute care hospitals are located in MSAs that have more than 2.5 million people.[18] The remaining 30 hospitals are located in smaller, rural areas with fewer than 10,000 people. Some hospitals in Michigan are part of larger systems of hospitals. Exhibit 3 also identifies system affiliation for Michigan acute care hospitals.

16. Hospital charges comprise the largest single share of all types of health care expenditures.[19] In Michigan, the average charge for a hospital stay in 2011 was $25,347; the median was $14,985.[20] Given these costs, most consumers or their

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[15] BCBSM employed a Peer Group (PG) system to compare Michigan hospitals to one another and to designate reimbursement models used in their contracts. See Section V for an additional description of BCBSM's Peer Group designations.

[16] AHA ANNUAL SURVEY DATABASE, FY2011. Chicago: Health Forum LLC, an American Hospital Association company, 2012 ("AHA Survey Database, 2011").

[17] For a description of how metropolitan areas are defined by the U.S. Department of Commerce, Bureau of the Census see http://www.census.gov/population/metro/about/.

[18] AHA Survey Database, 2011.

[19] Hospital charges are about 31 percent relative to doctor visits, prescription drugs, and other healthcare. "Healthcare Costs, A Primer. Key Information on Healthcare Costs and Their Impact", The Henry J. Kaiser Family Foundation, May 2012 at p. 10 In Michigan, private payors pay about 30 percent of hospital charges. *See, e.g.,* U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, State Statistics - 2011 Michigan ("Michigan Discharge Statistics for 2011":), *available at* http://hcupnet.ahrq.gov/HCUPnet.jsp?Parms=H4sIAAAAAAAAAEuxSCxOLEz09TQ0TMtKSwtOSk3KCXAMSUxOTElKSU5JScxMy0wEwjQwMEpM8rW0zDDIMMwwyjDOMMkwS0tLBABIG7aiQwAAAAD054CA17115D6AF7F43458EC7BABD4E4857C6CB6&JS=Y (last visited in October 2013). This is true for BCBSM as well. For example, in 2005, hospital visits were its largest dollar volume of claims relative to professional fees, master medical, pharmacy, dental, vision, and hearing. BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989372 and BLUECROSSMI-99-00989393.

[20] See Michigan Discharge Statistics for 2011. The average (median) charge for a hospital stay paid under private insurance (i.e., commercial) was $22,650 ($13,150) in 2011.

employers purchase health insurance.[21] Payment for hospital health care services therefore may involve multiple parties, including the patient, a health insurance provider and (often) the patient's employer.[22]

B. Health Insurance

17. Health insurance plans provide their covered participants with access to a network of health care providers, including hospitals, often at rates that are discounted compared with those paid for services outside of the plan.[23] The U.S. Census Bureau reports that about 87 percent of Michiganders with private insurance are covered by an employer-sponsored health plan.[24] Employers may cover all, some, or none of the

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http://hcupnet.ahrq.gov/HCUPnet.jsp?Parms=H4sIAAAAAAAAAEuxSCxOLEz09TQ0TMtKSwtOSk3KCXAMSUxOTElKSU5JScxMy0wEwjQwMEpM8rW0zDDIMMwwyjDOMMkwS0tLBABIG7aiQwAAAAD054CA17115D6AF7F43458EC7BABD4E4857C6CB6&JS=Y.

[21] About 18 percent of Americans are uninsured (*See, e.g.,* http://www.cdc.gov/nchs/fastats/hinsure.htm). In Michigan, about 87.5 percent of residents have some form of health insurance (12.5 percent of residents are thus uninsured). About 68.5 percent have private insurance. (http://www.census.gov/hhes/www/cpstables/032012/health/toc.htm

Additionally, about three percent of discharges from Michigan hospitals in 2011 were for uninsured individuals. (*See, e.g.,* http://hcupnet.ahrq.gov/HCUPnet.jsp?Parms=H4sIAAAAAAAAAEuxSCxOLEz09TQ0TMtKSwtOSk3KCXAMSUxOTElKSU5JScxMy0wEwjQwMEpM8rW0zDDIMMwwyjDOMMkwS0tLBABIG7aiQwAAAAD054CA17115D6AF7F43458EC7BABD4E4857C6CB6&JS=Y).

[22] Michael A. Morrisey, "Health Insurance" Health Administration Press, Chicago, Illinois AUPHA Press, Washington, DC, 2008 ("Morrisey") at p.42. ("Analysis of the demand for health insurance is complicated by the fact that most people in the United States get their insurance through their workplace."). *See also*, Katherine Ho, "The Welfare Effects of Restricted Hospital Choice in the US Medical Care Market," J. Appl. Econ. 21: 1039–1079 (2006) ("Ho (2006)") at p.1042. While some employers may offer employees a choice of plans, typically they offer only one plan of a benefit plan type (e.g., one PPO). (*See, e.g.*, The Kaiser Family Foundation and the Health Research & Educational Trust, "Employer Health Benefits 2012 Annual Survey: Survey," at p.65.). ("Most firms that offer health benefits offer only one type of health plan (82 percent)") For definitions of fully- and self- insured employers, see ¶24.

[23] Enrollees are given financial incentives to visit a specific provider, and the provider offers a discount in exchange for increased patient traffic resulting from the discount. See, e.g., Peter R. Kongstvedt, "Essentials of Managed Health Care, Sixth Ed., ("Kongstvedt Essentials") at p.144. Discounted rates mean that a provider charges a lower rate than its full billed charge (i.e., list price).

[24] United States Census Bureau, Health Insurance Coverage Status and Type of Coverage by State and Age for All People, available at http://www.census.gov/hhes/www/cpstables/032012/health/toc.htm, (Table h05_000.xls).

price of an employee's health insurance benefit plan (i.e., the "premium") as well as additional direct costs of health care procedures billed by providers.

18. Employer-sponsored health plans are financed under two mechanisms: full insurance or self insurance. Under a fully-insured plan, an employer pays a premium to a health insurance carrier such as BCBSM, which underwrites the risk (assumes financial responsibility) for the costs of employees' future health care needs.[25] With self insurance, the employer underwrites the cost of its employees' health care needs.[26] There are a variety of hybrid plans under which the employers and insurance companies share this responsibility.

19. A self-insured employer may contract with an insurance carrier such as BCBSM or a third-party administrator to handle claims processing under an administrative services only contract ("ASC" or "ASO"). As an ASC or ASO, a self-insured employer may also contract with an insurance carrier for access to its discounted network of health care providers, including hospitals.[27]

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[25] Minus contracted patient payment such as deductibles, co-payments, and/or co-insurance. "Delimitations of Health Insurance Terms," Bureau of Labor Statistics of the U.S. Department of Labor http://www.bls.gov/ncs/ebs/sp/healthterms.pdf. ("Health Terms")

[26] https://www.michigan.gov/lara/0,4601,7-154-35299_10555_12902_35510-263297--,00.html. Some self-insured firms purchase stop-loss coverage, or reinsurance that limits the amount an employer will have to pay for an employee's health care (also known as an individual limit) or an overall maximum for total expenses (i.e., a group limit). [redacted]

[27] Morrisey at p. 69. A self-insured payor may also lease a provider network from a payor but hire a third-party administrator ("TPA") for claims processing. For example, I understand from counsel that this is how Carpenter's, one of the named plaintiffs, manages its health plan. Carpenters leases a provider network from BCBSM but BeneSys administers its claims (*See, e.g.,* http://www.benesysinc.com/dnn/AdministrativeServices.aspx). At BCBSM:

> An ASC group assumes all of the benefit expense risk. Claims payments are the responsibility of the employer and not the insurance company. An ASC group will contract with an insurance company to administer the plan to receive the benefits of negotiated price discounts received by the insurer. The insurer may provide services that include enrollment, eligibility, claim and other administrative services. An ASC group will pay the insurer an administrative fee. ASC groups also have the option of purchasing stop-loss coverage. (BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989353).

20. BCBSM offers ASC plans to firms with more than 50 employees. A BCBSM executive testified that most employers with more than 1,500 employees buy ASC plans, while employers with between 50 and 1,500 employees either buy ASC contracts or fully-insure.[28] BCBSM sells local ASC plans to companies with most of their presence in Michigan as well as national plans for companies with multi-state locations.[29]

21. Health plans also vary according to the nature of the provider network available to the patient.[30] Traditional insurance (an indemnity plan) reimburses the member for covered health care expenses performed by any provider, at any hospital. This is also known as a fee-for-service health plan, because the provider bills for each service as it is performed.[31] Fee-for-service health plans represented a small and declining portion of the Michigan health insurance market during the period at issue. Furthermore, it is not clear that MFNs (which were directed at the discounts agreed to by hospitals from their billed charges) were even applicable here and so I understand are not in the Class. Hence, they have not been included in the analysis.[32]

22. In contrast to full indemnity plans, managed care plans offer lower premiums to patients (or their employers) for access to a more limited set of "in-network" providers. Hospitals typically discount their rates in order to participate in managed care networks. Under these plans, patients pay additional amounts if they use providers outside of the network ("OON").[33] The MFNs at issue in this case

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[28] BCBSM does not offer ASC plans to employers with fewer than 50 employees because there is no demand for it. *See,* Deposition of John Dunn, October 12, 2012 ("Dunn Deposition") at 160-163.

[29] Dunn Deposition at 165:16-19.

[30] Ho (2006) at 1042.

[31] Glossary of Health Care Terms and Health Terms.

[32] BCBSM EDW data, which includes claims covered by its PPO plans, may also have included indemnity plans. BCBSM did not provide sufficient means for distinguishing between different types of insurance networks in the EDW. "Supplemental Responses to Feb 14, 2013 Revised Questions for BCBSM Regarding EDW and BCN Data" at p.9 ("Product data as a subject area has not been implemented in the EDW."). However, it is my understanding that the vast majority of claims in the EDW are PPO claims. Of BCBSM enrollees in non-HMO commercial plans, 97 percent have a PPO plan.

[33] Ho (2006) at 1039, Health Terms, and http://www.bcbsm.com/providers/help/glossary/provider-m.html.

pertained to reimbursement paid to hospitals that participated in associated managed care networks.

23. There are different types of managed care plans including preferred provider organization plans ("PPOs"), Exclusive provider organization plans ("EPOs"), Health maintenance organizations ("HMOs"), and Point-of-service plans ("POSs"). The U.S. Bureau of Labor Statistics Employee Benefits Survey describes these plans as follows:

- **Preferred provider organization (PPO) plan** - An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or nondiscounted charges from the providers.

- **Exclusive provider organization (EPO) plan** - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

- **Health maintenance organization (HMO)** - A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.[34]

- **Point-of-service (POS) plan** - A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional

[34] An HMO is typically lower priced, with a smaller network. *See, e.g.,* Dunn Deposition at 154:12-13.

indemnity plans (e.g., provide reimbursement based on a fee schedule or usual, customary and reasonable charges).[35]

24. In 2012, 66 percent of commercially insured Michiganders had PPOs and 23 percent had HMOs (eight percent had POS and three percent had indemnity plans.) About 54 percent of people enrolled in commercial insurance in Michigan have a fully-insured plan. About 40 percent of people with a PPO or POS have a fully-insured plan. That share grows to 98 percent for HMO plans.

C. Health Insurance Payors

25. The insurance companies analyzed in my work to date--BCBSM, Priority Health, Health Alliance Plan ("HAP") and Aetna--include the three largest providers of managed care within the state. Together they accounted for about 80 percent of the state's commercial health insurance. Based upon the data provided in this case, the Affected combinations in Table 1 account for more than 700,000 hospital claims during the class period. I would expect those claims to involve thousands of individual Class members.

1) BCBSM

26. BCBSM designs, sells, and manages health benefit plans for individuals, families, and Michigan-based employers.[36] It is the largest of the 38 independently-licensed members of the Blue Cross Blue Shield Association,[37] With $19.3 billion in revenue in 2010[38] (and $6.1 billion in premiums earned from fully-insured plans in 2011),[39]

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[35] See Health Terms.

[36] Blue Cross Blue Shield website, Fast Facts, available at http://www.bcbsm.com/index/about-us/our-company/fast-facts.html (last visited in October 2013).

[37] BCBSA is a national federation of independently licensed, community-based and locally operated Blue Cross® and Blue Shield® companies http://www.bcbsm.com/index/about-us/our-company/blue-cross-blue-shield-association.html and http://www.bcbs.com/about-the-association. See Dunn Deposition Exhibit 9 (BLUECROSS-99-01577870) at BLUECROSS-99-01577882.

[38] BLUECROSS-MI-99-01577870 at BLUECROSS-MI-99-01577882.

[39] This excludes government-sponsored plans and workers compensation.

BCBSM is also the largest health insurer in Michigan.[40] It has the most members and the largest network of hospitals and physicians in the state.[41] In 2012, BCBSM represented 61 percent of commercial health coverage in Michigan, with 59 percent of fully insured and 63 percent of self-insured. Across 2003-2011, BCBSM's share of lives covered in the fully insured market ranged from 54 to 60 percent (Exhibit 4).

27. $5.6 billion of BCBSM's fully-insured premium revenue comes from commercial group plans.[42] Remaining income is derived from Medicare, Medicaid, and other state-funded programs, as well as individual insurance plans. BCBSM offers both PPO and HMO health benefit plans to groups and individuals. BCBSM also offers administrative services contracts ("ASCs") for self-insured organizations which use its provider network.[43] ASCs comprise about 47 percent of BCBSMs total enrollees. BCBSM administers health care plans for employees/retirees of Ford, Chrysler, General Motors and the State of Michigan.[44] BCN, a BCBSM subsidiary since 1998, offers BCBSM's HMO plans for groups and individuals and also manages some ASCs.[45] About 18 percent of BCBSM enrollees are in HMO plans.

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[40] State of Michigan Office of Financial and Insurance Regulation ("OFIR"), *Blue Cross Blue Shield of Michigan Annual Statement for 2011*, Statement of Revenue and Expenses. In 2010, BCBSM earned $6.6 billion in revenue and $205 million in net income. ("BCBSM OFIR Annual Statement 2011") at p.4.

[41] BCBSM has 4.4 million members, or more than 40 percent of the state's total population (with 1.2 million more members in other states) and its network includes 156 hospitals. (Available at BCBSM website, Fast Facts, available at http://www.bcbsm.com/index/about-us/our-company/fast-facts.html) *See also*, Connelly Deposition at 99:22-24.

[42] BCBSM OFIR Annual Statement 2011 at p. 4.

[43] Department of Insurance and Finance Service website, Blue Cross Blue Shield of Michigan (BCBSM), http://www.michigan.gov/lara/0,4601,7-154-35299_10555_12902_35510-262303--,00.html and BCBSM website, Fast Facts, available at http://www.bcbsm.com/index/about-us/our-company/fast-facts.html.

[44] Department of Insurance and Finance Service website, Blue Cross Blue Shield of Michigan (BCBSM), available at http://www.michigan.gov/difs/0,5269,7-303-12902_35510-262303--,00.html

[45] See BCBSM website, Fast Facts, available at http://www.bcbsm.com/index/about-us/our-company/about-bcn/fast-facts.html. Additional BCBSM subsidiaries include the Blue Cross Blue Shield of Michigan Foundation (funding for health care research), Accident Fund Holdings, Inc. (workers compensation insurance), and LifeSecure Insurance Company (long-term care, hospital recovery, and personal accident insurance). *See, e.g.,* Blue Cross Blue Shield of Michigan Foundation website, http://www.bcbsm.com/content/microsites/foundation/en/index.html, Accident Fund website,available at http://www.accidentfund.com/, and LifeSecure Insurance Company website, available at

2) **Priority Health**

[redacted]

[redacted]

3) HAP

30. Health Alliance Plan ("HAP"), a nonprofit, regional health plan based in Detroit and owned by the Henry Ford Health Care Corporation, is the third largest health provider in Michigan.[52] HAP was founded in 1956 as a physician group practice for the United Auto Workers and was licensed as a Michigan HMO in 1976. The company added a PPO network line in the 1990s, through its subsidiary Alliance Health and Life Insurance Company (AHL).[53] In 2006, HAP acquired CuraNet, LLC, a regional network of providers in Michigan as well as parts of Indiana and Ohio (Of 78 hospitals, 61 are in Michigan, 8 are in Ohio, and 9 are in Indiana).[54] CuraNet's PPO network is available to HAP's PPO customers through HAP Preferred and through AHL.[55]

31. HAP has more than 675,000 members.[56] Its HMO networks are available in nine counties surrounding Detroit, and its PPO networks are available there as well as in an additional 14 counties.[57] HAP leases its PPO network to third party administrators through its subsidiary company, HAP Preferred Inc.[58] In 2012, HAP represented 7 percent of commercial health coverage in Michigan, with 10 percent of fully insured and 2 percent of self-insured. HAP covered 22 percent of the HMO market and 2 percent of the PPO market. From 2003-2011, HAP's share of lives covered in the fully insured market ranged from 10-12% (Exhibit 4).

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[52] In terms of total commercial enrollment. Payor Market Share by Product Type - 2012.xlsx. History of HAP available at http://www.hap.org/corporate/history.php. HAP 2012 Annual Financial Statement available at http://www.michigan.gov/documents/difs/Health_Alliance_Plan_of_MI_413300_7.pdf.

[53] History of HAP available at http://www.hap.org/corporate/history.php.

[54] *See, e.g.,* http://www.curanet.org/pr.html and http://www.hap.org/internet/pcp/doc/pregeneratedPDF/ALL_03.pdf

[55] Of note, none of the Indiana or Ohio hospitals are in-network for the HAP Preferred Plan See, e.g., https://www.hap.org/internet/pcp/doc/pregeneratedPDF/PY1_03.pdf

[56] HAP fact sheet, available at http://www.hap.org/docs/fact_sheet.pdf .

[57] HAP Market Area available at http://www.hap.org/healthinsurance/service_area.php.

[58] HAP fact sheet available at http://www.hap.org/docs/fact_sheet.pdf.

4) **Aetna**

32. Aetna Inc. ("Aetna") is a national multiple line public insurance company, founded in 1853[59]. As of 2013, Aetna is the third largest health care benefits company in the country with 22 million members worldwide.[60] Aetna's medical insurance networks in the US include POSs, PPOs, HMOs, indemnity plans, and health savings accounts ("HSA") networks.[61] Aetna also offers Medicare and Medicaid networks and services.[62]

33. In June of 2005 Aetna entered the Michigan healthcare market through the acquisition of HMS Healthcare, a leading regional health care network which operated in Michigan as Preferred Provider Organization of Midwest ("PPOM").[63] Currently Aetna's only plan offerings in Michigan are PPOs.[64] In Michigan, Aetna currently holds a 4 percent share of the total commercial health insurance market. Aetna earned $129 million in premiums in 2011, with $97 million in premiums earned from commercial group plans and the remaining $31 million from individuals.[65] In 2012, Aetna represented 4 percent of commercial health coverage in Michigan, with 2

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[59] Aetna Corporate Profile, available at http://www.aetna.com/about-aetna-insurance/aetna-corporate-profile/index.html.

[60] Aetna at-A-Glance: Aetna Facts, available at http://www.aetna.com/about-aetna-insurance/aetna-corporate-profile/facts.html.

[61] Aetna Inc. Annual Report on Form 10-k For Year Ended December 31, 2012, available at http://services.corporate-ir.net/SEC.Enhanced/SecCapsule.aspx?c=110617&fid=8639283.

[62] Aetna Inc. Annual Report on Form 10-k For Year Ended December 31, 2012, available at http://services.corporate-ir.net/SEC.Enhanced/SecCapsule.aspx?c=110617&fid=8639283.

[63] "Aetna To Acquire HMS Healthcare," Aetna Press Release, June 24, 2005, available at http://www.aetna.com/news/2005/pr_20050624.htm.

[64] Aetna Michigan Health Insurance Plan Choices, available at http://healthinsurance.aetna.com/state/michigan/individual-health-insurance/health-plans. Although Aetna produced data from "Aetna's HMO systems," its executives testify that it has not had an HMO plan in Michigan since 2006. Therefore, I have excluded HMO claims in this database from my analysis. *See, e.g.,* Deposition of Bill Berenson, October 11, 2012,76-80; Deposition of Kirk Rosin, November 27, 2012 at 216-217.

[65] State of Michigan Office of Financial and Insurance Regulation ("OFIR") premium calculation. "Relevant market" includes individual and group coverage and excludes Medicare, other government coverage, stop loss, and standalone dental and vision plans. Premiums earned is the total premiums collected over the year pro-rated based on their effective life.

percent of fully insured and 7 percent of self-insured. Aetna covered 5 percent of the PPO market and virtually none of the HMO market. From 2003-2011, Aetna's share of fully insured lives in Michigan ranged from 0.4 to 3.0 percent (Exhibit 4).

D. Provider Networks

34. In managed care, the provider network plays an important role both in the cost and the attractiveness of the plan. As one author put it, "The backbone of any managed health care plan is the provider network."[66] Depending upon the size of a company and how dispersed are its employees' locations, the breadth of the network can determine which plans the employer buys.[67] Some consider a broad network vital.[68] Employees and individuals demand access to health care near where they live and work.[69]

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[66] Kongstvedt Essentials at p. 58.

[67] *See, e.g.*, Deposition of Douglas Darland (Volume II), November 15, 2012 ("Darland Deposition Vol. II") at 354:6-7 ("It would be more difficult to be able to secure certain customers without a broader network."). *See also* Deposition of Jeffrey L. Connolly, August 12, 2012 ("Connolly Deposition") at 99:1-8: "Q Why is it important to have an extensive provider network in each of your four regions? A Appropriate access for our existing membership or for new membership. Q Anything else? A Yeah. It really depends on the region, but, you know, it helps keep -- it helps mitigate the cost of care." *See also* 100:9-14 "Q When is the breadth of Blue Cross Blue Shield of Michigan's provider network as compared to your competitors a competitive advantage? A. A couple of examples would include if you have a large employer with employees located in multiple locations, that's considered a competitive advantage."

[68] Peter R. Kongstvedt, MD, *Managed Care: What it is and How it Works, Third Edition*, Jones and Bartlett Publishers 2013, at p. 75.

> Obviously, an MCO needs to have hospitals and institutional providers in its service area (e.g., acute care hospitals, skilled and intermediate care facilities, and all types of ambulatory facilities). Every MCO must ensure that all its members have access to reasonably convenient acute care, especially emergency care. […] Access is also a function of the services provided. For example, two nearby hospitals may differ in the services that they offer; only one of the two may offer obstetric services, whereas the other might be the sole provider of trauma services. An MCO must take the types of services into account, as well as location, when building its network of providers.

See also, Hall Deposition at 95:8-9 and 137:17-20. (Mark Hall, Vice-President of Commercial Sales and Service at Health Alliance Plan of Michigan ("HAP") testified that "[It is] an impediment if you don't have a network to cover all the employees of a certain customer" and considered HAP's lack of statewide network to be a weakness.)

[69] *See* Kongstvedt Essentials at p.75. [redacted]

> Access to care is the first and most important issue that an MCO [Managed Care Organization] faces. The MCO must ensure that the network is large enough and covers the proper geographic area to allow the MCO membership good access to all health care services. This means monitoring the number and types of provider practices by geographic location (usually zip code) […].[70]

35. BCBSM has almost every Michigan hospital in its PPO network.[71] Figures 1 and 2 show the location within the state of acute care hospitals that participate in BCBSMs PPO network. Commercial insurers recognize the value of broad networks. For example:

[redacted]

[70] Kongstvedt at p. 93.

[71] Dunn Deposition at 141:2-3 ("[I]n the PPO network, we've got every hospital, pretty much, in the state is in the network.").

[redacted]

[redacted]

- "[I]f you have a large employer with employees located in multiple locations, [then a large network is] considered a competitive advantage."[78]
- "[I]t would be more difficult to be able to secure certain customers" [without a broad network].[79]
- The strength of [BCBSM's] network (best access and discounts) and favorable brand positioning have traditionally provided competitive differentiation.[80]

E. Hospital Reimbursement

36. Hospitals typically maintain price lists for the health care procedures they offer,[81] often referred to as a charge master.[82] Hospitals use charge masters to arrive at

[redacted]

[78] Connolly Deposition at 100:9-14.

[79] Darland Deposition Vol. II at 354:6-7.

[80] Dunn Deposition Exhibit 9 (BLUECROSSMI-99-01577870 at BLUECROSSMI-99-01577884).

[81] These prices are typically called billed charges. FAIR Health defines a billed charge as "the amount billed by your physician or other healthcare provider for services you have received. If you use a provider in your plan's network, the billed charge usually is submitted directly to the insurer and is reduced by the claim

"billed amounts" for their services. Rarely, however, do insurance plans pay these billed amounts.[83] Instead, as diagrammed in Figure 3, the plan pays the hospital an "allowed amount" (for eligible claims) based upon its reimbursement agreement with the hospital.[84] I use the term "reimbursement rate" to refer to the percentage of the billed amount represented by the allowed amount. In effect, the hospital's agreement to accept the allowed amount constitutes its agreement to grant a discount relative to its list prices.

37. The amount paid to the hospital as reimbursement can be divided into two categories: plan liability and member liability. The plan liability is the share of the allowed amount paid directly to the hospital by the payor. This may be either the insurance company for fully-insured plans or the employer sponsoring a self-insured plan. Member liability is the share owed directly by the patient. The member's direct liability can be divided further into a deductible, copayment, and coinsurance. The federal Bureau of Labor Statistics ("BLS") defines these three payment categories as follows:

- Deductible: A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.

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payment system to the allowed amount, or contracted rate negotiated by your insurer and its network provider. But, if you use providers outside your network, you will generally have to pay the full difference between your insurer's allowed amount a the amount that your provider charges that exceeds the allowed amount unless you and your provider agree otherwise." http://www.fairhealthconsumer.org/glossary.aspx

[82] Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy," *Health Affairs*, 25, no. 1 (2006): 57-69 at p. 58 (http://content.healthaffairs.org/content/25/1/57.full.html) ("Reinhardt"). *See also*, Kongstvedt Essentials at p. 114.

[83] In some cases, contracts agree to reimbursement of "straight charges," or billed charges without any discounts. Kongstvedt at p.77. Theoretically, the uninsured pay actual charges. (*See, e.g.*, Reinhardt at p. 62). However, only a small share of uninsured patients pay their bills. See K. Kennedy, "Up to $49 billion unpaid by uninsured for hospitalizations", USA Today, May 13, 2011, available at http://usatoday30.usatoday.com/news/washington/2011-05-09-uninsured-unpaid-hospital-bills_n.htm

[84] Allowed (or allowable) amount is "the maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any co-insurance, deductible or amount beyond the annual maximum. Some plans may refer to the "allowable amount" as the "maximum allowable amount"; these terms have a similar meaning." ." http://www.fairhealthconsumer.org/glossary.aspx

- Copayment: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received.

- Coinsurance: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.[85]

V. BCBSM's MFN Clauses

38. The claim advanced by Plaintiffs in this case is that BCBSM included MFN clauses in its reimbursement agreements with many hospitals in Michigan, in some cases agreeing to increase the hospital's reimbursement rate as compensation for the hospital's agreement to accept and abide by MFN provisions, in order to limit the ability of other health care insurance providers to compete with it. In particular, by contractually guaranteeing that it would have the most favorable discount from hospitals (and, in many cases, the most favorable discount by a contractually stipulated margin), BCBSM forced those hospitals to set reimbursement rates with other insurers higher than they would have otherwise. Since the cost of hospital services is a key determinant in the overall costs of health insurance plans, this resulted in turn in higher insurance premiums on the part of other insurers, giving BCBSM more room competitively to charge higher rates and maintain higher market share. [redacted] Figures 1 and 2 show the location of hospitals within the State that agreed to MFN provisions in their contracts with BCBSM.

39. As I understand it, BCBSM followed a different approach to the formulation and implementation of its MFNs depending on the type of hospital. In that regard,

[85] *See* Health Terms.

[redacted]

BCBSM employed a Peer Group (PG) system to compare Michigan hospitals to one another and to designate reimbursement models used in their contracts.[87] BCBSM placed hospitals into one of five Peer Groups based upon their size (number of licensed beds and number of admissions), teaching status and location (rural versus urban).[88] PG 1 includes large teaching hospitals in urban areas. PG 2 through PG4 are other acute care hospitals of varying size and geography. PG 5 includes the smallest acute care hospitals with 100 or fewer licensed beds and fewer than 6,000 annual inpatient admissions. BCBSM employed a different reimbursement model for PG 5 hospitals than it did for PG 1 - PG 4 hospitals. Exhibit 5 reports the number and share of Michigan acute care hospitals by Peer Group.

A. Peer Group 5 Equal-to-MFN Clauses

40. Plaintiffs claim that beginning in 2007, BCBSM initiated a program to include MFNs in its contracts with all of its PG 5 hospitals.[89] As I understand it, Section V of the 2007 Second Amended and Restated PHA ("Second Amended PHA") created a PG 5 "Model Reimbursement Methodology" ("MRM") that computed hospital-wide reimbursement as a percent of billed charges.[90] Section V also included a "Most Favored Discount" ("MFD") provision requiring the hospital to attest that it would not agree to reimbursement rates for any other non-governmental commercial insurer

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[87] *See, e.g.*, BLUECROSSMI-99-204723 at BLUECROSSMI-99-204754 and BLUECROSSMI-99-06233228.pdf at 229. *See, also* BLUECROSSMI-99-103996.pdf at 104008-09. (In preparation for contract negotiations with hospitals, BCBSM has been known to prepare "Hospital Insight Reports" in which it benchmarks a hospital's performance relative to other hospitals in its peer group). *See, also* BLUECROSSMI-99-02245412.pdf at BLUECROSSMI-99-02245418. Additionally, in its 2000 calculation of a statewide base rate for hospital reimbursement, BCBSM calibrated this value using Peer Groups. The calibration shows how BCBSM regards Peer Groups as effective ways to compare hospitals. For example, the statewide base rate was calculated by summing the net costs for hospital-level base rates for all hospitals within a peer group and then, after certain adjustments, divided by the total admissions (adjusted for CMI) to create a "statewide base-year base rate for the peer group(s)" (BLUECROSSMI-99-103996.pdf at BLUECROSSMI-99-104008).

[88] Where rural is defined by the U.S. Census Bureau. Two additional peer groups designate psychiatric hospitals (PG 6) and rehabilitation facilities (PG 7). *See, e.g.*, BLUECROSSMI-99-204723 at BLUECROSSMI-99-204755 The analysis in this report does not address these facilities.

[89] I understand that the PHA relevant for PG1-4 hospitals was established in 2006, but did not contain an MFN requirement. *See, e.g.*, BLUECROSSMI-99-409543-590.

[90] *See, e.g.*, CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256025. See Section VI.C.1 for further discussion of BCBSM's reimbursement methodologies.

that were lower than BCBSM rates.[91] [redacted] PG 5 hospitals were required to be in compliance with this provision no later than their first fiscal year commencing on or after July 1, 2009.[93]

41. I understand that if a hospital did not agree to the MFD, BCBSM would calculate its reimbursement using the less favorable PG 1-4 model.[94] An e-mail exchange between Doug Darland of BCBSM and an executive for Sparrow Ionia Hospital outlined these consequences:

> [B]ased on the information available to us, it looks like the average discount provided to other commercial insurers is around 38 percent compared to our current discount of only 15 percent. This is "bad" because it officially exempts you from even being classified as a peer group 5 hospital. My guess is that the application of the peer group 4 reimbursement methodology would result in a discount in the 35 percent - 40 percent range.
>
> [...]
>
> [I]t is important that you address the discrepancy between the discount provided to BCBSM and the discount provided to other commercial payors. By my estimation, adjusting this discount to be equivalent to the discount you give BCBSM would increase your net revenue by over $1.5M.[95]

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[91] *See, e.g.*, CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256029.

[redacted]

[93] *See, e.g.*, CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256030. ("This section shall become effective no later than Hospital's fiscal year which commences on or after July 1, 2009")

[94] *See, e.g.*, Deposition of Steven Leach, March 15, 2012 ("Leach Deposition") at 78:24-79:4.

[95] Roeser Exhibits at SHS011937 (p.86).

42. Hence, by conditioning PG 5 status (and its higher reimbursement rate) upon acceptance of the MFN, BCBSM effectively paid PG 5 hospitals to accept that provision. In addition, BCBSM apparently offered in some cases to offer additional reimbursement even within the PG 5 methodology for hospitals that agreed to an MFN. Doug Darland encouraged Charlevoix Hospital to comply with the MFN noting that: "I think there is some room for discussion regarding year two and beyond, with key elements being the most favored discount issue and your overall financial viability."[96] Lastly, BCBSM employed a "standard update factor" as the automatic annual percentage rate increase in the PHA.[97] Another way BCBSM increased reimbursement to hospitals in exchange for an MFN was through an "update over the standard update." Mr. Darland testified that the MFN clause was seen by BCBSM as a "justification" for an additional update over the standard update.[98]

B. Peer Group 1-4 MFN-Plus Clauses

43. With the PHA's Model Reimbursement Methodology as the baseline for reimbursement for Peer Group 1-4 hospitals,[99] according to Plaintiffs, BCBSM approached PG 1-PG 4 hospitals seeking a different form of MFN protection, an MFN-Plus clause. This involves agreement by the hospital that any discount it gave to other commercial insurers would be no greater than the discount granted to BCBSM less an additional discount differential.[100]

44. In his contract negotiations with Ascension Health, Blue Cross executive Gerald Noxon discussed the MFN and BCBSM's "willingness to pay a premium for a

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[96] Deposition of William Jackson, Exhibit DOJ 10 (BLUECROSSMI-E-0113693). *See also,* Leach Deposition at 107:3-9 ("Q So the reason why there is an MFN clause in the contract with Paul Oliver and Kalkaska is for more favorable reimbursement? […] THE WITNESS: Correct. We're willing to live with the provision because we get favorable reimbursement.")

[97] CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256024 and CIVLIT-BCBSM-00256030

[98] Deposition of Douglas Darland, November 14, 2012 - Volume I ("Darland Deposition Vol. I"), at 49:6-10.

[99] See Section VI.C.1 for further discussion of the PHA MRM as applied to PG 1-4 hospitals.

[100] *See, e.g.*, Milewski Deposition, Exhibit 19 (BLUECROSSMI-E-0109264 at BLUECROSSMI-E-0109265 (Referencing negotiations with Metro Health Hospital, "It looks like we need to make sure that they get a price increase from Priority if we are going to increase their rates as you described."

commitment on this. BCBSM is looking for a significant spread,"[101] the value of a MFN spread (or "plus") greater than 20 points being "up to $7M."[102] In his contract negotiations with Beaumont Hospitals, Mr. Darland considered a 7-8 percent increase in exchange for a "strategic alliance" where Beaumont would shut out competing plans that approached them for a greater discount.[103]

VI. Common Evidence Capable of Proving Antitrust Injury To All or Virtually All Class Members

45. The antitrust injury sustained by Class members in this case is reflected in increased rates of hospital reimbursement—both those paid by BCBSM as consideration for hospitals' agreeing to MFNs and those imposed upon other insurers by hospitals in compliance with their MFN agreements with BCBSM. Higher reimbursement rates mean that the allowed charges remitted to the hospital for its services involve higher payment amounts.[104] Inasmuch as Class members are the ones who make these increased payments (excluding here the part of any increase in its reimbursement that

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[101] *See* Smith Deposition, DOJ Ex. 9 (AHSJP-037045 at -045).

[102] *See* Noxon Dep., DOJ Ex. 7 (BLUECROSSMI-10-009207 at -208) (document prepared for Ascension Meeting summarizing proposal terms from BCBSM including a $5 million one-time signing bonus payment and MFN clause, and the value of a MFN point spread); see also Noxon Dep., DOJ Ex. 8 (BLUECROSSMI-10-009368 at -371) (Noxon's Ascension discussion points document stating: "While a 10 point difference…is not the level of favored discount commitment that BCBSM had hoped, we are willing to add an addition .005 points to the 2008 update in order to help bring our discussions to completion. BCBSM would be willing to consider a larger add on if AH were willing to provide a larger point spread"). See also Darland Deposition, DOJ Ex. 5, (BLUECROSSMI-08-022036 at -036) (e-mail from Doug Darland to Kevin Seitz and Mike Schwartz regarding Beaumont hospitals and stating that "we should make sure we include some provision to protect our strategic advantage (i.e. better discount) if we are going to close the gap[,]" i.e. offer more than 4% increase in the first year of a three-year contract with $1.2 million signing bonus and standard update in the next two years).

[103] *See* M. Johnson Dep., DOJ Ex. 6 (BLUECROSSMI-99-051863 at -863) (email from Darland on 10/24/05 stating: "Beaumont offered to consider a 'strategic alliance' (my phrase) last year concerning their willingness to shut out competing plans that approach them for a greater discount, in exchange for an increase from BCBSM… It would likely cost us a substantial increase, say 7-8%, maybe a little more, but we would still have a 60+% discount, or about 30-50 points better than anyone else. I can't imagine this wouldn't be a fantastic long-term competitive advantage for us, despite the $25M upfront investment.").

[104] As an arithmetic matter, payment that provides an increased percentage of a fixed amount (the billed charge) must itself involve an increased amount.

is paid by BCBSM itself), increased reimbursement rates mean that Class members are overcharged in the amounts they pay for hospital services.

46. I find that as to each Affected combination shown in Table 1, there is economic evidence capable of showing that Plaintiffs' MFN agreements led to higher reimbursement rates for hospital healthcare services paid by Class members. For insurers other than BCBSM, this evidence derives in part from a comparison over time of the reimbursement rates at each of the Affected combinations with contemporaneous reimbursement rates being paid by BCBSM at those same hospitals. In this way, one can observe directly the manner in which increased reimbursement by the other insurer brought the hospital into compliance with its MFN. This evidence also includes statistical analysis of reimbursement rates from all of the Affected combinations in Table 1 (involving either BCBSM or the other insurers) in comparison to rates paid by the same insurer at comparable hospitals that did not have MFN agreements. This statistical analysis shows inflated reimbursement rates following the introduction of MFNs at all of the Affected combinations. This evidence is common to members of the proposed Class. I describe this evidence in more detail below.

A. Changing Reimbursement Rates and Compliance by Other Insurers

47. One way to observe the impact of an MFN on the reimbursement rate paid by a competing insurer at a BCBSM hospital with an MFN is through changes in the reimbursement rate following the introduction of the MFN. In particular, where the reimbursement rate being paid by a competing insurer was below the level required by the MFN,[105] one would expect to observe an increased reimbursement rate on the part of that insurer under its next effective contract to a level sufficient to bring the hospital into compliance. I observe this pattern for each of the Affected combinations (Table 1) that involve reimbursement by one of BCBSM's competitors. I summarize this evidence in Exhibit 6. Below, I describe an example of the patterns reflected in Exhibit 6 for each insurer.

[105] The BCBSM reimbursement rate in the case of an MFN clause and the BCBSM rate plus the contractual differential in the case of an MFN-plus clause.

1. *HAP reimbursement at Beaumont Hospital - Grosse Pointe under its PPO network*

48. BCBSM had an MFN-plus clause in its contract with Beaumont Hospital - Grosse Pointe that was effective on January 1, 2009.[106] In the years following the effective date of BCBSM's MFN-plus contract, BCBSM's reimbursement rate at that hospital for its PPO network averaged 39 percent. As I understand that clause, Beaumont Hospital - Grosse Pointe was required to negotiate a reimbursement rate from HAP that was at least 10 percentage points greater than its reimbursement rate from BCBSM.[107] In the years leading up to that new contract, HAP's reimbursement rate to Beaumont Hospital - Grosse Pointe under its PPO network ranged from 39 percent -46 percent, averaging 43 percent. On January 1, 2010, HAP entered into a new contract with the hospital.[108] In the years following the effective date of HAP's contract, its PPO reimbursement rate at the hospital averaged 49 percent, enough to bring it into compliance with the MFN-Plus clause. (Exhibit 6).

[redacted]

[106] BLUECROSSMI-99-388498.

[107] The contract required that BCBSM's rivals maintain the differential wedge between its reimbursement rate and that of its competitors that existed at the time of 2006 LOA, or minimally 10 percentage points. (BLUECROSSMI-99-388498).

[108] HAP-DOJ-003099.

[redacted] In some cases, the contract (or amendment) for the non-BCBSM insurers is dated

[redacted]

3. *Aetna reimbursement at Three Rivers Health under its PPO network*

50. BCBSM had an Equal-to-MFN clause in its contract with Three Rivers Health signed January 1, 2010.[111] As I understand that clause, Three Rivers Health was required to negotiate a reimbursement rate from Aetna that was greater than or equal to BCBSM's reimbursement rates. In the years following the effective date of BCBSM's MFN contract, its reimbursement rate at the hospital averaged 69 percent. In the years leading up to that new contract, Aetna's reimbursement rate to Three Rivers Health under its PPO contract ranged from 37 percent - 62 percent. On January 1, 2010, Aetna entered into a new agreement with the hospital.[112] Under the new contract, the rate paid by Aetna increased to73 percent. In the years following the effective date of Aetna's contract, its reimbursement rate at the hospital averaged 77 percent. (Exhibit 6).

B. Statistical Analysis of Difference-in-Differences in Reimbursement Rate

51. For purposes of analyzing the impact of BCBSM's MFNs on hospital reimbursement rates, I have employed difference-in-differences ("DID") analysis--implemented through a linear regression model--as to each of the Affected combinations.[113] In a

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prior to the official BCBSM MFN effective date. The reason for this is the effective date for the MFN was not July 1, 2009 but rather "no later than July 1, 2009." Some hospitals became compliant with the MFN before that date. Thus other insurers and hospitals arranged to comply with the BCBSM MFN before that date of compliance, sometimes well before July 1, 2009. [redacted]

[112] AETNA-00072525.

[113] For a discussion of DID regression analysis, See, James H. Stock and Mark W. Watson, *Introduction to Econometrics* at p. 480-483. For examples of DID used by economists, See, Joel Waldfogel and Jeffrey Milyo, "The Effect of Price Advertising on Prices: Evidence in the Wake of 44 Liquormart," American Economic

DID analysis, one measures the impact of an event on the potentially affected parties by comparing their experience before and after the event (i.e. the "difference" in results observed following the event) with the difference in results across the same time periods for a control group that was unaffected by the event. As an overarching matter, the selection of the control group in this analysis is a means for controlling for factors that may also have changed across the time periods in question other than the event of interest.

52. By embedding the DID analysis in a linear regression model, I am able to further account for factors that may differ among participants in the control group and, at the same time, the possibility that some of the relevant characteristics may have changed over time as to the affected party compared with the control group.[114]

53. In particular, I have estimated a regression equation for each Affected combination and its set of control group hospitals where the variable to be explained (i.e., the "dependent" variable) is the quarterly reimbursement rate of an insurer under one of its network plans at a particular hospital.[115] For purposes of identifying a control

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Review, 1999 at ; Justine Hastings, "Vertical Relationships and Competition in Retail Gasoline Markets: Empirical Evidence from Contract Changes in Southern California," American Economic Review 94, no. 1 (2004): 317–28;; Severin Borenstein, "Airline Mergers, Airport Dominance, and Market Power," American Economic Review 80, no. 2 (1990): 400–404; David Card and Alan B. Krueger, "Minimum Wages and Employment: A Case Study of the Fast-Food Industry in New Jersey and Pennsylvania," American Economic Review 84, no. 4 (1994): 772–93; and Joshua D. Angrist and Alan B. Krueger, "Does Compulsory School Attendance Affect Schooling and Earnings?" The Quarterly Journal of Economics 106, no. 4 (1991): 979–1014.

For examples where DID has been accepted by the courts, S*ee Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 815-16 (7th Cir. 2012); Expert Report of Dr. David Dranove Supporting Motion for Class Certification, Redacted Version for Public File, *In re: Evanston Northwestern Healthcare Corporation Antitrust Litigation,* February 18, 2009 ("Dranove Expert Report"); *See* Reply Report of Dr. David Dranove Supporting Motion for Class Certification, Redacted Version for Public File, *In re: Evanston Northwestern Healthcare Corporation Antitrust Litigation,* December 8, 2009 ("Dranove Reply Report"); *In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.,* No. 9315 (Fed. Trade Comm'n April 28, 2008), Initial Decision of Chief Administrative Law Judge Stephen J. McGuire (Aug. 6, 2007) as cited in Dranove Expert Report at p. 1 and 3; . *In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.,* No. 9315 (Fed. Trade Comm'n April 28, 2008), Opinion of Chairman Majoras (Aug. 6, 2007) as cited in Dranove Expert Report at p. 1 and 4.

[114] For an example where variables are added to a DID model to simultaneously account for factors in addition to the control group itself, *See* Dranove Reply Report at 38-46.

[115] MFN compliance is on an annual basis. However, I performed this analysis using quarterly-level

group, I have employed the Peer Group (PG) system utilized internally by BCBSM to group hospitals that share common characteristics for reimbursement purposes. In that regard, BCBSM utilizes five PGs which group hospitals based on their size (a range for the number of licensed beds and admissions), teaching status, and rural versus urban location.[116] BCBSM has employed these PGs for purposes of developing common reimbursement policies to be applied across similarly situated hospitals.[117] According to the Second Amended PHA: "Peer groups will be re-established to consider additional factors to more appropriately segregate hospitals into comparative groups."[118] The PG system effectively accounts for economic characteristics that are generally described in the literature as important to levels of hospital costs, which influence directly levels of reimbursement negotiated by hospitals and insurers.[119] Exhibit 7 shows the number of non-MFN hospitals within each of the first four PGs.

54. In order to be treated as a PG 5 hospital for reimbursement purposes, BCBSM required hospitals to agree to the Equal-to-MFN provision. Therefore, there are no PG 5 hospitals that do not have Equal-to-MFN clauses in their contracts with BCBSM. PG 4 and PG 5 hospitals are both located outside of major urban areas.[120] Other than the presence of an Equal-to-MFN, the only difference in the two PGs is (potentially) a 50-bed difference in size. I have not found evidence to suggest that this difference in size would play an important role in reimbursement generally. Importantly here, BCBSM told its PG 5 hospitals that, if they would not accept an Equal-to-MFN, they would be treated as a PG 4 hospital for purposes of reimbursement. Accordingly, I have used the reimbursement experience at PG 4

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reimbursement rates to ensure a sufficient sample size.

[116] BLUECROSSMI-99-204723 at BLUECROSSMI-99-204754.

[117] *See supra,* footnote 108.

[118] *See also* BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989373 (Included in a list of the main elements of the model reimbursement principles for the Second Amended PHA is the following: "Peer groups will be re-established to consider additional factors to more appropriately segregate hospitals into comparative groups.").

[119] *See, e.g.*, Dranove Expert Report at 24-27 and Dranove Reply Report at 37-46.

[120] BLUECROSSMI-99-204723 at BLUECROSSMI-99-204754.

hospitals without MFNs as a control group for purposes of the DID analysis as to the PG 5 hospitals listed in Table 1.[121]

55. As explanatory variables in the regression model in which the DID analysis is embedded, I have included the following:

- *MFN*: An indicator variable equal to one for Affected combinations and zero otherwise;
- *Post Period*: An indicator variable corresponding to the pre- versus post-MFN time period, where the variable equals one for the post-MFN period and zero for the pre-MFN period;
- *MFN*Post Period*: An interaction of *Post* and *MFN*, where the variable equals one for Affected combinations in the post-MFN period and zero otherwise. The coefficient on this variable measures the change in the reimbursement rate for an Affected combination relative to the control group in the post-MFN period;
- *Number of Beds*: A count variable of the total number of beds at a hospital per year, which controls for variation in the number of beds within a PG;
- *Average Length of Stay:* The annual total number of inpatient days at a hospital divided by the annual total of inpatient admissions, which provides a control for differences in the change in case severity by hospital over time;
- *Outpatient/Inpatient Ratio*: The ratio of a hospital's total outpatient visits to inpatient admissions each year, which provides another control for differences in the change in case severity by hospital over time;
- *Hospital Expenses*: A hospital's total annual expenses, which controls for variation in the change in expenses for hospitals of similar size over time;

[121] Even were it the case that a 50-bed size difference would itself normally produce a different level of reimbursement, this does not pose a problem for the DID analysis. The purpose of the control group is to establish a benchmark for the change in reimbursement as between the pre- and post-MFN periods. As long as the difference in levels associated with a 50-bed size difference remains the same in both periods, the PG4 control group will provide the right answer even given the differences in reimbursement levels.

- *Billed Amount:* The quarterly amount billed to an insurer under a specific network plan at a hospital, which controls for differences in the change in the influence of a specific insurer-network combination at a hospital over time;

- *Detroit CSA:* This variable is an indicator variable that takes on the value of one for hospitals in the BLS Detroit Combined Statistical Area, and zero otherwise. The Detroit CSA encircles an area generally considered to contain the area in which people in the Detroit area live, work, and play.[122] This indicator controls for differences in changes in macroeconomic conditions for hospitals located in Detroit and its environs relative to the rest of the State;[123] and

- *Quarterly fixed effects.*

56. I perform this analysis of reimbursement rates using the following data:

- Claims data provided by BCBSM, HAP, Priority and Aetna throughout the State of Michigan.[124]

- Counsel has provided effective dates (and, if available and relevant, termination dates)[125] for BCBSM MFN contracts (or LOUs) by network (i.e.,

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[122] *See* "OMB Bulletin No. 13-01: Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas," February 28, 2013 at p. 2 (A Combined Statistical Area (CSA) "can be characterized as representing larger regions that reflect broader social and economic interactions, such as wholesaling, commodity distribution, and weekend recreation activities, and are likely to be of considerable interest to regional authorities and the private sector." See also, p. 7.

[123] All hospitals in the regression models for two Affected combinations, Beaumont Hospital - Royal Oak/HAP/HMO and Beaumont Hospital - Troy/HAP/AHL PPO, are located in the Detroit CSA. Therefore, this variable is dropped from the regression in these instances.

[124] I understand that effective January 1, 2009, BCBSM instituted a "market-based pricing" initiative at certain PG 1-4 hospitals such that outpatient laboratory, radiology, and surgery services are priced similarly to the same procedures being performed by non-hospital facilities. I understand also that where hospital reimbursement for outpatient procedures was reduced due to this initiative, BCBSM increased reimbursement for inpatient procedures in a budget-neutral fashion that resulted in the same amount of overall reimbursement for the hospital as it received before the initiative. (MTH-EMAIL-001154 at MTH-EMAIL-001159). The potential influence of BCBSM shifting reimbursement from outpatient to inpatient payments is controlled by including both inpatient and outpatient claims in each regression model where BCBSM is a component of the Affected combination.

PPO or HMO), both for MFN Equal-To and MFN Plus agreements, at participating hospitals.

- Effective dates, provided by Counsel, for the first Priority Health, HAP or Aetna contract (or amendment) following the effective date of the MFN at the Affected hospital.

- Peer Group data produced by BCBSM and other data available publicly from the American Hospital Association.[126]

57. The results of this DID regression (in particular the coefficient estimated for the *MFN*Post Period* shift variable) show the impact on reimbursement for each Affected combination after accounting for the experience of the control group and the other factors included in the model. The results of this DID analysis are shown in Exhibit 8. As it shows, there were positive DIDs associated with each of the Affected combinations reflected in Table 1. That is to say, following the effective date of the MFN (or the date of the insurer's next contract after the effective date of BCBSM's MFN), reimbursement at each of the combinations shown in Table 1 was higher than the level one would have expected based upon the experience of the control group and the other variables included in the model. I conclude from this evidence that the MFN clauses produced increased rates of reimbursement (relative to levels that would otherwise have prevailed) at the combinations which define the members of the Class in this case.

C. Reimbursement Methodology

58. Having established that MFNs led to higher reimbursement rates and payments, the question then becomes whether or not those overcharges were born (at least in some

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[125] As far as MFN agreements that terminated within the Class period, Ascension Hospitals had a new BCBSM LOU effective 7/1/2010, including renewals at least until 2013, with no MFN. (BLUECROSSMI-99-153748 at 749). Beaumont Grosse Pointe, Troy, and Royal Oak had a new BCBSM contract effective 1/1/2012 through 12/31/2016, with no MFN. (BLUECROSSMI-99-02984062 at 063). I use claims data for my DID analysis of impact to BCBSM subscribers only through these dates. I am not aware that rival contracts were renewed before these dates and therefore do not restrict my DID analysis for them at these hospitals.

[126] AHA Survey Database, 2005-2011.

part) by all or virtually all Class members. Here again, there is evidence, common to members of the proposed Class, which indicates that the answer to this question is yes. That evidence derives from the reimbursement methodologies used by Priority, HAP, Aetna and BCBSM at the Affected Hospitals. In particular, the Provider Agreements that exist between each insurance company and each hospital (as applicable to each of the insurer's networks) set forth procedures by which the amount of reimbursement as to each eligible claim for coverage in regards to a particular hospital service is to be determined.

59. My analysis of those methodologies is capable of showing that higher reimbursement rates implemented as a result of the MFN agreements would have caused payments made for all (or virtually all) claims at the Affected combinations to increase, which means that all or virtually all of the payors of those claims (the Class members in this case) would all have paid at least some overcharge due to the MFNs. And, of course, the terms of insurer/hospital Provider Agreements constitutes evidence that is common to Class members. I discuss the reimbursement procedures associated with each insurer's Provider Agreements below, along with the basis for my conclusion that, within the context of those procedures, the effects of elevated reimbursement rates would be felt by all (or virtually all) Class members.

1. *BCBSM*

60. BCBSM utilized a standard provider agreement, called a Participating Hospital Agreement (PHA), with hospitals in Michigan.[127] That agreement both establishes an overall level of reimbursement for the hospital (relative to its costs) and provides a mechanism through which that overall level is translated into payments for each eligible claim. As noted above, the basis for the BCBSM hospital Model Reimbursement Methodology varies by Peer Group. As to overall reimbursement levels for PG 1- 4, the PHAs provided, generally speaking, for reimbursement at each hospital sufficient to cover the hospital's average cost of providing services, along with additional compensation for non-paying patients, teaching activities and a

[127] CIVLIT-BCBSM-00255983 and BLUECROSSMI-99-01010153.

margin.[128] BCBSM provides the following illustration in the PHA of how the Model Reimbursement Methodology works for PG 1-4 hospitals:

[128] CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256025 and BLUECROSSMI-99-01010153.

BCBSM's reimbursement methodology begins by covering a hospital's "Full-GAAP cost less bad debt, calculated using BCBSM charges and departmental costs." (CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256015). GAAP refers to "generally accepted accounting principles" which are a "set of assumptions, concepts, standards and procedures" that have been developed as an "underlying foundation for measuring and disclosing the results of business transactions and events." (Lanny M. Solomon, et.al., *Accounting Principles, 4th Ed. (Instructor's Edition)*, West Publishing Company, 1993 at p. 500.

BCBSM actually pays hospitals by making weekly prospectively determined interim payments ("BIP"). Then, periodic reconciliations are made relative to the actual claim reimbursement methodologies, described below, whereby the balance of payment either to or from the hospital is estimated. (CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00255997).

On top of the overall payment model illustrated above, due to their smaller size and other unique characteristics, BCBSM also compensates PG 5 hospitals for a share of the cost of uncompensated care (i.e., underfunding by government, bad debt and charity) and potential pay-for-performance. Reimbursement at the claim level, however, is on a percent of covered charges basis. BCBSM simply sets a reimbursement rate with the hospital and then calculates its payments as a percentage of the hospital's billed charges. For example, if the hospital billed $1,000 for a particular procedure and the reimbursement rate was 87 percent, BCBSM would pay the hospital $870 as an allowed amount for that procedure. (CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256025-74).

Table 2: BCBSM Peer Group 1-4 Patient Service Reimbursement

Cost Element	Percent	
Hospital Cost (GAAP Cost)	100.0 %	(a)
Margin	3.0	(b)
Uncompensated Care	3.1	(c)
Uncompensated Care Gross-up	1.0	(d)
Subtotal	107.1	
Pay for Performance	3.0	(e)
Total	110.1	
Other Operating Revenue Offset	(3.0)	(f)
BCBSM Patient Service Reimbursement	**107.1**	

(a) Full-GAAP cost less bad debt, calculated using BCBSM charges and departmental costs.

(b) Margin allowed on GAAP cost.

(c) Average statewide uncompensated care cost. The actual amount will be hospital specific and may be less than or greater than 3.1 percent.

(d) Up to an additional 1 percent payment on a statewide basis associated with the cost of uncompensated care.

(e) Potential P4P earnings on inpatient and outpatient operating costs is up to an additional 3 percent in the first year of the program, up to 4 percent in the second year and up to 5 percent by the third year and thereafter.

(f) Other operating revenue offset against BCBSM costs. The actual offset will be hospital specific and may be greater than or less than 3.0 percent.

Note: GAAP stands for generally accepted accounting principles.

Source: CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256015

61. To see how this would work in practice, I have overlaid the percentages shown above with some hypothetical cost amounts in the table below. In particular, I assume a hospital with $5 million in full-GAAP costs for the year in question.

Table 3: BCBSM Peer Group 1-4 Annual Patient Service Reimbursement Example

Cost Element[1]	Percent[1]	Example Amount ($)	Note
(1)	(2)	(3)	(4)
Hospital Cost (GAAP Cost)	100.0 %	$ 5,000,000	[a]	
Margin	3.0	$ 150,000	[b]	[B] = [a3]*[b2]
Uncompensated Care	3.1	$ 155,000	[c]	[C] = [a3]*[c2]
Uncompensated Care Gross-up	1.0	$ 50,000	[d]	[D] = [a3]*[d2]
Subtotal	107.1	$ 5,355,000	[e]	[E] = [a3]*[e2]
Pay for Performance	3.0	$ 150,000	[f]	[F] = [a3]*[f2]
Total	110.1	$ 5,505,000	[g]	[G] = Σ([B] through [F])
Other Operating Revenue Offset	(3.0)	$ (150,000)	[h]	[H] = [a3]*[h2]
BCBSM Patient Service Reimbursement	**107.1**	**$ 5,355,000**	[i]	[I] = [G] + [H]

Source: (1) CIVLIT-BCBSM-00255983 and BLUECROSSMI-99-103996.pdf

Note: Hospital Cost (GAAP Cost) presented as a hypothetical example.

62. Within the context of the overall reimbursement objective described above, the PHA provided reimbursement for inpatient claims using a DRG-adjusted base rate.[129] To obtain the DRG-adjusted base rate, BCBSM calculates an average dollar amount it will reimburse per procedure (referred to as the "base rate") that would achieve the overall dollar amount of intended reimbursement based upon the expected number of procedures.[130] In order to determine the specific reimbursement amount for each claim, the base rate is adjusted up or down by application of a weighting factor designed to adjust for the severity of the condition and the complexity of the treatment. These weights, which are used industry-wide, are referred to as Diagnosis Related Group ("DRG") weights. Originally, the Center for Medicare Services (CMS)

[129] The PHA also provides that, irrespective of the DRG-adjusted rate, the amount paid for the claim will not exceed the billed charge.

[130] BLUECROSSMI-99-103996.pdf at BLUECROSSMI-99-104007-08 (While this document describes BCBSM's reimbursement methodology from 2000, it lays out an example of how BCBSM starts with a hospital's GAAP costs, adds adjustments for other hospital costs and margin to arrive at a total expected payment, and then shows how this value is divided by the total number of admissions (adjusted for case mix) to arrive at the base rate, an average cost per case of "average complexity.").

created the DRG weights to be used in reimbursing hospital services under the Medicare program.[131] I refer below to this base rate with DRG adjustment methodology as "DRG-based reimbursement."

63. Under DRG-based reimbursement, the overall level of reimbursement for the hospital (with or without some amount of inflation by virtue of the agreement to include an MFN) is determined by the base rate. An agreement by BCBSM to increase reimbursement rates under this system is implemented through a higher base rate. And, if the base rate is inflated, that inflation will be carried into reimbursement for each claim in proportion to the DRG weight that is applied to that claim. Hence, under BCBSM's system of DRG-based reimbursement, inflation in overall reimbursement levels, of the sort identified through the DID analysis set forth above, will be carried into the reimbursement for each claim.

64. Here again, an example may be useful. Assume that the hypothetical hospital shown above is expected to have 1,000 claims over the course of the year. In order to generate overall reimbursement of $5,355,000, the base rate would be set at $5,355. Assuming the billed charges associated with these 1,000 claims was $7,500,000, the reimbursement rate at this hospital would be approximately 71 percent (i.e., $5,355 divided by $7,500.) Assume further that there are three types of claims with DRG weights of .75, 1 and 1.25 that occur with equal frequency. The per claim reimbursement for the three claim types would then be $4,016 (75 percent of $5,355), $5,355 and $6,694 (125 percent of $5,355), respectively.

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[131] Acute Inpatient PPS, Center for Medicare & Medicaid Services Website, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/01_overview.asp (last accessed in October 2013).

> A key part of PPS [the Prospective Payment System] is the categorization of medical and surgical services into diagnosis-related groups (DRGs). The DRGs "bundle" services (labor and non-labor resources) that are needed to treat a patient with a particular disease. The DRG payment rates cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services. The CMS creates a rate of payment based on the "average" cost to deliver care (bundled services) to a patient with a particular disease. http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf

See also, Reinhardt at p, 60.

65. Now suppose that in the negotiation to include an MFN, the hospital insists on a higher reimbursement rate of 80 percent (as opposed to 71 percent) as a condition for its acceptance of the MFN (This yields a $645,000 increase in overall reimbursement for the hospital for a total overall reimbursement amount of just over $6 million) Under this scenario, the base rate would now be $6,000 ($6,000,000, divided by 1,000 claims), with reimbursement as to each of the three claims now rising to $4,500, $6000 and $7,500. This yields a 12 percent overcharge (9/71). Furthermore, as one can readily calculate using the individual claim amounts shown above, the payment for *each claim* is inflated by that same 12%. In this fashion, BCBSM's system of base rate reimbursement combined with DRG adjustments served to distribute any overcharge embedded in the overall reimbursement level across all of the individual claims--and ultimately, to all Class members (the payors of those claims). Thus, given the evidence regarding inflation in the overall rate of reimbursement at the Affected combinations involving BCBSM, I conclude that all (or virtually all) Class members associated with these combinations paid at least some overcharge.

[redacted]

[redacted]

[redacted]

[redacted]

3. *HAP*

68. The contracts produced by HAP in this matter[133] identified pricing for two PPO networks, HAP Preferred ("PHP") and Alliance Health and Life Insurance Company ("AHLIC" or "AHL"). Therefore, I have treated PHP and AHL each as its own payor-network combination in the DID regression analysis. Among the Affected combinations in which it was involved, HAP used different reimbursement methodologies under different provider agreements. These methods included DRG-based reimbursement,[134] percentage-of-charge reimbursement and flat rates.[135] As described above, the first two of these reimbursement methods produce impact associated with inflated overall reimbursement that is shared in common by Class members paying for those services. The following HAP Affected combinations utilized these two reimbursement methods:

- Percent of Charges
  - Beaumont Hospital - Grosse Pointe - PHP & AHL PPO Network
  - Beaumont Hospital - Royal Oak - PHP & AHL PPO Networks
  - Beaumont Hospital - Troy - PHP & AHL PPO Networks
- DRG-Base Rates
  - Beaumont Hospital - Royal Oak - AHL PPO Network
  - Beaumont Hospital - Troy - AHL PPO Network

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[133] And in the claims data produced by HAP.

[134] HAP uses the term "case rates."

[135] HAP and the three Beaumont Hospitals signed a contract effective January 1, 2010 which is the "post-MFN" contract for Grosse Pointe. In addition to DRG-based reimbursement and percent-of-charges, this contract also uses reimbursement per diem and per modality. However, a comparison of these reimbursement types is not necessary as this contract stipulates that all of the rates therein "are based on an agreed upon contractual rate increase of three (3%) percent for the services outlined […]" and that these terms "shall apply to all HAP Preferred and AHLIC products." (HAP-DOJ-003099).

- Beaumont Hospital - Royal Oak - HMO Network[136]

69. As to these combinations, therefore, inflation in the overall reimbursement rate leads to inflated payments as to each claim. Accordingly, the DID results (showing that overall HAP reimbursement rates at each Affected MFN Hospital were inflated) taken in combination with the structure of reimbursement under HAP's contracts constitutes evidence showing that all (or virtually all) Class members were impacted.

70. A review of HAP contracts shows that in instances where reimbursement methods vary by procedure within a contract, percent increases in pricing from the pre- to the post-MFN contract were the same for nearly all procedures. For example, in its first contract with Beaumont Hospital - Grosse Pointe after BCBSM's MFN-Plus clause (effective January 1, 2010), HAP contracted for a three percent increase in reimbursement across the board.[137] Therefore if that rate was inflated in the aggregate, it was also inflated as to every charge in the Class period. Accordingly, the DID results (showing that overall HAP PPO reimbursement rates at Beaumont Hospital - Grosse Point were inflated) taken in combination with the structure of reimbursement under this HAP contract shows that all (or virtually all) Class members associated with this hospital under a HAP plan were impacted.

71. Similarly, percent increases in pricing from the pre- to the post-MFN contract were the same for nearly all procedures in HAP's first contract with Beaumont Hospital - Royal Oak and Troy after BCBSM's MFN-Plus clause (effective May 1, 2008) for PHP. Seventeen of 18 inpatient or outpatient health care services or groups of services were reimbursed as a percentage of billed charges. The percentage took on three values: nine services were reimbursed at 59.72 percent, eight were reimbursed at 59.86 percent, and one service was reimbursed at 73.5 percent. One health care service, kidney transplant (MS-DRG 652) was carved out at a flat reimbursement rate of $60,019.

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[136] Inpatient claims only.

[137] HAP-DOJ-003099 ("These rates are based on an agreed upon contractual rate increase of three (3%) percent for the services outlined in the aforementioned attachments. Reimbursement terms shall apply to all HAP Preferred and AHLIC networks.")

72. I compared these reimbursement rates to the rates for PHP in the last contract between HAP and these two hospitals prior to the BCBSM MFN-Plus agreement. Eighteen services or groups of services were present in both contracts. Seventeen of eighteen services increased by five percent and the 18th (kidney transplant) increased by 4.2 percent. Additionally, there is an escalator clause in the contract with updated reimbursement rates effective January 1, 2009. Every service or group of services increased by three percent, including the carve out for kidney transplant. Accordingly, the DID results (showing that overall HAP PHP PPO reimbursement rates at Beaumont Hospital - Royal Oak and Troy were inflated) taken in combination with the structure of reimbursement under this HAP contract constitute evidence common Class members showing that all or nearly all the claims they paid were inflated. I have determined that in each of the Affected combinations involving HAP in which flat rates were used for reimbursement, those flat rates changed over time in the same fashion as did overall reimbursement at that hospital for that network. In that case, the inflation in overall reimbursement reflected in the DID analysis would have been carried into reimbursement for each claim.

73. Percent increases in pricing from the pre- to the post-MFN contract were the same for nearly all outpatient procedures in HAP's first contract with Beaumont Hospital - Royal Oak and Troy after BCBSM's MFN-Plus clause (effective May 1, 2008) for AHL as well. Outpatient claims were reimbursed either on a case rate or per diem basis or as a percentage of billed charges, consistent with the pre-MFN AHL PPO contract.[138] Seven increased by 9.7 percent and two increased by 9.6 percent.[139] Despite the variation in the form of payment described, if the aggregate reimbursement for outpatient claims is inflated for the AHL PPO plan, then it is also inflated for nearly all claims reimbursed under its conditions because nearly all of the health care services increased by about 9.7 percent.[140] Inpatient procedures were

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[138] With a per diem or per modality reimbursement methodology, the insurer pays a fixed amount either per day or modality of treatment.

[139] An additional category, "Observational Max" increased at 22 percent. However, when the pre-MFN contract is compared to pricing for January 1, 2008 - which is presented in the May 1, 2008 contract, it too increased at 9.7 percent.

[140] The slight variation between 9.6 and 9.7 percent is likely due to contract negotiators efforts to come to approximately the same percentage increase across types of reimbursement.

reimbursed based on DRG-base rates. Accordingly, the DID results (showing that overall HAP AHL PPO reimbursement rates for outpatient claims both at Beaumont Hospital - Royal Oak and at Beaumont Hospital - Troy were inflated) taken in combination with the structure of reimbursement under this HAP contract constitute evidence showing that all (or virtually all) Class members were impacted.

4. *Aetna*

74. As noted in Table 1, Aetna had agreements with two of the Affected hospitals -Three Rivers Health and Bronson Lakeview Community Hospital. Aetna's PPO contracts during the Class period with Three Rivers and Bronson Lakeview utilize percentage-of-charge reimbursement.[141] Accordingly, the DID results (showing that overall PPO Aetna reimbursement rates at Three Rivers and Bronson Lakeview were inflated) taken in combination with the structure of reimbursement under these two Aetna contracts constitute evidence common to the corresponding payers showing that payment for all (or virtually all) claims were inflated.

VII. Computing Aggregate Class-wide Overcharges

75. I have concluded that the amount of overcharges incurred by the Class are readily ascertainable in a formulaic manner. In particular, the amount of overcharges can be calculated by using the DID results from the regression associated with each of the Affected combinations to find its overcharge percentage. To do so, one divides the estimated DID coefficient (in particular, the coefficient associated with the interaction of the MFN indicator and the post-MFN time period indicator) by the average reimbursement rate during the Class period. To calculate the overcharge amount, one then multiplies the overcharge percentage by the aggregate allowed amount during the Class period. For purposes of demonstrating the feasibility of this formulaic approach to calculating Class-wide overcharges, I provide an illustrative overcharge calculation. I show this calculation for each of the Affected Hospitals in Exhibit 9, and present an example here.

76. HAP's reimbursement rate to Beaumont Hospital - Royal Oak from July 15, 2006 through January 18, 2013 (the period commencing with its July 15, 2006 contract, or

[141] AETNA-00077640, AETNA_00071563-81, and AETNA-00075021.

the Class period for this payor-network-hospital combination) was 47 percent, which yielded $111 million in total payments to the hospital. However, the DID regression shows that HAP's reimbursement was inflated by 11.5 percentage points. That implies overcharges of about 25 percent (11.4/47). 25 percent of $111 million is $27.4 million. In total the aggregate overcharges shown in my illustration for all Affected combinations is approximately $118 million.[142] This illustration doesn't represent a final opinion on my part regarding the amount of overcharges. Rather, it demonstrates the basis for my conclusion that those overcharges can be calculated in a class-wide, formulaic fashion.

VIII. Economic Analysis of the Antitrust Violation

77. The anticompetitive harm that is alleged to flow from BCBSM's MFNs is reduced competition in the provision of health insurance and higher health care costs. As described above, Plaintiffs allege that BCBSM contracted for MFNs in its hospital contracts as a means for raising its rival insurance sellers' costs, limiting their ability to compete and enhancing BCBSM's monopoly power as a seller of health insurance in the State of Michigan. As the DOJ described it in connection with the case against BCBSM's use of MFNs:

> At trial, the department and the Michigan Attorney General intended to demonstrate that BCBSM's MFN clauses reduced competition between BCBSM and its rival insurers and discouraged other health plans from entering or expanding in markets throughout Michigan, which increased prices self-funded employers and their employees paid to hospitals, and likely increased prices other Michigan residents and their employers paid to health plans and hospitals.
>
> [...]

[142] Plaintiff Michigan Regional Council of Carpenters Employee Benefits Fund made purchases during the relevant time periods at the following affected combinations: BCBSM Non-HMO purchases at Beaumont Hospital – Grosse Pointe, Beaumont Hospital – Royal Oak, Beaumont Hospital – Troy, Providence Park Hospital, and St. John Hospital and Medical Center, as well as HAP HMO purchases at Beaumont Hospital – Royal Oak and HAP PPO (AHL) purchases at Beaumont Hospital – Grosse Pointe, Beaumont Hospital – Royal Oak, and Beaumont Hospital – Troy. See ABABEN071203.

> The department has observed that MFN clauses used by health plans that have market power in the sale of health insurance can reduce competition by, for example, encouraging hospitals to contract with smaller health plans at higher rates or through less efficient reimbursement models.[143]

78. As I understand it, the economic analysis of the antitrust violation in this case would focus on three areas: 1) The anticompetitive effects of BCBSMs MFNs; 2) whether the MFNs created, enhanced or maintained monopoly power for BCBSM; and 3) whether there are procompetitive benefits that justify any anticompetitive effects. In my opinion, the analysis in all of these areas would involve evidence that is common to members of the proposed Class. Individualized inquiries pertaining to the circumstances of each Class member will not be needed to address these issues. I explain why that is so for each of these topic areas below.

A. Anticompetitive Effects

79. The theory of anticompetitive effect in this matter is raising rival's costs.[144] As an economic matter, by committing hospitals to charge prices to rivals that are higher (or at least as high for rivals which previously had lower prices) than those charged to BCBSM (through market power and/or through payment), BCBSM's MFN clauses serve to increase the costs incurred by its rival insurance providers. As BCBSM has noted internally, health care costs--the majority of which are hospital costs--impact what it can charge for premiums and the out-of-pocket costs of its members and therefore influence employers' health plan choices.[145] Hospital reimbursement rates

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[143] "Justice Department Files Motion to Dismiss Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts," U.S. Department of Justice, March 25, 2013, available at http://www.justice.gov/atr/public/press_releases/2013/295114.htm.

[144] *See, e.g.,* Thomas G. Krattenmaker and Steven C. Salop, "Anticompetitive Exclusion: Raising Rivals' Costs To Achieve Power over Price," 96 Yale L.J. 209, December, 1986 ("Krattenmaker and Salop") at p.238. ("[T]he purchaser, in effect, orchestrates cartel-like discriminatory input pricing against its rivals. […] [A] firm purchasing a vertical restraint may, as part of the agreement, induce a number of its suppliers to deal with the purchaser's rivals only on terms disadvantageous to those rivals.") and at p.246 ("Thus, if exclusionary rights significantly raise costs for potential entrants, such rights will raise entry barriers into the market and enhance established firms' power to raise price.").

[145] BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989395. See also BLUECROSSMI-99-00989396

are the primary driver of insurer costs[146] and, therefore, an important aspect of a health insurer's value proposition.[147] By increasing rivals' costs, BCBSM can increase its own market power in the sale of health insurance.[148]

80. BCBSM has noted internally that health care costs--the majority of which are hospital costs--impact what it can charge for premiums as well as the out-of-pocket costs of its members.[149] BCBSM clearly valued the advantage in its own discount relative to that of its rivals. As noted by Doug Darland:

> Clearly the only market share worth attacking by a new competitor is ours. Beaumont offered to consider a "strategic alliance" (my phrase) last year concerning their willingness to shut out competing plans that approach them for a greater discount, in exchange for an increase from BCBSM. For some reason, Kevin [Seitz] and Mike [Schwartz] did not pursue this possibility. I thought it would have been well worth the investment […] It would likely cost us a substantial increase, say 7-8%, maybe a little more, but we would still have a 60+% discount, or about 30-50 points better than anyone else. I can't imagine this wouldn't be a

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("The ability to manage and predict benefit costs is perhaps the single most important core competency a health plan must have. Management and control of costs will determine, in the long-run, the ability of a health plan to survive in a competitive marketplace. The ability to predict costs will impact the appropriateness of prices, which in turn determine the financial viability of an entity. By comparison, all other elements of a health plan's success are modest.")

[146] BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989371 ("[B]enefit expense represents 90 percent of premiums and, therefore, plays a critical role in managing BCBSM's overall operating results […] Many factors impact benefit expenses, including provider reimbursement contracts.") and BLUECROSSMI-99-00989372 (The largest category of benefit expense is hospital).

[147] Dunn Deposition Exhibit 9 (BLUECROSS-99-01577870) at BLUECROSS-99-01577875.

[148] *See, e.g.,* Steven C. Salop and David T. Scheffman, "Raising Rivals Costs," The American Economic Review, Vol. 73, No. 2, Papers and Proceedings of the Ninety-Fifth Annual Meeting of the American Economic Association (May, 1983), pp. 267-271. (At p. 267 "[R]aising rivals' costs can be profitable even if the rival does not exit from the market." And p. 270 "For antitrust analysis, exclusionary strategies may be characterized by three conditions- profitability to the dominant firm; competitor injury; consumer welfare reduction- and their sum, the allocational efficiency (or aggregate welfare) effect)"

[149] Anthony J. Dennis, "Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts," 4 Ann. Health L. 71 ("Dennis") at p.80 ("[T]he largest single expense item for any health plan is typically hospital costs.").

> fantastic long-term competitive advantage for us, despite the $25M upfront investment.[150]

81. Mr. Darland also testified to the link between higher hospital discounts and BCBSM's ability to provide lower cost plans and out-of-pocket payments by its members.

> Q. So in the part of the e-mail one down from the -- from the top, you write in the second sentence to Mr. Seitz, "Everyone acknowledges that we have the best hospital discounts by far, and that it is a core strength." Did I read that correctly?
>
> A. Yes, you did.
>
> Q. The "we" is Blue Cross, correct?
>
> A. Yes.
>
> Q. And the best hospital discounts are your reimbursement rates which are lower than other commercial payors; is that right?
>
> A. Yes.
>
> Q. And that's a core strength because lower costs for Blue Cross in terms of paying hospitals means that Blue Cross is more likely to be able to provide lower cost plans, lower deductibles, premiums and other payments for Blue Cross's customers; is that right?
>
> A. Yes.[151]

82. In 2010, Mr. John Dunn, Vice President of Middle and Small Group Business at BCBSM, wrote that, "Our hospital discounts remain an important advantage. Against the local HMO competitors, they range from 8 to 12 percentage point difference by region which translates into an average hospital premium difference of 15 % to 25 % and 7.5 % to 12.5 % difference on overall premium."[152] Similarly, he

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[150] Darland Deposition Government Exhibit 6, BLUECROSSMI-99-051863.

[151] Darland Deposition Vol. II at 419:22-420:16.

[152] Dunn Exhibit 5 at p.11 (BLUECROSSMI-99-02030679 at BLUECROSSMI-99-02030689).

testified that, "[T]he advantage in the self-funded markets we have on cost […] is driven a lot by our provider discounts."[153] The first item in a list of "[c]ritical components that should be prioritized" in BCBSM's GBCM Five Year Business Plan, 2012-2016 was "Maintaining facility discount advantage and professional discount parity by leveraging local market leadership."[154]

83. The DID regression analysis shows that MFNs increased the hospital network costs of BCBSM's competing insurers. By raising the costs of inputs to health insurance networks, MFNs effectively placed a floor not only under rates for hospital healthcare services. And, since the cost of delivering healthcare is most of a health plan's costs, setting a price floor for those hospital costs will inevitably establish a price floor for their health insurance offerings as well.[155] "The […] anticompetitive effect is an unnecessary price increase to the entire market without any material change in networks or services."[156]

84. The evidence necessary to demonstrate the relationship between hospital costs and insurance rate setting is the same for all Class members. Similarly, evidence about competition between insurance rivals is also common. Finally, the DID regression analysis reported herein entails evidence that is common to Class members.

B. Monopoly Power Effects of MFNs

85. The phrase monopoly power is typically used to describe the ability of a firm to profitably maintain prices significantly above competitive levels for a non-transitory period of time. From that perspective, it can be thought of as a significant degree of market power. [157] Monopoly power can be identified directly from evidence that

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[153] Dunn Deposition at 170:5-9.

[154] Dunn Deposition Exhibit 9 (BLUECROSSMI-99-01577870 at BLUECROSSMI-99-01577879).

[155] Dennis at p.80.

[156] Beth Ann Wright, "How MFN Clauses Used in the Health Care Industry Unreasonably Restrain Trade Under the Sherman Act," 18 J.L. & Health 29 at p.37.

[157] The FTC defines market power as "[a] firm's ability to maintain prices above competitive levels at its profit-maximizing level of output." (See http://www.ftc.gov/opp/jointvent/classic3.shtm, last visited October 2013.

prices are elevated relative to competitive levels or that output has been curtailed in a meaningful way relative to competitive levels.

86. Economists also look frequently to structural evidence such as market share (or concentration) and entry barriers from which they draw inferences about the presence and degree of market power. This kind of evidence is often supplemented with internal documents from the firm in question about pricing considerations and the nature and degree of competition.[158] The centerpiece of this inferential exercise is relevant market definition.

87. In regards to this issue, it is important to focus properly on the nature of the monopoly power (including the business activity to which it relates) that is at issue here. As an economic matter, the only rational way to understand BCBSM's desire to increase its rivals' hospital costs, including agreements to increase its own costs as a means of doing so, is with regard to the potential benefits that such a strategy may produce for BCBSM in its capacity as a seller of insurance. As a buyer of hospital services, BCBSM would not rationally want to pay more for the same services or see other insurance company buyers offering more than it did. After all, from its standpoint, higher reimbursement rates simply mean higher costs to provide insurance. Under normal procompetitive circumstances, a seller of health insurance would prefer lower costs associated with the underlying services.

88. Hence, to understand why BCBSM would want to increase hospital reimbursement rates for it and its rivals, one must look further. Monopoly power effects can explain this conduct. However, the market in which limits on reimbursement rates extended to other insurers would matter to BCBSM's monopoly power is the market pertaining to its sales of health insurance. It is there, logically, that changes in reimbursement could be expected to impact the competition that BCBSM faces. From that perspective, the overcharges here are a direct component of an anticompetitive

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[158] There is extensive economics literature addressing the relationship between market share and market power. (*See, e.g.,* Schmalansee, R., "Inter-Industry Studies of Structure and Performance," *Handbook of Industrial Organization*, Vol. II, 1989, Ch. 16, and references therein.) This literature generally stands for the proposition that a firm with a dominant share of the market in which it competes will be able to exercise market power (i.e., raise prices). In this same vein, conduct which serves to consolidate a firm's market share will improve the firm's ability to raise prices. *See also* U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC), *Horizontal Merger Guidelines* (2010) (hereafter "Merger Guidelines"), § 2.1.3.

scheme employed within an upstream market (hospital services) intended, according to Plaintiffs, to illegally enhance BCBSM's monopoly power in the downstream market (insurance services). I turn below to the Class-wide nature of the economic evidence relevant to that monopoly power question.

1. ***Market Definition***

89. A relevant market defined for antitrust purposes is not the same thing as a "market" in the everyday sense of the term. Rather, a relevant antitrust market is an analytical construct designed to capture the sources of competitive discipline that would prevent the alleged conduct from resulting in supra-competitive pricing. A relevant antitrust market always should be defined in relation to the conduct at issue. As Professors Edlin and Rubinfeld have written, "[b]ecause there are frequently many possible markets one can take into consideration, the relevant markets depend on the competitive concerns that are at issue."[159] In essence, one seeks through market definition to identify the alternatives (both in network and geographic dimensions) that would prevent the firm in question from acquiring or maintaining monopoly power. [160]

90. The conceptual framework for market definition generally employed today is taken from the Merger Guidelines that have been issued and continually refined by the US antitrust enforcement agencies. The operative principle is that the relevant market should only include those competing alternative networks that would prevent the Defendant from profitably increasing prices through the conduct at issue.[161] The goal in market definition is to identify "… a group of networks and a geographic area

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[159] Edlin, A. and D. Rubinfeld, "Exclusion or Efficient Pricing: The 'Big Deal' Bundling of Academic Journals," *Antitrust Law Journal*, v.72, no.1, 2004 at 126. *See also*, Baker, J., "Market Definition: An Analytical Overview," *Antitrust Law Journal*, v.74, no.1, 2007 at 173 ("Moreover, market definition does not take place in a vacuum: in any particular case, demand substitution must be evaluated with reference to the specific allegations of anticompetitive effect in the matter under review."); Larner, R. and C. Nelson, "Market Definition in Cases Involving Branded and Generic Pharmaceuticals," *ABA Economics Committee Newsletter*, v.7, no. 2, Fall 2007 at 4-7 ("[…]the proper antitrust market in a case is the market relevant to an analysis of the competitive effects of the alleged behavior").

[160] Merger Guidelines, § 4.

[161] Merger Guidelines, § 4.1.1 ("… the purpose of defining the [relevant] market and measuring market shares is to illuminate the evaluation of competitive effects.").

that is no bigger than necessary to satisfy this test."[162] Product interchangeability, substitutability, and cross-price elasticity are all factors that may be considered in this regard.[163] The key issue, however, is not simply whether these factors are present when it comes to other alternatives, but whether they exist to a sufficient degree as to confer competitive discipline on pricing.

91. In identifying such alternatives, one uses the "hypothetical monopolist" framework set forth in the Guidelines.[164] Within that framework, networks belong in the relevant market if a hypothetical monopolist of the networks at issue in the case would need to control them (either in terms of price or output) in order to have significant market power; i.e., in order to be able to profitably raise prices above the level that competition would otherwise provide by a significant, non-transitory amount (what the antitrust agencies refer to using the acronym SSNIP).[165]

92. To define the relevant network market using this conceptual approach, one starts with the networks and services affected by the conduct in question as a candidate relevant network market, and then ask whether or not a hypothetical monopolist (as the only seller of these networks) would have significant market power. If the answer is "yes"--i.e., a hypothetical monopolist would have that power based upon control of those networks alone--then the process stops and the candidate market becomes the relevant network market for analyzing the conduct at issue. If the evidence shows instead that a hypothetical monopolist in this candidate market would not have significant market power, then the candidate market is expanded to include the next

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[162] Merger Guidelines, § 2.0.

[163] "The relevant network market . . . 'is composed of networks that have reasonable interchangeability for the purposes for which they are produced . . . .'" *Found. For Interior Design Educ. Research v. Savannah Coll. of Art & Design,* 244 F.3d 521, 531 (6th Cir. 2001) (quoting *United States v. E.I. DuPont de Nemours & Co.,* 351 U.S. 377, 404 (1956)); See also *Worldwide basketball & Sport Tours, Inc. v. Nat'l Collegiate Athletic Ass'n*, 388 F.3d 955, 961 (6th Cir. 2004) (citing *White & White, Inc. v. Am. Hosp. Supply Corp.*, 723 F.2d 495, 500 (6th Cir. 1983)).

[164] Merger Guidelines, , § 4.1.1. First introduced in 1982, the hypothetical monopolist test has been updated and refined over time, most recently in 2010. (*See* http://www.justice.gov/atr/hmerger/11248.htm; Merger Guidelines, , § 1 (footnote 1).

[165] The DOJ/FTC "most often" define a SSNIP (small, significant but non-transitory price increase) to be 5 percent. *See also*, Merger Guidelines, § 4.1.2 ("The SSNIP is intended to represent a 'small but significant' increase in the prices charged by firms in the candidate market for the value they contribute to the networks or services used by customers.").

closest network substitute and the market power that would flow from monopoly control of this expanded network market is then assessed. This process is repeated until the candidate relevant market is broad enough such that the hypothetical monopolist would have significant market power.

93. This analysis does not require individualized inquiries regarding the circumstances of particular Class members. BCBSM is a seller of commercial health insurance in the State of Michigan. The conduct at issue in this case is BCBSM's use of MFN clauses in contracts with hospitals, allegedly to raise the costs of its rival health insurance sellers and thereby increase its market power as a health insurance seller. Thus, the starting point in defining the relevant market for purposes of analyzing these allegations is to consider whether a hypothetical monopolist with respect to commercial health insurance in Michigan would have monopoly power.

94. From the network standpoint, the inquiry here would be whether the ability to utilize other alternatives to commercial insurance--say, self-funded, self-administered programs directly between employers and health care providers--would prevent the hypothetical monopolist from profitably setting supra-competitive rates. This would involve questions such as whether such alternatives are feasible; if so, for what part of the health care market; and whether that would represent enough potential diversion to provide competitive discipline on the monopolist's commercial insurance rates. The evidence one would use in answering these questions--evidence regarding the economic underpinnings and value associated with commercial insurance, efficiencies associated with pooling risk, economies of scale and scope in health care contracting--would be the same viewed from the perspective of every Class member. So too would the ultimate answers to these questions be common to Class members.

95. It may be argued here that fully insured plans such as those underwritten by the insurance companies are in a different network market than a self insured plan administered by an insurance company under an administrative services only contract ("ASC" or "ASO"). The resolution of that question still involves common evidentiary questions from the standpoint of the Class. A self-insured employer may also contract with a carrier to lease access to its discounted network of health care

providers, including hospitals.[166] Rather than a premium, the firm pays an administrative services fee.[167] The difference between fully-insured and self-insured plans (as well as hybrids thereof) is essentially a question of which entity carries the financial risk associated with the insurance. Whether or not the identity of the party carrying the underlying risk delineates separate markets is certainly a question that is common to Class members.

96. As an aside, there is clearly evidence that supports the presence of one network market including both types of plans. Mr. Dunn testified that there is a large group of employers with between 50 and 1,000 employees who purchase either fully-insured or self-insured plans, suggesting that these networks do compete with one another.[168] [redacted] Documentary evidence shows that employers have been substituting self-insured for fully-insured BCBSM plans.[170]

97. The relevant market also has a geographic dimension. Typically, one defines the relevant geographic market using a two-step process. In the first step, one begins

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[166] See Bureau of Labor Statistics, Definitions of Health Insurance Terms, available at http://www.bls.gov/ncs/ebs/sp/healthterms.pdf. A self-insured payor may also lease a provider network from a payor but hire a third-party administrator ("TPA") for claims processing. For example, I understand from counsel that this is how Carpenter's, one of the named plaintiffs, manages its health plan. Carpenters leases a provider network from BCBSM but BeneSys administers its claims (*See, e.g.,* http://www.benesysinc.com/dnn/AdministrativeServices.aspx). At BCBSM:

> An ASC group assumes all of the benefit expense risk. Claims payments are the responsibility of the employer and not the insurance company. An ASC group will contract with an insurance company to administer the plan to receive the benefits of negotiated price discounts received by the insurer. The insurer may provide services that include enrollment, eligibility, claim and other administrative services. An ASC group will pay the insurer an administrative fee. ASC groups also have the option of purchasing stop-loss coverage. (BLUECROSSMI-00989332 at BLUECROSSMI-99-00989353).

[167] Self-insured firms may purchase stop loss insurance to limit their risk *See, e.g.,* Health Terms and BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989364.

[168] Dunn Deposition at 159-161.

[redacted]

[170] Dunn Deposition, Exhibit 9 (BLUECROSSMI-99-01577870 at BLUECROSSMI-99-01577877 and -912).

with the area directly affected by the conduct at issue in the case and then develops a "candidate" geographic market that is broad enough to include most of the defendant's sales of the relevant network that originate from within the affected areas--i.e., the defendant "trade area" affected by the conduct.[171] In the second step, the defendant's trade area is expanded further, as necessary, to capture other nearby sellers whose presence would prevent a hypothetical monopolist in the defendant's trade area from raising prices.[172] This method makes intuitive sense; if the firms in a geographic area could not profit by collectively raising price, then it must be the case that consumers view firms outside the area as close substitutes. The geographic market should be expanded to include these additional firms.

98. BCBSM serves the State of Michigan (and only Michigan).[173] BCBSM describes its "statewide presence" as a competitive strength, even for smaller employers.[174] The Complaint in this case alleges that BCBSM has employed MFNs to limit competition and enhance its monopoly power in the State of Michigan. Therefore, the state of Michigan certainly provides at least an appropriate candidate market from which to begin the analysis of relevant geographic market.

99. It would appear unlikely here that circumstances would lead one to expand the relevant geographic market to include commercial health insurance companies that operated entirely out of state--although this is the position taken by BCBSM's economic expert in another related case involving BCBSM and these same MFNs.[175]

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[171] *Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 573 F. Supp. 2d 1125, 1148 (E.D. Ark. 2008) ("[I]t seems logical that the relevant geographic market will not be smaller and usually will be larger than the trade area because, by definition, the business is competing for customers throughout its trade area…."). As I understand it, this condition corresponds to the first part of the test for a relevant geographic market set forth by the 8th Circuit in *Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 591 F.3d 591, 598 (8th Circ. 209) *cirt. denied* 130 S. Ct. 3506 (2010).

[172] This requirement is consistent with the second part of the 8th Circuit test. (*Little Rock Cardiology Clinic*, 591 F.3d at 598).

[173] Michigan Department of Insurance and Financial Services, Blue Cross Blue Shield of Michigan (BCBSM), available at http://www.michigan.gov/difs/0,5269,7-303-12902_35510-262303--,00.html (last visited in October 2013).

[174] Dunn Deposition at 237-238.

[175] Draft Expert Report of David T. Scheffman, Ph.D., April 17, 2013 at 352.

Apparently, some Michigan residents do travel to hospitals just over the border into Wisconsin, Ohio, or Indiana.[176] However, they are a small share of the market and it is unlikely that more Michigan residents would practicably turn to a health insurance plan that required travel to Wisconsin or Indiana for health care in order to avoid the effects of a small but significant increase in price by a state-wide health insurance payor. The added cost to travel to providers out of state would readily outweigh the effects of a SSNIP-sized price increase. It is equally unlikely that Indiana or Wisconsin-based plans would be able to capture market share from BCBSM or its rival Michigan payors if they do not have a network of providers in Michigan. Further, given its regulatory mandate and non-compete agreement with other Blue Cross plans, BCBSM would not be able to expand its membership to Indiana or Wisconsin residents. Even under (what would appear to be) the unlikely circumstance that a relevant geographic market broader than the State of Michigan was appropriate, the answer to that question would still be the same as to all Class members. So too would the evidence needed to do so. In short, it would still be a common question.

100. It do not expect that localized geographic markets will be appropriate for purposes of evaluating whether or not MFN clauses enhanced BCBSM's monopoly power. First, as noted above, the proper inquiry here is to the potential for monopoly power effects in markets for commercial health insurance. Hence, the geographic market

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[176] For example, HAP owns CuraNet, LLC, a regional network of providers in Michigan, Indiana, and Ohio which includes 78 hospitals (Of 78 hospitals, 61 are in Michigan, 8 are in Ohio, and 9 are in Indiana). CuraNet's PPO network is available to HAP PPO customers through HAP's two subsidiaries, HAP Preferred and Alliance Health and Life Insurance Company. When HAP acquired CuraNet in 2006, it noted the following benefits:

> "For HAP, the CuraNet acquisition strengthens our outstate provider network, enabling us to compete effectively for business in key Michigan markets while maintaining our responsiveness to the local market," said Fran Parker, HAP president and CEO. "Current and future clients will gain access to high quality physicians and hospitals through this geographic expansion, and I'm looking forward to working with our new provider partners."

"This acquisition will enable CuraNet to better serve our existing clients," said Harry Dalsey, sole owner and president of CuraNet. "It simplifies administrative services for our clients by enabling HAP, a trusted name in health coverage and claims pricing administration, to serve as the single coordination point between provider network partners and payors." See CuraNet website at http://www.curanet.org/.

issue here should not be confused with whether or not hospitals serve local markets, or whether they compete locally. The question here is whether BCBSM competes in a statewide market for health care insurance or whether that competition is more localized in nature. Figure 1 shows the locations of hospitals whose contracts included MFN and MFN-Plus clauses. Those locations include most of the top 10 metropolitan areas and 72 of the state's 83 counties. In 2010, the counties which contained BCBSM's MFN hospitals represented 79 percent of the State's population. [redacted] Aetna and HAP also offer insurance plans broadly to residents of the State. While its HMO network focuses on nine counties in Southeast Michigan, HAP's PPO networks cover the same nine counties plus an additional 14 elsewhere in the state.[178] On the basis of these facts, it is implausible that the effects of BCBSM's MFNs on its monopoly power as a seller of health insurance, if any, would come down to highly localized geographic markets within the State.

2. *Measures of Monopoly Power*

101. Given a properly defined relevant market, the assessment of market power proceeds with an examination of market shares, market concentration, demand elasticity and barriers to entry. The evidence required for these assessments is common, Class-wide evidence. No customer-specific assessments of competitive conditions or market power would be necessary or relevant.

102. As noted above in Section IV.C.1 and seen in Exhibit 4, BCBSM's market share, for fully-insured plans in terms of lives covered, has exceeded 54 percent every year between 2003 and 2011, with an average of 57 percent and a high of 60 percent in 2008 and 2009.[179] The U.S. DOJ's Antitrust Division counsels that "concern begins to arise when the plan imposing an MFN provision accounts for 35 percent or more of the participating providers' revenues."[180] BCBSM's share of hospital

[redacted]

[178] Market Area, HAP Website, available at http://www.hap.org/healthinsurance/service_area.php (last visited in October 2013).

[179] Exhibit 4.

[180] Antitrust Health Care Handbook at p. 192.

reimbursements in the State of Michigan averages just under 60 percent between 2005 and 2010.[181] [redacted] The next largest payors are Health Plus and United Health, each with about two percent of the membership.

103. OFIR began reporting membership data for administrative services plans in 2011. BCBSM had an 83 percent share, in terms of lives covered (Exhibit 10). HealthLeaders InterStudy, an alternative data source, reports that BCBSM had about 63 percent of the commercial self-insured market in 2012.

3. ***Demand Elasticity***

104. Price elasticity of demand measures the sensitivity of demand for a product to a change in its price. Markets in which demand changes little in response to changing prices are said to be inelastic. Markets in which demand reacts strongly to changing prices are said to be elastic. Markets with elastic demand are less likely to be monopolized—the added profitability that one can achieve through monopoly control is much less in elastic markets than it is in inelastic markets.

105. The demand for health insurance is generally described as inelastic. In a recent unpublished manuscript (forthcoming at the *RAND Journal of Economics*), Starc uses data from the National Association of Insurance Commissioners (NAIC) and the Medicare Current Beneficiary Survey for 2006-2008 to estimate firm price elasticity of demand for health insurance.[183] She finds that nationally, firm price elasticity is -1.12, which is close to one. An elasticity of -1.12 means that a 1 percent increase in the price of health insurance will lead to a 1.12 percent reduction in the quantity of health

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[181] Michigan Office of Financial and Insurance Regulation (OFIR).These market share values are conservative given a market definition which includes all types of health plans. When measured separately, BCBSM has about 73 percent of the PPO market and about 36.6 percent of the HMO market.

[redacted]

[183] Starc, A. "Insurer Pricing and Consumer Welfare: Evidence from Medigap." February 22, 2012 (*Forthcoming, RAND Journal of Economics*).

insurance plans purchased. [184] This result is consistent with research which shows that the price elasticity of demand for hospital care is very low, especially for inpatient services.[185]

4. *Entry Barriers*

106. Barriers to entry protect the market power that high market share or other mechanisms for controlling actual competition can provide. It seems likely that entry barriers will apply to health insurance markets in Michigan. Entry into the Michigan market requires a significant investment, the most difficult and important component of which is contracting with hospitals and providers to develop a provider network. As seen in documentary evidence produced in this case, it can take years to negotiate a payor-hospital contract.[186] Other costs include the design of administrative functions necessary to market and sell the new plan, manage health and wellness of members, and manage and process claims administration.

107. Priority Health acquired CareChoices in 2007 for $39.9 million. This purchase added about 143,000 members to Priority Health's then approximate 460,000 membership and access to a network of hospitals in six Eastern counties where it was not already located. This acquisition took over a year to complete.[187] This acquisition made

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[184] *See also*, Jeanne Ringel, et. al. "the Elasticity of Demand for Healthcare : A Review of the Literature and its Application to the Military Health System," at p. xiii, which surveys the literature ("the estimates of the elasticity of the demand for health insurance with respect to price range between –1.8 and –0.1."). (Hereafter, "Ringel") Available at http://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf.

[185] [The elasticity of demand for health care] "tends to center on –0.17, meaning that a 1 percent increase in the price of health care will lead to a 0.17 percent reduction in health care expenditures." (Ringel at p. xi. The price elasticity for inpatient hospital services has been measured as about -0.14 and about -0.31 for outpatient services (Ringel at \ p. 32-33).

[186] Rental networks are available, but they cannot cover an entirely new health plan for very long.

[187] See, J. Greene, "New Priority Health CEO sees membership growth in Southern Michigan, *Crain's Detroit Business*, December 14, 2012, available at http://www.crainsdetroit.com/article/20121214/NEWS/121219910/new-priority-health-ceo-sees-membership-growth-in-southeast-michigan.(last visited October 2013). See also, Priority Health company history, Priority Health Website, available at http://priorityhealth.com/about-us/profile/history (last visited October 2013).

[redacted]

108. In addition, there is some reason to believe that the conduct at issue in this case raised barriers to competitive expansion. In that regard, former Chairperson of the FTC, Deborah Platt Majoras, has noted that MFNs can "chill the willingness of providers to discount their prices, raise entry barriers to new plans, and create expansion barriers for incumbent plans."[189]

109. [redacted]

[redacted]

[189] Antitrust Health Care Handbook at p. 191, citing Deborah Platt Majoras remarks at Health Care and Competition Law and Policy Workshop, September 9, 2002.

[redacted]

110. [redacted]

C. Potential Procompetitive Justifications

111. A rule of reason analysis associated with allegedly anticompetitive behavior can require a balancing of pro- and anti-competitive effects. Typically, the justification of potentially restrictive practices through pro-competitive effects involves analysis showing cognizable savings that were achievable only through the use of the restrictive practices. For instance, BCBSM has argued here that MFNs allow it to secure the best prices available for their customers and help control costs.[194] While there is a facial implausibility to this claim--one would suppose that reluctance to grant an MFN, tying their hands with respect to other negotiations, would lead a hospital to insist on higher reimbursement, not the reverse--whether or not it is indeed a justification for BCBSM's statewide institution of MFNs raises common questions for Class members that would be addressed through common evidence. How did hospitals respond to BCBSM's efforts to secure MFNs? Were reimbursement rates generally higher or lower as a result? Could the same (or lower) rates have been achieved by BCBSM without MFNs? There is no reason here to expect that the economic analysis of pro-competitive justifications for MFNs would raise evidentiary issues that are individualized to specific Class members.

[redacted]

[194] Reed Abelson, *Antitrust Suit in Michigan Tests Health Law*, N.Y TIMES, Dec. 20 2010 at 3.

Jeffrey Leitzinger, Ph.D.
October 21, 2013

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EDUCATION

Ph.D., Economics, University of California, Los Angeles
M.A., Economics, University of California, Los Angeles
B.S., Economics, Santa Clara University

WORK EXPERIENCE

Econ One Research, Inc., President, July 1997 to date
Founded *Econ One Research, Inc.,* 1997

Micronomics, Inc., President and CEO, 1994-1997
Micronomics, Inc., Executive Vice President, 1988-1994
Cofounded *Micronomics, Inc.*, 1988

National Economic Research Associates, Inc. 1980-1988
(Last position was Senior Vice President and member of the Board of Directors)

California State University, Northridge, Lecturer, 1979-1980

AREAS OF EXPERTISE

Has offered expert testimony regarding:

- Competition economics
- Commercial damages
- Econometrics and statistics
- Intellectual property
- Valuation

INVITED PRESENTATIONS

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October 2009 – September 2013

	Proceeding	Court/Commission/Agency	Docket or File	Deposition/ Trial/Hearing	Date	On Behalf Of
1.	Columbus Drywall & Insulation, Inc., et al. v. Masco Corporation, et al.	U.S. District Court, Northern District of Georgia, Atlanta Division	Civil Action No. 1:04-CV-3066-JEC	Deposition Deposition	November 2006 December 2009	Plaintiff
2.	City of San Antonio, Texas, et al. v. Hotels.com, L.P., et al.	United States District Court, Western District of Texas, San Antonio Division	Case No. SA-06-CV-381-OLG	Deposition Hearing Deposition Trial	March 2007 May 2007 August 2008 October 2009	Plaintiff
3.	Universal Delaware, Inc., et al., on behalf of themselves and all others similarly situated v. Comdata Corporation	U.S. District Court, Eastern District of Pennsylvania	Civil Action No. 07-1078-JKG	Deposition	October 2009	Plaintiff
4.	Sun-Rype Products Ltd. and Wendy Weberg v. Archer Daniels Midland Company, et al.	Supreme Court of British Columbia	Docket No. L051456	Deposition	February 2010	Plaintiff
5.	In Re: Flonase Direct Purchaser Antitrust Litigation	U.S. District Court, Eastern District of Pennsylvania	Case No. 2:08-CV-03149	Deposition Deposition	March 2010 March 2012	Plaintiff
6.	In Re: Wellbutrin XL Antitrust Litigation	U.S. District Court, Eastern District of Pennsylvania	Case No. 2:08-CV-2431	Deposition Hearing Deposition	March 2010 April 2011 November 2011	Plaintiff

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	Proceeding	Court/Commission/Agency	Docket or File	Deposition/ Trial/Hearing	Date	On Behalf Of
7.	ConocoPhillips Petrozuata B.V., ConocoPhillips Hamaca B.V., ConocoPhillips Gulf of Paria B.V., and ConocoPhillips Company v. The Bolivarian Republic of Venezuela	The International Centre for Settlement of Investment Disputes	Case No. ARB/07/30	Hearing	June 2010	Respondent
8.	Mobil Cerro Negro, Ltd. v. Petróleos de Venezuela, S.A. and PDVSA Cerro Negro S.A.	The International Court of Arbitration of the International Chamber of Commerce	Case No. 15416/JRF	Hearing	September 2010	Respondent
9.	CNA Holdings, Inc. and Celanese Americas Corporation v. Kaye Scholer, LLP and Robert A. Bernstein	U.S. District Court, Southern District of New York	No. 08 CV 5547 (NRB)	Deposition	December 2010	Counterclaim-Defendant
10.	Neon Enterprise Software, LLC v. International Business Machines Corporation	U.S. District Court, Western District of Texas, Austin Division	No. 1:09-CV-00896-JRN	Deposition	April 2011	Plaintiff
11.	State of Iowa v. Abbott Laboratories, et al. and The City of New York, et al. v. Abbott Laboratories, Inc., et al.	U.S. District Court, District of Massachusetts	No. 01-CV-12257-PBS	Deposition	May 2011	Plaintiff
12.	King Drug Company of Florence, Inc., et al. v. Cephalon, Inc., et al.	U.S. District Court, Eastern District of Pennsylvania	No. 06-CV-1791-MSG	Deposition	August 2011	Plaintiff

Dr. Jeffrey Leitzinger
October 2009 – September 2013

	Proceeding	Court/Commission/Agency	Docket or File	Deposition/ Trial/Hearing	Date	On Behalf Of
13.	Rochester Drug Co-Operative, Inc., at al. v. Braintree Laboratories	U.S. District Court, District of Delaware	Case No. 07-142 (SLR)	Deposition	October 2011	Plaintiff
14.	In Re: Wholesale Grocery Products Antitrust Litigation	U.S. District Court, District of Minnesota	Civil Action No. 09-md-02090 ADM/AJB	Deposition Hearing	December 2011 May 2012	Plaintiff
15.	Altana Pharma AG, and Wyeth v. Teva Pharmaceuticals USA, Inc. and Teva Pharmaceutical Industries, Ltd.	U.S. District Court, District of New Jersey	Civil Action No. 04-2355; 05-1966; 05-3920; 06-3672; 08-2877; (JLL) (CCC) on all	Deposition Trial	June 2012 June 2013	Defendant Defendant
16.	Apotex, Inc. and Apotex, Corp. v. Sanofi-Aventis, Sanofi-Synthelabo, Inc., Bristol-Myers Squibb Company and Bristol-Myers Squibb Sanofi Pharmaceuticals Holding Partnership	Circuit Court, Broward County, Florida, 17th Judicial Circuit	No. 11-001243	Deposition Trial	July 2012 March 2013	Plaintiff Plaintiff
17.	In Re: AndroGel Antitrust Litigation	U.S. District Court, Northern District of Georgia	No. 1:09-MD-2084-TWT	Deposition	July 2012	Plaintiff
18.	Tyco Healthcare Group LP, and Mallinckrodt, Inc. v. Pharmaceutical Holdings Corporation, et al.	U.S. District Court, District of New Jersey	Civil Action No. 07-CV-1299 (SRC)(MAS)	Deposition	August 2012	Plaintiff

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October 2009 – September 2013

	Proceeding	Court/Commission/Agency	Docket or File	Deposition/ Trial/Hearing	Date	On Behalf Of
19.	Allergan, Inc., et al. v. Athena Cosmetics, Inc., et al.	U.S. District Court, Central District of California, Southern Division	Case No. SACV07-1316 JVS (RNBx); Case No. SACV09-0328 JVS (RNBx)	Deposition	February 2013	Defendant
20.	Mylan Pharmaceuticals, Inc., et al. v. Warner Chilcott Public Limited Company, et al.	U.S. District Court, Eastern District of Pennsylvania	CIV No. 12-3824	Deposition	May 2013	Plaintiff
21.	In Re: Polyurethane Foam Antitrust Litigation	U.S. District Court, Northern District of Ohio	Case No. 10-MD-2196	Deposition	July 2013	Plaintiff
22.	Marchbanks Truck Service, Inc. d/b/a Bear Mountain Travel Stop, et al., v. Comdata Network, Inc. d/b/a Comdata Corporation, et al.	U.S. District Court, Eastern District of Pennsylvania	No. 07-1078-JKG	Deposition	August 2013	Plaintiff
23.	Astrzaeneca AB, Aktiebolaget Hässle, KBI-E Inc., KBI Inc., and Astrazeneca, LP v. Apotex Corp., Apotex Inc. and Torpharm, Inc.	U.S. District Court, Southern District of New York	Civil Action No. 01-CIV-9351 (BSJ)	Deposition	August 2013	Defendant
24.	In re: Cathode Ray Tube (CRT) Antitrust Litigation	U.S. District Court, Northern District of California, San Francisco Division	Case No. 3:07-CV-5944 SC	Deposition	August 2013	Plaintiff

Exhibit 2
In re: The Shane Group, Inc., et al. v. Blue Cross Blue Shield of Michigan
List of Materials Reviewed

Pleadings

Blue Cross Blue Shield United of Wisconsin, et al. v. Marshfield Clinic, et al., Case No. 95-1965 (7th Cir. slip op. September 18, 1995)
Interior Design Educ. Research v. Savannah Coll. of Art & Design, 244 F.3d 521, 531 (6th Cir. 2001)
Opinion and Order, Little-Rock-Cardiology-Clinic, P.A., v. Baptist-Health et al. (8/29/2008)
Complaint, United States of America and the State of Michigan v. Blue Cross Blue Shield of Michigan, No. 2:10-cv-14155-DPH-MKM (10/18/2010)
Class Action Complaint, The Shane Group, Inc. et al. v. BCBSM (10/29/2010)
Consolidated Amended Complaint, The Shane Group, Inc. et al. v. BCBSM (6/22/2012)
Appendix A of Defendant Blue Cross Blue Shield of Michigan's Answers and Objections to Plaintiffs' Second Set of Interrogatories (2/24/2012)
Class Action Complaint, Scott Steele, Inc. et al. v. BCBSM (1/30/2011)
Class Action Complaint, Michigan Regional Council of Carpenters Employee Benefit Fund, Inc. et al. v. BCBSM (12/08/2010)

Correspondences

BCN Responses to 1.9.2013 Class Questions re: BCN Data.
DOJ BCBSM BCN FACETS Questions, November 19, 2012.
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Letter from M. Alamo to D. Hedlund re: BCBSM Responses to DOJ's 11.19.2012 Questions Regarding BCN FACETS DATA, January 22, 2013.
Letter from M. Fait to L. Burns re: Subpoena requesting the production of documents, October 28, 2011.
Letter from M. Fait to S. Hessen re: Steven Andrews Deposition which is to take place on November 2, 2011., October 31, 2011.
Letter from S. Wilson to R. Danks and J. Martin, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, August 24, 2012.
Letter from S. Wilson to J. Beach, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, December,17, 2012.
Letter from S. Wilson to J. Beach, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, December 26, 2012.
Letter from S. Wilson to J. Martin, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, October 4, 2012.
Responses to Question re: Shane Group's Feb 14 2013 BCBSM Data Questions, November 19, 2013.
Supplemental Responses to Feb 14, 2013 Revised Questions for BCBSM Regarding EDW and BCN Data.

Telephone Interview

Conference call regarding EDW data with a BCBSM representative (1/28/2013)
Conference call regarding HAP data (3/12/2013)
Conference call regarding HAP data (4/30/2013)
Discussion of Aetna data with an Aetna representative (7/2/2013)

Depositions and/or Exhibits

Andreshak, Michael (10/29/2012)
Andrews, Steve (11/02/2011)
Berenson, Bill (10/11/2012)
Byrnes, Alan (11/26/2012)
Connolly, Jeffrey L. (8/27/2012)
Crofoot, Ronald (11/29/2012)
Darland, Douglas (11/14/2012, 11/15/2012)
Dunn, John (10/12/2012)
Fifer, Joseph (8/23/2012)
Hall, Mark (11/14/2012)
Harning, Richard (11/7/2011)
Horn, Kimberly (11/9/2012)
Leach, Steven (3/15/2012)
Roeser, William (8/8/2012)
Rosin, Kirk W. (11/27/2012)
Smith, Robert (11/14/2012)
Whitford, Donald (11/21/2012)

Expert Reports

Scheffman, David T. (4/17/2013)
Vellturo, Christopher A. (1/30/2013)

Documents

AETNA prefix
00068037
00071138
00071563 - 00071583
00072525 - 00072529
00075021 - 00075028
00077640 - 00077641
00746986

AGH prefix
04-000049 - 000080
06-000621

BLUECROSSMI-10 prefix

Exhibit 2
In re: The Shane Group, Inc., et al. v. Blue Cross Blue Shield of Michigan
List of Materials Reviewed

002455 - 002465

BLUECROSSMI-99 prefix

076711
103996 - 104020
126613 - 126622
139506 - 139509
142614
153748 - 153755
166650
170729 - 170732
176762
179584 - 179589
194458 - 194459
204723 - 204778
362030 - 362074
388498 - 388503
390019
396831
403836 403839
409543 - 409590
637450
848507 - 848510
00989332 - 00989463
01010153
01983963 - 01983989
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02279582 - 02279585
02280185
02984062 - 02984066
03785568
06233228 - 06233239

CAH prefix

000457 - 000494

CIVLIT prefix

00361349
00270479 - 00270489

HAP-DOJ prefix

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002911
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003099 - 003109
003114
003875 - 003898
003911

NPI prefix

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1568739423
1578501367
1639186521
1750694790

PH-DOJ prefix

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0001642

Exhibit 2
In re: The Shane Group, Inc., et al. v. Blue Cross Blue Shield of Michigan
List of Materials Reviewed

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Exhibit 3: Michigan Acute Care Hospitals, 2011

	Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1	Allegan General Hospital	QHR	5	Equal-to-MFN	Allegan	4,990	Holland, MI	111,591	25	879
2	Allegiance Health		2	Equal-to-MFN	Jackson	33,425	Jackson, MI	159,810	305	20,280
3	Alpena Regional Medical Center		3	MFN Plus	Alpena	10,410	Alpena, MI	29,352	125	4,902
4	Aspirus Grand View Hospital[4]		5	Equal-to-MFN	Ironwood	5,335				992
5	Aspirus Keweenaw Hospital	Aspirus, Inc.	5	Equal-to-MFN	Laurium	1,977	Houghton, MI	38,943	25	1,097
6	Aspirus Ontonagon Hospital	Aspirus, Inc.	5	Equal-to-MFN	Ontonagon	1,455			18	631
7	Baraga County Memorial Hospital		5	Equal-to-MFN	L'anse	1,998			15	558
8	Beaumont Hospital - Grosse Pointe	Beaumont Health System	2	MFN Plus	Grosse Pointe	5,365	Detroit-Warren-Dearborn, MI	4,287,966	250	10,301
9	Beaumont Hospital - Royal Oak	Beaumont Health System	1	MFN Plus	Royal Oak	57,607	Detroit-Warren-Dearborn, MI	4,287,966	1,070	55,689
10	Beaumont Hospital - Troy	Beaumont Health System	2	MFN Plus	Troy	81,508	Detroit-Warren-Dearborn, MI	4,287,966	394	28,966
11	Bell Hospital		5	Equal-to-MFN	Ishpeming	6,531	Marquette, MI	67,563	25	1,396
12	Borgess Medical Center	Ascension Health	1	MFN Plus	Kalamazoo	74,743	Kalamazoo-Portage, MI	328,353	387	19,607
13	Borgess-Lee Memorial Hospital	Ascension Health	5	Equal-to-MFN	Dowagiac	5,843	South Bend-Mishawaka, IN-MI	319,235	25	830
14	Botsford Hospital		1	MFN Plus	Farmington Hills	80,258	Detroit-Warren-Dearborn, MI	4,287,966	306	16,364
15	Bronson Battle Creek	Bronson Healthcare Group, Inc.	2		Battle Creek	52,093	Battle Creek, MI	135,529	218	10,361
16	Bronson LakeView Hospital	Bronson Healthcare Group, Inc.	5	Equal-to-MFN	Paw Paw	3,529	Kalamazoo-Portage, MI	328,353	35	1,007
17	Bronson Methodist Hospital	Bronson Healthcare Group, Inc.	1		Kalamazoo	74,743	Kalamazoo-Portage, MI	328,353	368	22,681
18	Caro Community Hospital		5	Equal-to-MFN	Caro	4,208			25	183
19	Carson City Hospital		4		Carson City	1,089	Grand Rapids-Wyoming, MI	996,454	62	1,874
20	Charlevoix Area Hospital		5	Equal-to-MFN	Charlevoix	2,518			25	1,018
21	Cheboygan Memorial Hospital[5]		4	Equal-to-MFN	Cheboygan	4,826			91	2,302
22	Chelsea Community Hospital	Trinity Health	4		Chelsea	4,991	Ann Arbor, MI	348,637	102	3,835
23	County		4	Equal-to-MFN	Coldwater	10,931	Coldwater, MI	43,902	96	3,508
24	Covenant Medical Center		1	MFN Plus	Saginaw	51,230	Saginaw, MI	198,990	533	27,634
25	Crittenton Hospital Medical Center		3		Rochester	12,793	Detroit-Warren-Dearborn, MI	4,287,966	254	12,921
26	Deckerville Community Hospital		5	Equal-to-MFN	Deckerville	820			15	198
27	Health Center	Vanguard Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	268	12,977
28	Dickinson County Healthcare System		4	MFN Plus	Iron Mountain	7,630	Iron Mountain, MI-WI	30,596	96	3,397
29	Doctors' Hospital of Michigan		1		Pontiac	59,887	Detroit-Warren-Dearborn, MI	4,287,966	77	2,812
30	Eaton Rapids Medical Center		5	Equal-to-MFN	Eaton Rapids	5,229	Lansing-East Lansing, MI	465,614	20	368
31	Forest Health Medical Center		3		Ypsilanti	19,596	Ann Arbor, MI	348,637	24	1,463
32	Garden City Hospital		1		Garden City	27,408	Detroit-Warren-Dearborn, MI	4,287,966	220	9,480
33	Genesys Regional Medical Center	Ascension Health	1	MFN Plus	Grand Blanc	8,204	Flint, MI	422,053	410	22,057
34	Harbor Beach Community Hospital		5	Equal-to-MFN	Harbor Beach	1,681			54	137
35	Women's Hospital	Vanguard Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	535	21,547
36	Hayes Green Beach Memorial Hospital	QHR	5	Equal-to-MFN	Charlotte	9,099	Lansing-East Lansing, MI	465,614	25	654
37	Helen Newberry Joy Hospital		5	Equal-to-MFN	Newberry	1,507			73	504
38	Henry Ford Cottage Hospital[6]		2		Farms	9,382	Detroit-Warren-Dearborn, MI	4,287,966	80	3,357
39	Henry Ford Hospital	Henry Ford Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	759	41,056
40	Campus		2		Warren	134,243	Detroit-Warren-Dearborn, MI	4,287,966	122	6,045
41	Henry Ford Macomb Hospitals	Henry Ford Health System	2		township	96,931	Detroit-Warren-Dearborn, MI	4,287,966	421	23,651
42	Henry Ford West Bloomfield Hospital	Henry Ford Health System	3		charter township	65,110	Detroit-Warren-Dearborn, MI	4,287,966	191	12,553
43	Henry Ford Wyandotte Hospital	Henry Ford Health System	2		Wyandotte	25,618	Detroit-Warren-Dearborn, MI	4,287,966	348	19,648
44	Hills & Dales General Hospital		5	Equal-to-MFN	Cass City	2,415			25	503
45	Hillsdale Community Health Center		4		Hillsdale	8,278	Hillsdale, MI	46,565	84	3,564
46	Holland Hospital		3		Holland	33,270	Grand Rapids-Wyoming, MI	996,454	130	6,964
47	Hurley Medical Center		1		Flint	101,558	Flint, MI	422,053	418	17,988
48	Huron Medical Center		5	Equal-to-MFN	Bad Axe	3,090			37	1,592
49	Huron Valley-Sinai Hospital	Vanguard Health System	2		township	40,449	Detroit-Warren-Dearborn, MI	4,287,966	153	9,136

Exhibit 3: Michigan Acute Care Hospitals, 2011

	Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
50	Kalkaska Memorial Health Center	Munson Healthcare	5	Equal-to-MFN	Kalkaska	2,022	Traverse City, MI	144,585	96	183
51	Watervliet	Lakeland Healthcare	5	Equal-to-MFN	Watervliet	1,736	Niles-Benton Harbor, MI	156,489	38	834
52	Joseph	Lakeland Healthcare	2		St. Joseph	8,372	Niles-Benton Harbor, MI	156,489	250	16,105
53	Mackinac Straits Health System		5	Equal-to-MFN	St. Ignace	2,435			63	320
54	Marlette Regional Hospital		5	Equal-to-MFN	Marlette	1,854			74	1,180
55	Marquette General Health System		2	MFN Plus	Marquette	21,524	Marquette, MI	67,563	276	10,535
56	McKenzie Health System		5	Equal-to-MFN	Sandusky	2,650			25	451
57	McLaren Bay Region	McLaren Health Care Corporation	2		Bay City	34,717	Bay City, MI	107,273	338	16,647
58	McLaren Central Michigan	McLaren Health Care Corporation	3		Mount Pleasant	26,111	Mount Pleasant, MI	70,636	78	3,813
59	McLaren Flint	McLaren Health Care Corporation	1		Flint	101,558	Flint, MI	422,053	336	21,520
60	McLaren Greater Lansing	McLaren Health Care Corporation	1		Lansing	114,605	Lansing-East Lansing, MI	465,614	318	15,927
61	McLaren Lapeer Region	McLaren Health Care Corporation	3		Lapeer	8,819	Detroit-Warren-Dearborn, MI	4,287,966	157	6,914
62	McLaren Macomb	McLaren Health Care Corporation	1		Mount Clemens	16,334	Detroit-Warren-Dearborn, MI	4,287,966	288	14,941
63	McLaren Northern Michigan	McLaren Health Care Corporation	3		Petoskey	5,696			178	8,803
64	McLaren Oakland	McLaren Health Care Corporation	1		Pontiac	59,887	Detroit-Warren-Dearborn, MI	4,287,966	288	6,160
65	Mecosta County Medical Center		4		Big Rapids	10,695	Big Rapids, MI	43,296	49	2,324
66	Memorial Healthcare		3		Owosso	15,024	Owosso, MI	69,934	134	4,039
67	Michigan		4	Equal-to-MFN	Ludington	8,069	Ludington, MI	28,642	80	2,379
68	Campus	Trinity Health	3		Muskegon	38,225	Muskegon, MI	170,021	213	8,902
69	Campus	Trinity Health	5	Equal-to-MFN	Shelby	2,060			24	488
70	Mercy Health Partners, Mercy Campus	Trinity Health	2		Muskegon	38,225	Muskegon, MI	170,021	188	10,170
71	Mercy Hospital Cadillac	Trinity Health	3		Cadillac	10,349	Cadillac, MI	47,622	65	4,044
72	Mercy Hospital Grayling	Trinity Health	4		Grayling	1,876			94	3,761
73	Mercy Memorial Hospital System		3		Monroe	20,672	Monroe, MI	151,609	169	9,605
74	Metro Health Hospital		2	MFN Plus	Wyoming	72,833	Grand Rapids-Wyoming, MI	996,454	208	10,147
75	MidMichigan Medical Center-Clare	MidMichigan Health	5	Equal-to-MFN	Clare	3,128			49	1,608
76	MidMichigan Medical Center-Gladwin	MidMichigan Health	5	Equal-to-MFN	Gladwin	2,950			25	592
77	MidMichigan Medical Center-Gratiot	MidMichigan Health	3	MFN Plus	Alma	9,312	Alma, MI	42,139	136	5,734
78	MidMichigan Medical Center-Midland	MidMichigan Health	2	MFN Plus	Midland	42,075	Midland, MI	84,015	250	11,133
79	Munising Memorial Hospital		5	Equal-to-MFN	Munising	2,329			25	193
80	Munson Medical Center	Munson Healthcare	2	MFN Plus	Traverse City	14,894	Traverse City, MI	144,585	391	23,392
81	NORTHSTAR Health System		5	Equal-to-MFN	Iron River	3,025			25	906
82	North Ottawa Community Hospital		4		Grand Haven	10,511	Grand Rapids-Wyoming, MI	996,454	39	1,615
83	OSF St. Francis Hospital	OSF Healthcare System	4		Escanaba	12,627	Escanaba, MI	36,955	48	2,042
84	Oakland Regional Hospital		3		Southfield	72,201	Detroit-Warren-Dearborn, MI	4,287,966	71	323
85	Oaklawn Hospital		4		Marshall	7,053	Battle Creek, MI	135,529	78	3,805
86	Oakwood Annapolis Hospital	Oakwood Healthcare, Inc.	2		Wayne	17,414	Detroit-Warren-Dearborn, MI	4,287,966	211	8,748
87	Oakwood Heritage Hospital	Oakwood Healthcare, Inc.	3		Taylor	62,489	Detroit-Warren-Dearborn, MI	4,287,966	183	8,029
88	Dearborn	Oakwood Healthcare, Inc.	1		Dearborn	97,144	Detroit-Warren-Dearborn, MI	4,287,966	553	31,762
89	Oakwood Southshore Medical Center	Oakwood Healthcare, Inc.	3		Trenton	18,662	Detroit-Warren-Dearborn, MI	4,287,966	144	8,334
90	Otsego Memorial Hospital		5	Equal-to-MFN	Gaylord	3,632			80	1,584
91	Paul Oliver Memorial Hospital	Munson Healthcare	5	Equal-to-MFN	Frankfort	1,280	Traverse City, MI	144,585	47	77
92	Pennock Hospital		4	Equal-to-MFN	Hastings	7,308	Grand Rapids-Wyoming, MI	996,454	58	2,673
93	Port Huron Hospital	Corporation	3		Port Huron	29,928	Detroit-Warren-Dearborn, MI	4,287,966	186	12,017
94	Portage Health		5	Equal-to-MFN	Hancock	4,635	Houghton, MI	38,943	96	1,730
95	ProMedica Bixby Hospital	ProMedica Health System	3		Adrian	21,045	Adrian, MI	99,340	66	4,217
96	ProMedica Herrick Hospital	ProMedica Health System	4	Equal-to-MFN	Tecumseh	8,481	Adrian, MI	99,340	60	1,640
97	Providence Hospital	Ascension Health	1	MFN Plus	Southfield	72,201	Detroit-Warren-Dearborn, MI	4,287,966	430	20,728
98	Providence Park Hospital		3	MFN Plus	Novi	55,583	Detroit-Warren-Dearborn, MI	4,287,966	222	12,771

Exhibit 3: Michigan Acute Care Hospitals, 2011

	Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
99	Saint Mary's Health Care	Trinity Health	1		Grand Rapids	189,815	Grand Rapids-Wyoming, MI	996,454	344	19,919
100	Scheurer Hospital		5	Equal-to-MFN	Pigeon	1,193			44	555
101	Schoolcraft Memorial Hospital		5	Equal-to-MFN	Manistique	3,098			18	336
102	Sheridan Community Hospital		5	Equal-to-MFN	Sheridan	646	Grand Rapids-Wyoming, MI	996,454	22	276
103	Sinai-Grace Hospital	Vanguard Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	337	18,414
104	South Haven Health System		5	Equal-to-MFN	South Haven	4,396	Kalamazoo-Portage, MI	328,353	33	1,135
105	Southeast Michigan Surgical Hospital	National Surgical Hospitals	3		Warren	134,243	Detroit-Warren-Dearborn, MI	4,287,966	20	106
106	Sparrow Clinton Hospital	Sparrow Health System	5	Equal-to-MFN	St. Johns	7,873	Lansing-East Lansing, MI	465,614	25	769
107	Sparrow Hospital	Sparrow Health System	1	MFN Plus	Lansing	114,605	Lansing-East Lansing, MI	465,614	638	32,611
108	Sparrow Ionia Hospital	Sparrow Health System	5	Equal-to-MFN	Ionia	11,402	Ionia, MI	63,898	25	501
109	Spectrum Health Butterworth Hospital	Spectrum Health	1		Grand Rapids	189,815	Grand Rapids-Wyoming, MI	996,454	1,066	57,057
110	Spectrum Health Gerber Memorial	Spectrum Health	4		Fremont	4,078			40	2,571
111	Spectrum Health Kelsey Hospital[7]	Spectrum Health	5	Equal-to-MFN	Lakeview	1,003	Grand Rapids-Wyoming, MI	996,454	29	321
112	Spectrum Health Reed City Hospital	Spectrum Health	5	Equal-to-MFN	Reed City	2,423			74	858
113	Hospital	Spectrum Health	4		Greenville	8,460	Grand Rapids-Wyoming, MI	996,454	88	2,748
114	Hospital		3		Zeeland	5,556	Grand Rapids-Wyoming, MI	996,454	57	1,590
115	St John Detroit Riverview Hosp[8]	Ascension Health	2		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	285	11,432
116	St. John Hospital and Medical Center	Ascension Health	1	MFN Plus	Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	680	34,376
117	Macomb Center	Ascension Health	2	MFN Plus	Warren	134,243	Detroit-Warren-Dearborn, MI	4,287,966	336	20,029
118	Oakland Center[9]	Ascension Health	2		Madison Heights	29,887	Detroit-Warren-Dearborn, MI	4,287,966	157	7,425
119	St. John North Shores Hospital[6]	Ascension Health	3	MFN Plus	township	24,622	Detroit-Warren-Dearborn, MI	4,287,966	60	979
120	St. John River District Hospital	Ascension Health	3	MFN Plus	township	3,757	Detroit-Warren-Dearborn, MI	4,287,966	68	1,888
121	St. Joseph Health System	Ascension Health	4	MFN Plus	Tawas City	1,806			20	1,113
122	St. Joseph Mercy Hospital	Trinity Health	1		Ypsilanti	19,596	Ann Arbor, MI	348,637	530	31,956
123	St. Joseph Mercy Livingston Hospital	Trinity Health	4		Howell	9,527	Detroit-Warren-Dearborn, MI	4,287,966	55	3,481
124	St. Joseph Mercy Oakland	Trinity Health	1		Pontiac	59,887	Detroit-Warren-Dearborn, MI	4,287,966	409	19,385
125	St. Joseph Mercy Port Huron	Trinity Health	3		Port Huron	29,928	Detroit-Warren-Dearborn, MI	4,287,966	119	4,196
126	St. Joseph Mercy Saline Hospital[5]	Trinity Health	3		Saline	8,893	Ann Arbor, MI	348,637	24	883
127	St. Mary Mercy Hospital	Trinity Health	3		Livonia	95,958	Detroit-Warren-Dearborn, MI	4,287,966	289	16,877
128	St. Mary's of Michigan	Ascension Health	2	MFN Plus	Saginaw	51,230	Saginaw, MI	198,990	228	11,149
129	Hospital	Ascension Health	5	Equal-to-MFN	Standish	1,487			68	968
130	Straith Hospital for Special Surgery		3		Southfield	72,201	Detroit-Warren-Dearborn, MI	4,287,966	24	611
131	Sturgis Hospital	QHR	4		Sturgis	10,967	Sturgis, MI	61,016	49	1,625
132	Three Rivers Health	QHR	5	Equal-to-MFN	Three Rivers	7,791	Sturgis, MI	61,016	35	1,737
133	Health Centers		1		Ann Arbor	114,925	Ann Arbor, MI	348,637	919	45,137
134	War Memorial Hospital		4		Sault Ste. Marie	14,253	Sault Ste. Marie, MI	38,776	139	3,316
135	West Branch Regional Medical Center		4		West Branch	2,127			78	2,330
136	West Shore Medical Center		5	Equal-to-MFN	Manistee	6,220			34	1,666

Note:

[1] Core Based Statistical Area is a collective term for both metropolitan and micropolitan statistical areas. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. See http://www.census.gov/population/metro/. Last accessed May 16, 2013.

[2] Total beds; HOSPBD in AHA Annual Survey Database.

[3] Total facility admissions; ADMTOT in AHA Annual Survey Database.

[4] AHA data have been adjusted to correct for partial year.

[5] Beds and Admissions data are from 2010.

[6] Beds and Admissions data are from 2009.

Exhibit 3: Michigan Acute Care Hospitals, 2011

Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

[7] Combined with Spectrum Health United Hospital in the AHA database. These hospitals have been separated here using the relative shares in Medicare data.
[8] Beds and Admissions data are from 2006.
[9] Merged with St. John Macomb-Oakland Hospital, Macomb Center, in 2007, per http://www.stjohnprovidence.org/Oakland/. Last accessed May 16, 2013.

Source:

Cols. (1), (2), (5), (9) & (10): AHA Annual Survey Database, 2011 unless otherwise noted.

Col. (3): BLUECROSSMI-99-02245412, BLUECROSSMI-99-01366299, BLUECROSSMI-99-439825, BLUECROSSMI-99-196148, BLUECROSSMI-99-658742, BCBSM EDW MED_BILL_PROV_HSTY Tables.
For Crittenton Hospital Medical Center, Lakeland Regional Medical Center-St. Joseph, MidMichigan Medical Center-Clare, Oakland Regional Hospital, St. Jospeh Mercy Saline Hospital, and St. Mary Mercy Hospital, peer groups were inferred from AHA Annual Survey Database and BLUECROSSMI-99-01010153.

Col. (4): MFN hospitals: DOJ v. BCBSM Defendant's Answers and Objections to Plaintiffs' Second Set of Interrogations, BLUECROSSMI-99-06171298; MFN Pluses: BLUECROSSMI-99-127218, BLUECROSSMI-99-135673, BLUECROSSMI-99-141212, BLUECROSSMI-99-142614, BLUECROSSMI-99-144371, BLUECROSSMI-99-169218, BLUECROSSMI-99-191636, BLUECROSSMI-99-193227, BLUECROSSMI-99-194458, BLUECROSSMI-99-388498, CIVLIT-BCBSM-00270479, MHC-EDMI-000930

Col. (6): U.S. Census Bureau Population Estimates, Incorporated Places and Minor Civil Divisions - Datasets, Michigan, at http://www.census.gov/popest/data/cities/totals/2011/SUB-EST2011-states.html. Last accessed May 16, 2013.

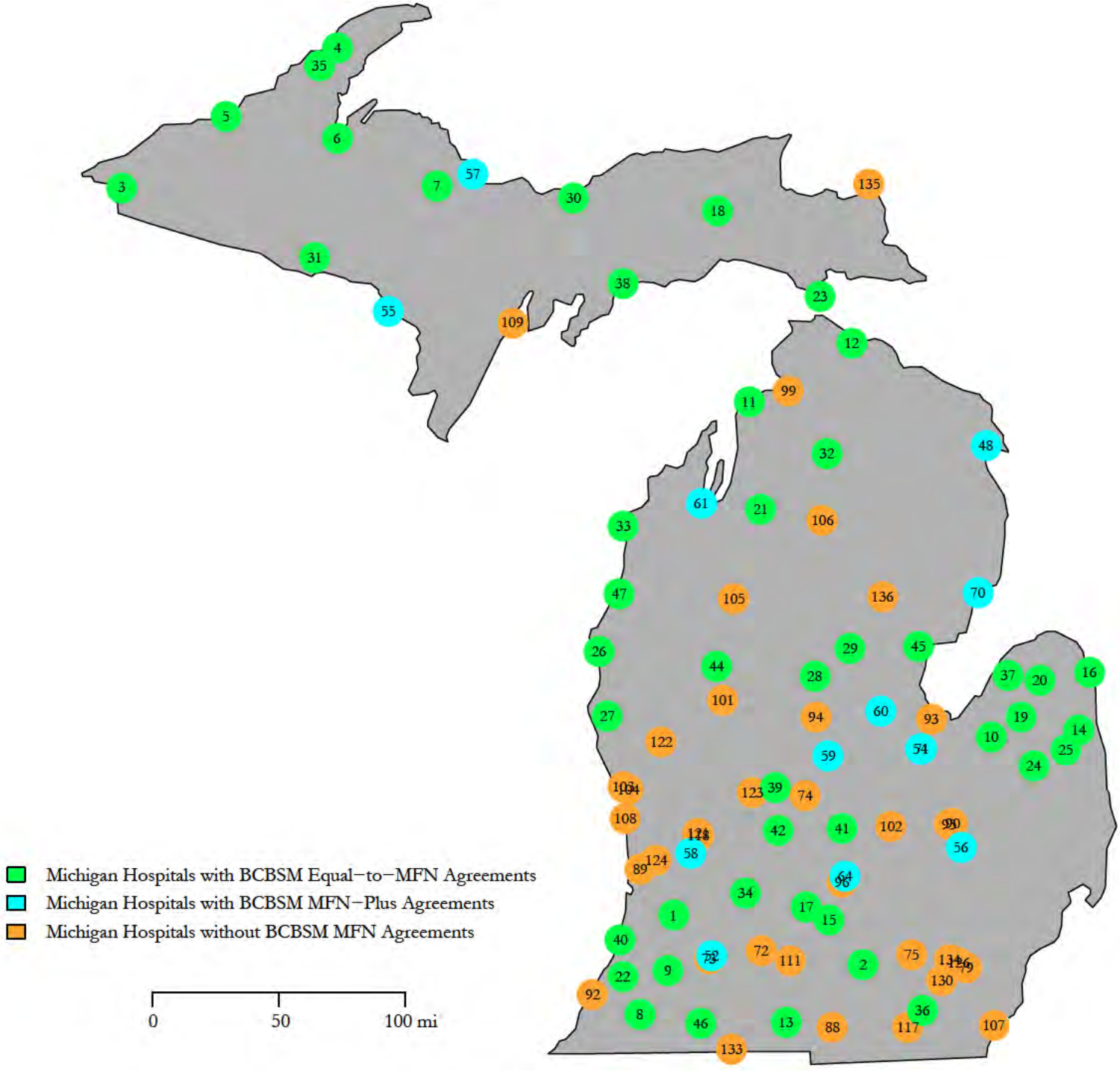
Cols. (7) & (8): U.S. Census Bureau Metropolitan and Micropolitan Delineation Files, Core based statistical areas (CBSAs) and combined statistical areas (CSAs), Feb. 2013, at http://www.census.gov/population/metro/data/def.html. Last accessed May 16, 2013.
U.S. Census Bureau Population Estimates, Metropolitan and Micropolitan Statistical Areas, Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2010 to July 1, 2012 (CBSA-EST2012-01), at http://www.census.gov/popest/data/metro/totals/2012/index.html. Last accessed May 16, 2013.

Exhibit 4: Fully-Insured Commercial Insurance: Share by Lives Covered

	2003	2004	2005	2006	2007	2008	2009	2010	2011
	(Percent)								
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
BCBSM	56 %	54 %	56 %	57 %	59 %	60 %	60 %	58 %	55 %
Priority Health	11	12	13	13	10	10	13	14	16
Health Alliance Plan	11	11	12	12	11	10	10	10	11
HealthPlus	2	2	2	2	2	3	2	3	3
UnitedHealth	2	2	2	3	2	3	2	3	3
Aetna	1	1	0	1	2	3	2	2	2
All others	18	18	14	13	13	11	11	10	9

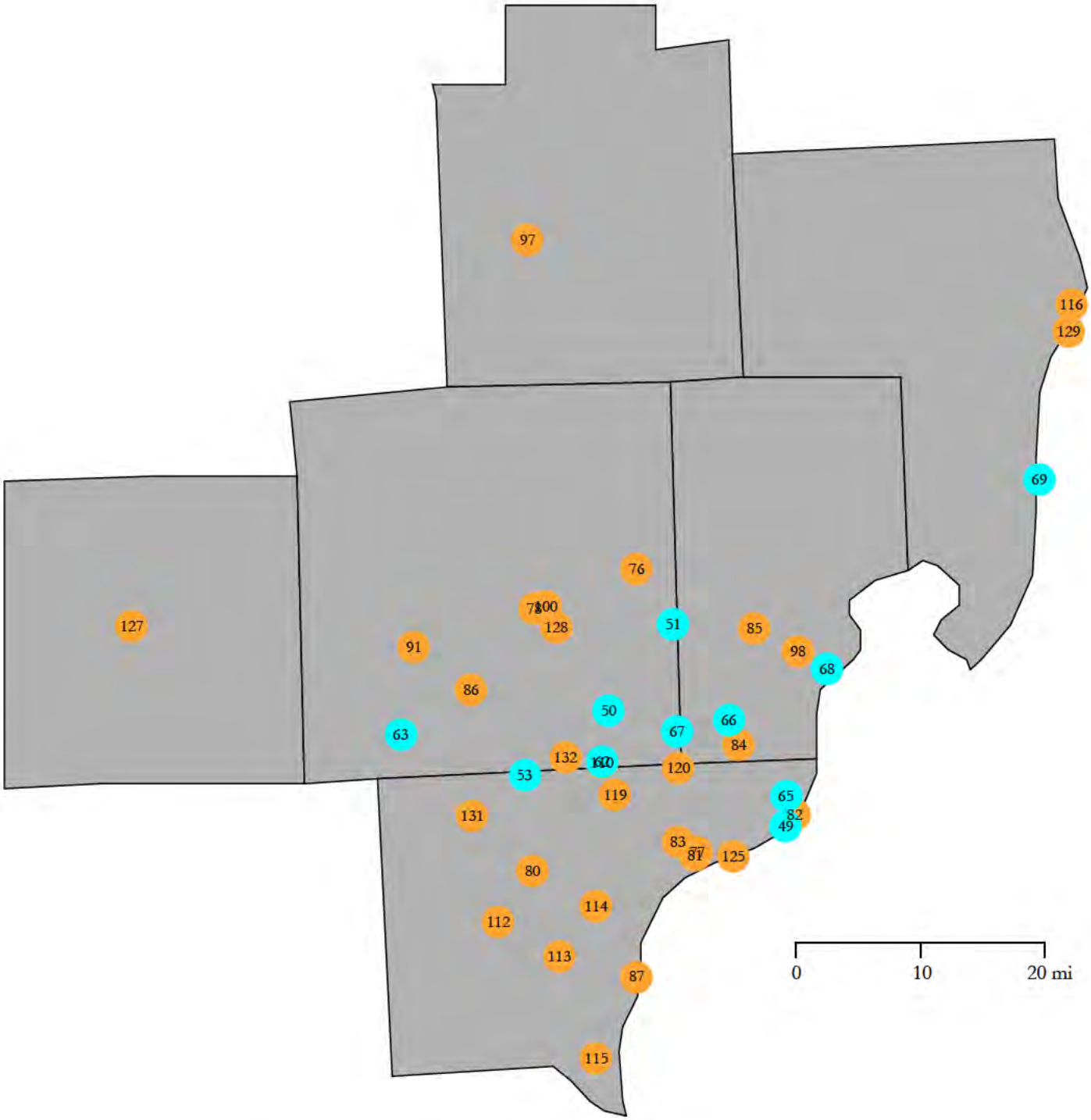
Source: Michigan Office of Financial and Insurance Regulation (OFIR).

Figure 1: Michigan Acute Care Hospital Locations Outside of the Detroit–Warren–Livonia Metropolitan Division



Source: AHA Annual Survey Data.

Figure 2: Acute Care Hospital Locations in the Detroit–Warren–Livonia Metropolitan Division



Michigan Hospitals with BCBSM Equal–to–MFN Agreements
Michigan Hospitals with BCBSM MFN–Plus Agreements
Michigan Hospitals without BCBSM MFN Agreements

Source: AHA Annual Survey Data.

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
1	Allegan General Hospital	Equal-to-MFN
2	Allegiance Health	Equal-to-MFN
3	Aspirus Grand View Hospital	Equal-to-MFN
4	Aspirus Keweenaw Hospital	Equal-to-MFN
5	Aspirus Ontonagon Hospital	Equal-to-MFN
6	Baraga County Memorial Hospital	Equal-to-MFN
7	Bell Hospital	Equal-to-MFN
8	Borgess-Lee Memorial Hospital	Equal-to-MFN
9	Bronson LakeView Hospital	Equal-to-MFN
10	Caro Community Hospital	Equal-to-MFN
11	Charlevoix Area Hospital	Equal-to-MFN
12	Cheboygan Memorial Hospital	Equal-to-MFN
13	Community Health Center of Branch County	Equal-to-MFN
14	Deckerville Community Hospital	Equal-to-MFN
15	Eaton Rapids Medical Center	Equal-to-MFN
16	Harbor Beach Community Hospital	Equal-to-MFN
17	Hayes Green Beach Memorial Hospital	Equal-to-MFN
18	Helen Newberry Joy Hospital	Equal-to-MFN
19	Hills & Dales General Hospital	Equal-to-MFN
20	Huron Medical Center	Equal-to-MFN
21	Kalkaska Memorial Health Center	Equal-to-MFN
22	Lakeland Community Hospital Watervliet	Equal-to-MFN
23	Mackinac Straits Health System	Equal-to-MFN
24	Marlette Regional Hospital	Equal-to-MFN
25	McKenzie Health System	Equal-to-MFN
26	Memorial Medical Center of West Michigan	Equal-to-MFN
27	Mercy Health Partners, Lakeshore Campus	Equal-to-MFN
28	MidMichigan Medical Center-Clare	Equal-to-MFN
29	MidMichigan Medical Center-Gladwin	Equal-to-MFN
30	Munising Memorial Hospital	Equal-to-MFN
31	NORTHSTAR Health System	Equal-to-MFN
32	Otsego Memorial Hospital	Equal-to-MFN
33	Paul Oliver Memorial Hospital	Equal-to-MFN
34	Pennock Hospital	Equal-to-MFN
35	Portage Health	Equal-to-MFN
36	ProMedica Herrick Hospital	Equal-to-MFN
37	Scheurer Hospital	Equal-to-MFN
38	Schoolcraft Memorial Hospital	Equal-to-MFN
39	Sheridan Community Hospital	Equal-to-MFN
40	South Haven Health System	Equal-to-MFN
41	Sparrow Clinton Hospital	Equal-to-MFN
42	Sparrow Ionia Hospital	Equal-to-MFN
43	Spectrum Health Kelsey Hospital	Equal-to-MFN

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
44	Spectrum Health Reed City Hospital	Equal-to-MFN
45	St. Mary's of Michigan Standish Hospital	Equal-to-MFN
46	Three Rivers Health	Equal-to-MFN
47	West Shore Medical Center	Equal-to-MFN
48	Alpena Regional Medical Center	MFN PLUS
49	Beaumont Hospital - Grosse Pointe	MFN PLUS
50	Beaumont Hospital - Royal Oak	MFN PLUS
51	Beaumont Hospital - Troy	MFN PLUS
52	Borgess Medical Center	MFN PLUS
53	Botsford Hospital	MFN PLUS
54	Covenant Medical Center	MFN PLUS
55	Dickinson County Healthcare System	MFN PLUS
56	Genesys Regional Medical Center	MFN PLUS
57	Marquette General Health System	MFN PLUS
58	Metro Health Hospital	MFN PLUS
59	MidMichigan Medical Center-Gratiot	MFN PLUS
60	MidMichigan Medical Center-Midland	MFN PLUS
61	Munson Medical Center	MFN PLUS
62	Providence Hospital	MFN PLUS
63	Providence Park Hospital	MFN PLUS
64	Sparrow Hospital	MFN PLUS
65	St. John Hospital and Medical Center	MFN PLUS
66	St. John Macomb-Oakland Hospital, Macomb Center	MFN PLUS
67	St. John Macomb-Oakland Hospital, Oakland Center	MFN PLUS
68	St. John North Shores Hospital	MFN PLUS
69	St. John River District Hospital	MFN PLUS
70	St. Joseph Health System	MFN PLUS
71	St. Mary's of Michigan	MFN PLUS
72	Bronson Battle Creek	NON MFN
73	Bronson Methodist Hospital	NON MFN
74	Carson City Hospital	NON MFN
75	Chelsea Community Hospital	NON MFN
76	Crittenton Hospital Medical Center	NON MFN
77	Detroit Receiving Hospital/University Health Center	NON MFN
78	Doctors' Hospital of Michigan	NON MFN
79	Forest Health Medical Center	NON MFN
80	Garden City Hospital	NON MFN
81	Harper University Hospital/Hutzel Women's Hospital	NON MFN
82	Henry Ford Cottage Hospital	NON MFN
83	Henry Ford Hospital	NON MFN
84	Henry Ford Macomb Hospital-Warren Campus	NON MFN
85	Henry Ford Macomb Hospitals	NON MFN
86	Henry Ford West Bloomfield Hospital	NON MFN

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
87	Henry Ford Wyandotte Hospital	NON MFN
88	Hillsdale Community Health Center	NON MFN
89	Holland Hospital	NON MFN
90	Hurley Medical Center	NON MFN
91	Huron Valley-Sinai Hospital	NON MFN
92	Lakeland Regional Medical Center-St. Joseph	NON MFN
93	McLaren Bay Region	NON MFN
94	McLaren Central Michigan	NON MFN
95	McLaren Flint	NON MFN
96	McLaren Greater Lansing	NON MFN
97	McLaren Lapeer Region	NON MFN
98	McLaren Macomb	NON MFN
99	McLaren Northern Michigan	NON MFN
100	McLaren Oakland	NON MFN
101	Mecosta County Medical Center	NON MFN
102	Memorial Healthcare	NON MFN
103	Mercy Health Partners, Hackley Campus	NON MFN
104	Mercy Health Partners, Mercy Campus	NON MFN
105	Mercy Hospital Cadillac	NON MFN
106	Mercy Hospital Grayling	NON MFN
107	Mercy Memorial Hospital System	NON MFN
108	North Ottawa Community Hospital	NON MFN
109	OSF St. Francis Hospital	NON MFN
110	Oakland Regional Hospital	NON MFN
111	Oaklawn Hospital	NON MFN
112	Oakwood Annapolis Hospital	NON MFN
113	Oakwood Heritage Hospital	NON MFN
114	Oakwood Hospital & Medical Center-Dearborn	NON MFN
115	Oakwood Southshore Medical Center	NON MFN
116	Port Huron Hospital	NON MFN
117	ProMedica Bixby Hospital	NON MFN
118	Saint Mary's Health Care	NON MFN
119	Sinai-Grace Hospital	NON MFN
120	Southeast Michigan Surgical Hospital	NON MFN
121	Spectrum Health Butterworth Hospital	NON MFN
122	Spectrum Health Gerber Memorial	NON MFN
123	Spectrum Health United Memorial Hospital	NON MFN
124	Spectrum Health Zeeland Community Hospital	NON MFN
125	St John Detroit Riverview Hosp	NON MFN
126	St. Joseph Mercy Hospital	NON MFN
127	St. Joseph Mercy Livingston Hospital	NON MFN
128	St. Joseph Mercy Oakland	NON MFN
129	St. Joseph Mercy Port Huron	NON MFN

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
130	St. Joseph Mercy Saline Hospital	NON MFN
131	St. Mary Mercy Hospital	NON MFN
132	Straith Hospital for Special Surgery	NON MFN
133	Sturgis Hospital	NON MFN
134	University of Michigan Hospitals and Health Centers	NON MFN
135	War Memorial Hospital	NON MFN
136	West Branch Regional Medical Center	NON MFN

Source: AHA Annual Survey Data

Figure 3: Path of a Claim

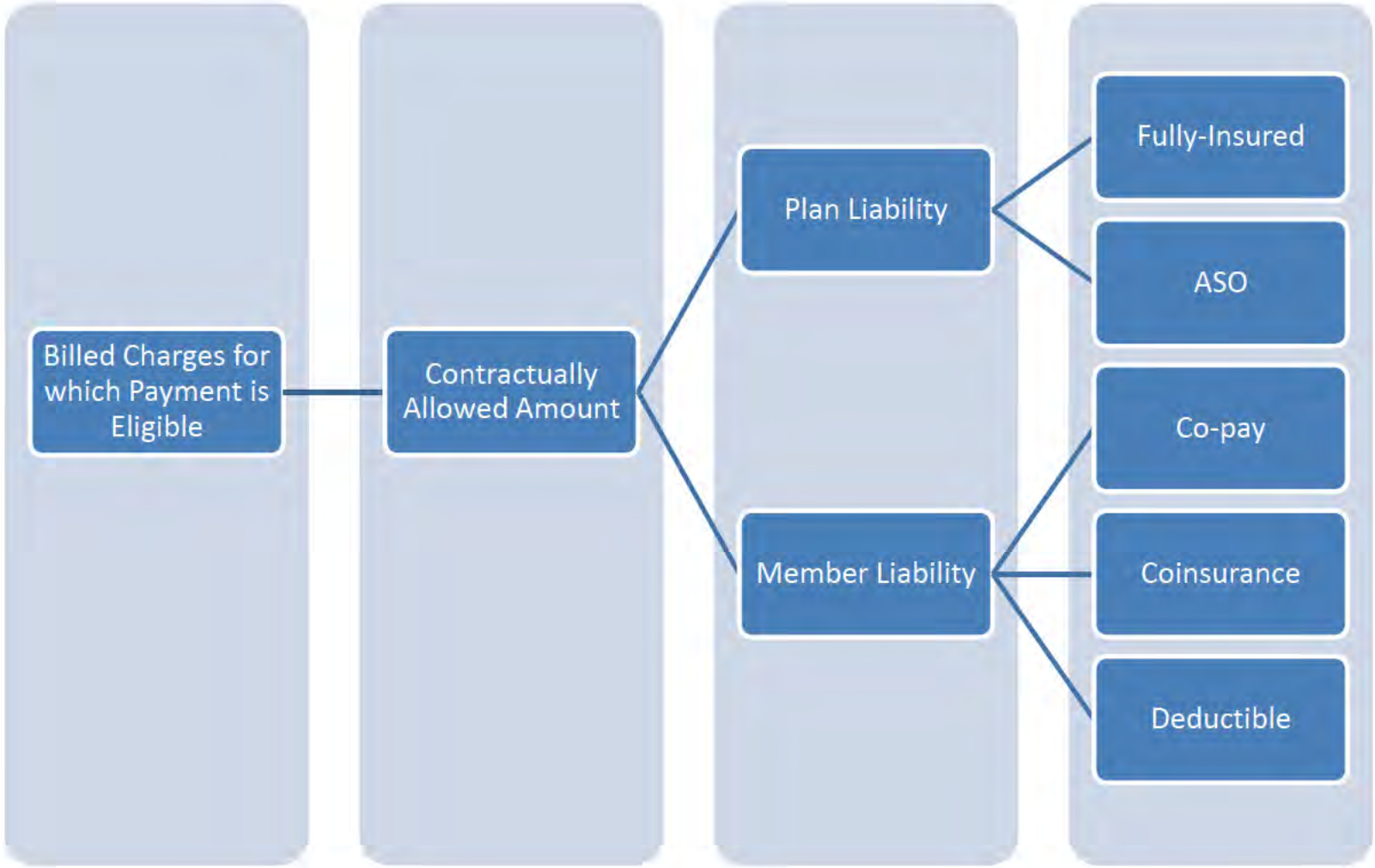


Exhibit 5: Counts and Shares of Acute Care Hospitals and Beds by Peer Group, 2011

Peer Group	Hospitals[1]		Beds[2]	
	Count	Share	Count	Share
		(Percent)		(Percent)
(1)	(2)	(3)	(4)	(5)
0	26	19.1 %	12,487	51.3 %
0	21	15.4	5,409	22.2
0	27	19.9	3,387	13.9
0	21	15.4	1,506	6.2
0	41	30.1	1,541	6.3
Total	136		24,330	

Note: [1] The following hospitals are excluded due to having no peer group information: CareLink of Jackson, Kindred Hospital-Detroit, and United Community Hospital.

[2] Total beds; HOSPBD in AHA Annual Survey Database.

Source: AHA Annual Survey Database, 2011;
BLUECROSSMI-99-02245412, BLUECROSSMI-99-01366299, BLUECROSSMI-99-439825, BLUECROSSMI-99-196148, BLUECROSSMI-99-658742, BCBSM EDW MED_BILL_PROV_HSTY Tables;
For Crittenton Hospital Medical Center, Lakeland Regional Medical Center-St. Joseph, MidMichigan Medical Center-Clare, Oakland Regional Hospital, St. Jospeh Mercy Saline Hospital, and St. Mary Mercy Hospital, peer groups were inferred from AHA Annual Survey Database and BLUECROSSMI-99-01010153.

Exhibit 6: Reimbursement Rates for Affected Combinations

Insurer	Hospital Name	Peer Group	Network	MFN Effective Date	MFN Terms	Insurer Contract Date	BCBSM Rate Before	BCBSM Rate After	Insurer Rate Before	Insurer Rate After
							(Percent)			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Priority	Allegan General Hospital	5	HMO	1/1/2010	Equal-to MFN: At least as favorable	1/1/2009	63 %	70 %	53 %	77 %
Priority	Allegan General Hospital	5	PPO	1/1/2010	Equal-to MFN: At least as favorable	1/1/2009	73	76	58	78
Priority	Charlevoix Area Hospital	5	PPO	7/1/2009	Equal-to MFN: At least as favorable	1/1/2009	83	75	68	91
Priority	Kalkaska Memorial Health Center	5	PPO	7/1/2009	Equal-to MFN: At least as favorable	7/1/2009	81	67	46	84
Priority	Mercy Health Partners, Lakeshore Campus	5	HMO	7/1/2009	Equal-to MFN: At least as favorable	1/1/2009	74	80	51	89
Priority	Mercy Health Partners, Lakeshore Campus	5	PPO	7/1/2009	Equal-to MFN: At least as favorable	1/1/2009	83	73	63	90
Priority	Paul Oliver Memorial Hospital	5	HMO	7/1/2009	Equal-to MFN: At least as favorable	7/1/2009	54	62	40	82
Priority	Paul Oliver Memorial Hospital	5	PPO	7/1/2009	Equal-to MFN: At least as favorable	7/1/2009	75	66	44	82
Priority	Sparrow Ionia Hospital	5	HMO	7/1/2009	Equal-to MFN: At least as favorable	12/1/2008	55	59	45	64
HAP	Beaumont Hospital - Grosse Pointe	2	PPO	1/1/2009	MFN Plus: "The estimated differential is minimally ten	1/1/2010	33	39	43	49
HAP	Beaumont Hospital - Royal Oak	1	HMO	2/7/2006	MFN Plus: "Beaumont Hospitals will guarantee that the	7/15/2006	27	29	43	47
HAP	Beaumont Hospital - Royal Oak	1	PPO	2/7/2006	MFN Plus: "Beaumont Hospitals will guarantee that the	5/1/2008	31	34	57	60
HAP	Beaumont Hospital - Troy	2	PPO	2/7/2006	MFN Plus: "Beaumont Hospitals will guarantee that the	5/1/2008	30	34	57	60
Aetna	Bronson LakeView Hospital	5	PPO	1/1/2010	Equal-to MFN: At least as favorable	1/1/2008	77	71	67	82
Aetna	Three Rivers Health	5	PPO	1/1/2010	Equal-to MFN: At least as favorable	1/1/2010	72	69	56	77

Note: BCBSM reimbursement rates are calculated before and after the MFN effective date. Insurer reimbursement rates are calculated before and after the insurer contract date.

Source: Insurers' claims data, Affected Hospital Contracts.xlsx.

Exhibit 7: Number of Non-MFN Hospitals by Peer Group and Insurer

	BCBSM	Priority Health	HAP	Aetna
	(Number of Hospitals)			
	(1)	(2)	(3)	(4)
Peer Group 1	18	14	17	12
Peer Group 2	11	8	11	9
Peer Group 3	22	16	19	18
Peer Group 4	15	12	13	11
Total	**66**	**50**	**60**	**50**

Source: Insurers' claims data 2004-2012.

Exhibit 8: DID Results for Affected Combinations

Hospital Name	MFN Type	Insurer	Network	Hospital Peer Group	Control Peer Group	DID (MFN*Post Period) (Percentage points)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Beaumont Hospital - Grosse Pointe	MFN Plus	BCBSM	PPO	2	2	15.8
Beaumont Hospital - Royal Oak	MFN Plus	BCBSM	PPO	1	1	0.9
Beaumont Hospital - Troy	MFN Plus	BCBSM	PPO	2	2	2.8
Providence Park Hospital	MFN Plus	BCBSM	PPO	3	3	13.6
St. John Hospital and Medical Center	MFN Plus	BCBSM	PPO	1	1	2.9
Allegan General Hospital	Equal-to-MFN	Priority	HMO	5	4	21.3
Allegan General Hospital	Equal-to-MFN	Priority	PPO	5	4	24.6
Charlevoix Area Hospital	Equal-to-MFN	Priority	PPO	5	4	28.9
Kalkaska Memorial Health Center	Equal-to-MFN	Priority	PPO	5	4	44.6
Mercy Health Partners, Lakeshore Campus	Equal-to-MFN	Priority	HMO	5	4	43.3
Mercy Health Partners, Lakeshore Campus	Equal-to-MFN	Priority	PPO	5	4	35.4
Paul Oliver Memorial Hospital	Equal-to-MFN	Priority	HMO	5	4	33.3
Paul Oliver Memorial Hospital	Equal-to-MFN	Priority	PPO	5	4	40.3
Sparrow Ionia Hospital	Equal-to-MFN	Priority	HMO	5	4	21.7
Beaumont Hospital - Grosse Pointe	MFN Plus	HAP	AHL	2	2	22.2
Beaumont Hospital - Grosse Pointe	MFN Plus	HAP	PHP	2	2	7.7
Beaumont Hospital - Royal Oak	MFN Plus	HAP	AHL	1	1	11.5
Beaumont Hospital - Royal Oak	MFN Plus	HAP	HMO	1	1	11.5
Beaumont Hospital - Royal Oak	MFN Plus	HAP	PHP	1	1	8.8
Beaumont Hospital - Troy	MFN Plus	HAP	AHL	2	2	9.8
Beaumont Hospital - Troy	MFN Plus	HAP	PHP	2	2	7.8
Bronson LakeView Hospital	Equal-to-MFN	Aetna	PPO	5	4	17.8
Three Rivers Health	Equal-to-MFN	Aetna	PPO	5	4	32.1

Source: Insurers' claims data, Affected Hospital Contracts.xlsx.

Exhibit 9: Estimated Overcharges for Affected Combinations

Hospital Name	MFN Type	Insurer	Network	DID (MFN*Post Period)	Average Reimbursement Rate After MFN	Allowed Amount After MFN	Percent Overcharged	Overcharges
				(Percentage points)	(Percent)	(Dollars)	(Percent)	(Dollars)
							(5)/(6)	(7)*(8)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Beaumont Hospital - Grosse Pointe	MFN Plus	BCBSM	PPO	15 8	39 0 %	$ 33,262,546	40 6 %	$ 13,501,625
Beaumont Hospital - Royal Oak	MFN Plus	BCBSM	PPO	0 9	34 4	362,792,315	2 5	9,229,462
Beaumont Hospital - Troy	MFN Plus	BCBSM	PPO	2 8	33 9	137,048,340	8 4	11,452,048
Providence Park Hospital	MFN Plus	BCBSM	PPO	13 6	39 8	15,987,154	34 2	5,461,108
St John Hospital and Medical Center	MFN Plus	BCBSM	PPO	2 9	38 7	92,512,783	7 6	7,040,473
Allegan General Hospital	Equal-to-MFN	Priority	HMO	21 3	76 7	6,980,137	27 7	1,935,949
Allegan General Hospital	Equal-to-MFN	Priority	PPO	24 6	77 6	3,933,523	31 6	1,244,127
Charlevoix Area Hospital	Equal-to-MFN	Priority	PPO	28 9	90 7	3,670,375	31 9	1,169,431
Kalkaska Memorial Health Center	Equal-to-MFN	Priority	PPO	44 6	84 4	1,780,674	52 8	940,391
Mercy Health Partners, Lakeshore Campus	Equal-to-MFN	Priority	HMO	43 3	89 3	2,946,551	48 5	1,428,005
Mercy Health Partners, Lakeshore Campus	Equal-to-MFN	Priority	PPO	35 4	89 6	1,207,093	39 5	476,347
Paul Oliver Memorial Hospital	Equal-to-MFN	Priority	HMO	33 3	82 2	2,846,896	40 5	1,152,036
Paul Oliver Memorial Hospital	Equal-to-MFN	Priority	PPO	40 3	81 8	1,161,480	49 2	571,457
Sparrow Ionia Hospital	Equal-to-MFN	Priority	HMO	21 7	64 5	4,169,828	33 6	1,402,701
Beaumont Hospital - Grosse Pointe	MFN Plus	HAP	AHL	22 2	52 7	2,524,149	42 2	1,065,338
Beaumont Hospital - Grosse Pointe	MFN Plus	HAP	PHP	7 7	47 9	5,780,608	16 0	927,454
Beaumont Hospital - Royal Oak	MFN Plus	HAP	AHL	11 5	52 3	27,228,829	21 9	5,961,008
Beaumont Hospital - Royal Oak	MFN Plus	HAP	HMO	11 5	47 0	111,749,970	24 5	27,399,650
Beaumont Hospital - Royal Oak	MFN Plus	HAP	PHP	8 8	62 6	101,240,903	14 1	14,308,818
Beaumont Hospital - Troy	MFN Plus	HAP	AHL	9 8	53 7	18,082,212	18 1	3,280,425
Beaumont Hospital - Troy	MFN Plus	HAP	PHP	7 8	62 9	50,217,628	12 4	6,231,966
Bronson LakeView Hospital	Equal-to-MFN	Aetna	PPO	17 8	82 1	4,113,161	21 7	892,361
Three Rivers Health	Equal-to-MFN	Aetna	PPO	32 1	76 6	3,101,168	41 9	1,298,849
Total						**$ 994,338,324**		**$ 118,371,027**

Source: Insurers' claims data, Affected Hospital Contracts xlsx

Exhibit 10: Fully-Insured Commercial Insurance: Share of Administrative Services by Lives Covered

	2011 (Percent)
BCBSM	83 %
Cigna	6
HAP	6
Aetna	5
All other ASO plans*	0.2

* This category includes only one other company: Principal Life Insurance Company.

Source: Michigan Office of Financial and Insurance Regulation (OFIR).

APPENDIX 32

Rule 1006 Summary of MFN Differential Contract Dates, Terms and Other Information

MFN Date	Hospital	Bed Count	MFN Terms	Required differential/ Year Prior Differential	Geography
2/7/06	**Beaumont**	1,714	Guarantee differential "to the same degree" as on date of contract	Never calculated/28[1]	Detroit/Warren Livonia MSA
2007	**None**	N/A	N/A	N/A	N/A
1/1/08	**Botsford**	306	No differential required; hospital "attests . . . discount provided to BCBSM . . . greater than . . . discount offered to [others]"	None/13	Detroit/Warren Livonia MSA
1/1/08	**Dickinson**	96	No differential required; hospital "attests . . . discount provided to BCBSM . . . greater than . . . discount offered to [others]"	None/52	Dickinson County on Upper Peninsula
7/1/08	**Ascension**	2,965	10 percent (not percentage points) differential required	10/20[2]	Primarily Detroit/Warren Livonia MSA

[1] The actual amount of the differential that would have been required was never calculated by the parties in the ordinary course of business and has not been calculated by any expert in the litigation due to data limitations for parties other than Aetna and Blue Cross.

[2] Differential is 10 *percent*, not *percentage points*. Aetna rate data reported separately for different hospital in system. Year prior differential varies from 29% (Borgess) to 5% (St. Joseph Tawas).

7/1/08	**Marquette**	276	15 point differential required	15/28	Marquette
7/1/08	**Metro Health**	208	Sliding scale differential required, starting at 3.6 points in 2008	3.6/28[3]	Grand Rapids MSA
7/1/08	**Mid-Michigan**	136	8 point differential required	8/23	3 hospitals in Clare, Gladwin, and Midland counties
1/1/09	**Beaumont**	1,714	10 point differential required	10/13	Detroit/Warren Livonia MSA
6/3/09[4]	**Sparrow**	638	5 point differential required	5/35	Lansing
7/1/09	**Covenant**	533	15 point differential required	15/33	Saginaw
7/1/09	**Munson**	391	Blue Cross rates guaranteed "less than the next best"	Less than/33	Traverse City
1/1/10	**Alpena**	125	20 point differential required	20/28	Alpena

[3] Required differential is "sliding scale" starting at 3.6 and increasing to "5% for HMO, and 10% for PPO/POS" by July 1, 2011.

[4] Contract negotiated on this date but takes effect retroactively to 1/1/08

Sources:

Column 1 ("**MFN date**") shows the effective date of the MFN Differential Contract as stated in the relevant LOU or LOA, except that the date shown for Sparrow is the date the MFN was ultimately agreed to according to paragraph 141 of Dr. Vellturo's rebuttal report.

Column 2 (**Hospital**) shows the name of the hospital.

Column 3 ("**Bed Count**") shows the bed count as report in Dr. Vellturo's exhibit 6.

Column 4 ("**MFN Terms**") shows the terms contained in the relevant LOU or LOA.

Column 5 ("**Required Differential/Year Prior Differential**") shows the differential required to be maintained by the LOU, then the actual percentage point differential that existed between Aetna and Blue Cross the year prior to the MFN Differential Contract, as shown on Exhibit I to Dr. Scheffman's report.

Column 6 ("**Geography**") shows the relevant city, county or Metropolitan statistical area as shown in Exhibit 6 to Dr. Vellturo's report.

The LOUs summarized here are as follows:

- Alpena -- BLUECROSSMI-99-196176 at 78
- Ascension -- AHSJP-017024 at 31
- Beaumont -- BLUECROSSMI-08-004027 at 28 (2006); BLUECROSSMI-99-390466 at 470 (2009)
- Botsford -- BLUECROSSMI-08-011701
- Covenant -- BLUECROSSMI-R-00109966 at 69-70
- Dickinson – BLUECROSSMI-98-000062
- Marquette -- BLUECROSSMI-99-407870 at 73
- Metro Health BLUECROSSMI-R-00109978 at 81
- Mid Michigan -- MidMichH-DOJ-000003 at 10
- Munson -- MHC000145 at 147
- Sparrow --SHS003256 at 3264

APPENDIX 33

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

THE SHANE GROUP, INC., BRADLEY A. VENEBERG, MICHIGAN REGIONAL COUNCIL OF CARPENTERS EMPLOYEE BENEFITS FUND, ABATEMENT WORKERS NATIONAL HEALTH AND WELFARE FUND, MONROE PLUMBERS & PIPEFITTER LOCAL 671 WELFARE FUND, and SCOTT STEELE,

Plaintiffs, on behalf of themselves and all others similarly situated,

vs. Case No. 2:10-cv-14360-DPH-MKM
Hon. Denise Page Hood

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.
_____/

The Videotaped Deposition of JOAN JANKS,
Taken at 1901 St. Antoine, 6th Floor at Ford Field,
Detroit, Michigan, Commencing at 8:55 a.m.,
Friday, January 17, 2014,
Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

the options, but for active commercial currently?
A. Okay. Currently, no, they have just one option. It's under HAP.
Q. Okay. And is that an HMO or PPO?
A. No. That's PPO.
Q. And have the network options changed for active commercial since 2005?
A. Yes.
Q. Let's go year by year. What are the changes? Let's start with 2005. What were the options?
A. In 2005, the options were the Blue Cross Community Blue PPO, the PPOM, and the HAP PPO.
Q. And were the deductible amounts the same under all of those options in 2005?
A. You know, I don't remember 2005. I can't say for sure. Let me ask you to clarify that. Are we only talking about the active commercial or each plan?
Q. We're still talking just about active commercial, but if there are differences -- when you say --
A. Okay, active commercial, yes, they were all the same.
Q. Okay. When you say each plan, you're distinguishing between active commercial, poured wall, millmen residential, and early retirees?
A. Correct, yes.
Q. And the deductible amounts between those four plans

were different?
A. They could have been. That's what I'm -- I can't remember exactly if back then they were all the same.
Q. In order to determine that, would we have to look at the individual plan under each class; for example, we'd have to look at active commercial plan, poured wall plan, millmen plan to determine that?
A. Correct.
Q. In the same vein, to determine whether or not an individual in the active commercial in 2005 had chosen the Blue Cross PPO versus PPOM or HAP, you'd have to look at the individual choice of that employee?
MR. JOHNSON: Objection to the form.
A. Right, that would be based really on the contribution rate and then, right, absolutely, this would be the final determination.
BY MR. GOURLEY:
Q. So for active commercial in 2005, an employee could choose between Blue Cross PPO, PPOM, and HAP PPO, correct?
A. Correct.
Q. And when you said that would be based really on the contribution rate, what did you mean?
A. Well, whatever it was at that time. It wasn't 7.05 at the time, but the contribution rate would determine

Q. And then the amount that you're, that Carpenters would reimburse the particular member would be the amount of the covered benefit, not the total amount of the charged benefit?
A. Correct.
Q. I think we've gone over some of this, but I just want to circle back, cover the bases. From 2006 to the present, which network providers did Carpenters contract with?
A. Okay. Starting in 2006?
Q. Yes.
A. It was the Blue Cross Blue Shield Community Blue PPO, the HAP PPO, and PPOM Cofinity PPO, and then they went down to just the Blue Cross, and then after Blue Cross, it was broken out between the Cofinity PPOM and the HAP PPO, and today they just have the HAP PPO.
Q. If you can, can you break down those changes by year, approximate year?
A. I can try. Okay. Up through October of 2008, they had the three options between the Blue Cross, HAP, and PPOM. And then from October, 2008, the commercial people, they started October, 2008. Residential and poured wall started January 1st of 2009. And they all had Blue Cross exclusively up through December 31st of 2009.

So January 1st of 2010, they were given the option to choose between the PPOM Cofinity and the HAP PPO, and that remained in place up until it was either February or March of 2012, and I'm going to tell you right now, I'm not -- I'm thinking if it was 2011 or 2012. Let me think about this. The millmen came on board -- what are we in now, 2014?

I'm not going to say that for sure because I'm not thinking right now. It was '11 or '12.

MR. JOHNSON: That was a pretty good job anyway.

MR. GOURLEY: Yeah.

THE WITNESS: It was close. I want to say it was '12, but --

BY MR. GOURLEY:

Q. When you say the millmen came on board, what do you mean?

A. There was a Detroit millmen plan that merged in with the Carpenters July 1st of 2011. It was a smaller group, and they were in the poorer contribution rate.

Q. So for that time period, 2006 to the present that you just kind of laid out for us, what were the reasons behind the changes in network providers?

A. Okay. Starting with the changes that occurred in 2008, those changes primarily came about -- there was

A. From what I read in the documents, I do know those hospitals.
Q. And when you say "from what I read in the documents", which documents are you referring to?
A. I believe that was in the Complaint document.
Q. Other than any specific examples contained in the Complaint in this case, do you know a specific -- all hospitals that Blue Cross Blue Shield of Michigan had MFN provisions with in its contracts in Michigan?
MR. JOHNSON: Objection to the form.
A. No.
BY MR. GOURLEY:
Q. Do you know which hospitals in Michigan Blue Cross Blue Shield had MFN-plus provisions with?
A. No.
Q. Do you know whether Blue Cross Blue Shield of Michigan had MFN provisions of any kind in all of its contracts with all Michigan hospitals?
A. No.
Q. In order to determine that, we'd have to look at the individual contracts with each hospital, correct?
A. Correct.
Q. Is Carpenters interested in seeking to recover any profits that Priority might have lost as a result of MFNs?

A. The Carpenters are not.
Q. Are the Carpenters seeking to recover any profits that United or HAP might have lost because of the MFN provisions?
A. The Carpenters are not seeking a profit.
Q. Are the Carpenters seeking to represent Priority's interests in this case in an effort to recover any profits Priority might have lost because of the MFNs?
A. I'm not sure of that answer.
Q. You might be, you might not be; you just don't know?
A. Right, I'm not clear.
MR. JOHNSON: Objection to the form.
BY MR. GOURLEY:
Q. You're just not clear?
A. Right.
Q. Do you believe that Carpenters' interest in recovery in this case would be aligned with Priority, United, HAP, or any other commercial insurer?
A. Yes, I think they're seeking the best interest of the insureds.
Q. I was asking about insurance companies, not necessarily the insureds. So do you believe that Carpenters' interest and recovery in this case is aligned with the commercial insurance companies like Priority, United, and HAP, that might also seek

A. No.
Q. Does Carpenters know what the price of hospital services would have been for Aetna subscribers at Beaumont, St. John, and Providence in the absence of MFNs?
MR. JOHNSON: Same objection, calls for speculation.
A. No.
BY MR. GOURLEY:
Q. What about Priority subscribers?
A. No.
Q. Carpenters doesn't have knowledge of other people's alleged damages in this case, correct?
A. Correct.
Q. We'd have to look at the individual subscriber contracts for each potential insurer like Aetna, HAP, Priority, in order to determine that, correct?
MR. JOHNSON: Objection, calls for expert testimony and legal conclusion.
A. Can you restate the question, please.
BY MR. GOURLEY:
Q. Let's do it this way.
A. Okay.
Q. You can only look at the data for Carpenters members in terms of what amounts people paid for hospital

healthcare services?

A. Correct.

MR. JOHNSON: Objection to the form.

BY MR. GOURLEY:

Q. You have no knowledge of what amounts subscribers in any other ERISA plan other than Carpenters would have paid?

MR. JOHNSON: Objection to the form.

A. Correct.

BY MR. GOURLEY:

Q. In determining that one of Carpenters members received a knee surgery with a certain co-pay at Beaumont would do nothing to determine whether an Aetna subscriber under a different ERISA plan also received a knee surgery with a certain deductible at Beaumont?

A. Correct.

MR. GOURLEY: This one is redacted.

MARKED FOR IDENTIFICATION:

EXHIBIT 6

1:19 p.m.

BY MR. GOURLEY:

Q. Ms. Janks, I'm showing you what we've marked as Blue Cross Janks Exhibit 6, which is a redacted copy of the Consolidated Amended Complaint filed in this action. Are you familiar with this document?

different for any member, depending on where they sought service, what type of service, what their coverage options were, and so forth?

MR. JOHNSON: Objection to the form.

A. Well, no. There's standards as far as how the claims come in, and most of that information is required by the providers to submit with the claims. So the physician -- the facility charges and the hospital and then the physician charges, those data fields are required to be submitted. So the only thing that would differ, of course, would be the services that they had and the charges.

BY MR. GOURLEY:

Q. Right, the information to fill in the data fields?

A. Correct, yes.

Q. That's kind of what I was getting at.

A. Yes.

Q. In order to determine what service was provided, what the coverage limitations were for that service for any particular member, we would have to look member by member, claim by claim?

A. Correct.

MR. JOHNSON: Objection to the form.

A. Correct.

BY MR. GOURLEY:

APPENDIX 34

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

THE SHANE GROUP, INC., BRADLEY A. VENEBERG, MICHIGAN REGIONAL COUNCIL OF CARPENTERS EMPLOYEE BENEFITS FUND, ABATEMENT WORKERS NATIONAL HEALTH AND WELFARE FUND, MONROE PLUMBERS & PIPEFITTER LOCAL 671 WELFARE FUND, and SCOTT STEELE,

Plaintiffs, on behalf of themselves and all others similarly situated,

vs. Case No. 2:10-cv-14360-DPH-MKM
Hon. Denise Page Hood

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.
_____/

The Videotaped Deposition of ANNE PATRICE NOAH,
Taken at 1901 St. Antoine, 6th Floor at Ford Field,
Detroit, Michigan, Commencing at 9:14 a.m.,
Thursday, January 9, 2014,
Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

Q. Okay. What health insurance plans does Crystal Mountain offer to its employees?
A. Three different Priority Health plans.
Q. And what are those three different Priority Health plans?
A. One is a catastrophic plan with a high deductible, another is a 70/30 plan, and another is an 80/20 plan.
Q. Can you tell me what you mean by 30/70?
A. It means that once I've met my deductible, I pay 30% of the costs associated with the services and Priority Health pays 70 up to a certain threshold.
Q. And I assume the same general concept applies to 80/20?
A. Yes.
Q. So you would pay 20% after the deductible is met for that plan?
A. Yes.
Q. Okay. And which Priority Health plan do you currently have?
A. The 70/30.
Q. And have you always had the 70/30 plan since you've been employed at Crystal Mountain?
A. As long as they've offered it.
Q. And how long have they offered it?
A. I honestly can't recall because there have been

several different changes in the offerings over the years.

Q. And there's been changes in the offerings since you've been there?

A. Yes.

Q. So have you had different coverage plans during the eight years you've been at Crystal Mountain depending on the year?

A. Yes, slightly different but not significantly different in terms of either cost or coverage.

Q. Okay. If we could, just to the best of your ability to remember, go through by year what your coverage plan was for each year, so did you start in 2005?

A. The very end of 2005, December 13th.

Q. Okay. And do you know what the benefit plan year is for your Priority coverage?

A. December 1st to November 30th.

Q. And has it always been that?

A. As far as I can remember, yes.

Q. So the December 1st to November 30th plan year is the year used to determine whether or not you met the deductible in that time period, correct?

A. Yes.

Q. So for your first year at Crystal Mountain, 2006, what health plan did you have?

seeking as a plaintiff?
A. To recover costs that I paid that were higher than they should have been to receive hospital services.
Q. Okay. So let's break that down. First was to recover costs that you paid. With respect to those costs, can you break that down for me; is that -- are you saying you're looking for the amount of deductible payments and co-pay payments that you made?
A. No. I am seeking to recover any overages that I paid that were higher than they should have been otherwise without this.
Q. What other charges outside of deductibles and co-payments would be included in that?
A. Noncovered services.
Q. Okay. So any out-of-pocket costs for noncovered services you're also seeking as a remedy?
A. Yes.
Q. And do you know a dollar amount of noncovered services that you spent from 2006 to the present?
A. No, I don't.
Q. And how would you determine that amount?
A. My records with my attorneys' assistance and their expert would determine that amount.
Q. What records would you look at or would your attorneys look at to determine the amount of out-of-pocket costs

for noncovered services that you spent from 2006 to the present?

A. They would look at payments received by the named hospitals that I sought services from, my checking account and paid receipts I have kept in my own records.

Q. Have you produced all checking account records and paid receipts records for payments you made for noncovered services that you're seeking to recover in this action?

A. I have produced as many of them as I could find. I believe that it's fairly complete.

Q. And for the payments that you can't find for noncovered services, how would you, how would you support the request for that, those amounts for damages?

A. Go to Paul Oliver Hospital's accounting office and get their record of my account and payments made.

Q. So for any, any payments you made, you would have to go to the service provider to get their records for what was actually paid for a particular service, correct?

A. If I wanted to be complete, I would get both --

Q. Okay.

A. -- and match them.

A. Any of us who sought hospital services from those named hospitals.
Q. When you say "any of us", you mean individuals who received hospital services?
A. Yes.
Q. Are you seeking also to represent the interest of insurance companies like Aetna or United?
A. I'm seeking to represent anyone who sought hospital services and paid higher costs as a result of the MFN agreements Blue Cross Blue Shield of Michigan had with those hospitals.
Q. And so insurance companies like Aetna didn't seek hospital services, so I'm trying to understand if you as a class rep are trying to also represent the interest of insurance companies like, you know, like an Aetna, like a United, like a HAP?
A. I'm not an attorney, but I know that the request for class representation specifies who those individuals are. So I'd have to look to that class and have my attorneys tell me exactly what that definition is.
Q. Are you seeking to recover any profits that Priority might have lost because of use of MFNs?
MR. HEDLUND: Object to the form of the question, but if you understand it, you can answer.
A. No.

Q. In addition to the services we've discussed already, do you also receive hospital services in a typical year?
A. Yes.
Q. And I guess to drill down on that, let's go away from general and more to specific years. So for the time period that you've been employed with Crystal Mountain, at what hospitals have you received healthcare services?
A. Paul Oliver Hospital and Munson Medical Center.
Q. Have you received healthcare services at any other hospital besides Paul Oliver and Munson Medical Center during the time you've been employed at Crystal Mountain?
A. Not that I can recall.
Q. This might get tedious.
A. It's okay.
Q. So actually, if you want to take -- I don't know if you're ready for a break?
A. I could use a restroom, yes.

MR. GOURLEY: Okay. We'll take a break.

THE WITNESS: Okay.

VIDEO TECHNICIAN: The time is now 10:08 a.m. We are off the record.

(Recess taken at 10:08 a.m.)

A. Right.
BY MR. GOURLEY:
Q. Correct?
A. Yes, correct.
Q. And the same concept can be applied to the types of services that any individual received in a given plan year, correct, if they can differ from yours?
A. That's correct.
Q. And determining that you had a certain set of services performed in one year doesn't help to determine what services any other person might have had in that same year?
A. That's correct.
Q. And we talked a bit earlier about, I was giving you, you know, a hard time about whether you had the old checks or not, but, but, you know, looking at actual documentary evidence for the fact that you actually made a payment toward your deductible at a hospital wouldn't help to determine whether a different person actually paid a certain amount to any hospital?
A. That's correct.
Q. We also talked a little about, you know, under your plan, you know, trying to determine whether or not one service required a percentage co-pay versus a flat co-pay. Even if we were to determine that for your

plan, we wouldn't know whether or not another person had the same percentage co-payment for the same service, correct?

A. Correct.

Q. And we wouldn't be able to determine that by looking just at your service?

A. That's correct.

MR. GOURLEY: We can go off the record for one second.

VIDEO TECHNICIAN: The time is now 12:11 p.m. We are off the record.

(Off the record at 12:11 p.m.)

(Back on the record at 12:12 p.m.)

VIDEO TECHNICIAN: We are back on the record. The time is 12:12 p.m.

MARKED FOR IDENTIFICATION:

EXHIBIT 4

12:12 p.m.

BY MR. GOURLEY:

Q. Ms. Noah, I'm handing you what we've marked as Blue Cross Noah Exhibit 4. It will be the first in a series of exhibits of the Explanation of Benefits by year hopefully that you have produced prior to today's deposition, okay?

A. Yes.

APPENDIX 35

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

THE SHANE GROUP, INC., BRADLEY A. VENEBERG, MICHIGAN REGIONAL COUNCIL OF CARPENTERS EMPLOYEE BENEFITS FUND, ABATEMENT WORKERS NATIONAL HEALTH AND WELFARE FUND, MONROE PLUMBERS & PIPEFITTER LOCAL 671 WELFARE FUND, and SCOTT STEELE,

Plaintiffs, on behalf of themselves and all others similarly situated,

vs. Case No. 2:10-cv-14360-DPH-MKM
Hon. Denise Page Hood

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.
_____/

The Videotaped Deposition of SUSAN BAYNARD,
Taken at 1901 St. Antoine, 6th Floor at Ford Field,
Detroit, Michigan, Commencing at 9:00 a.m.,
Monday, January 13, 2014,
Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

A. I don't know.
Q. And in order to determine that, we would have to look at the individual benefits packages that you received from Crystal Mountain for each benefit year?
MR. HEDLUND: Object to the form of the question, but you can answer if you understand.
A. Yes.
BY MR. GOURLEY:
Q. And do you understand the term "benefit year"?
A. Yes.
Q. Okay. What does that mean to you?
A. It's the plan year, December 1st through November 30th.
Q. So Crystal Mountain's health insurance plan year runs December 1st through November 30th of each year?
A. Correct.
Q. And how long has that been the case at Crystal Mountain?
A. I think forever or since I've been employed there.
Q. Okay. Since 2006, have you had any other Priority HMO plan other than the 70/30 plan?
A. Yes.
Q. What other plans have you had?
A. I had the 80/20.
Q. And do you know which years you had the 80/20?

A. I know it was last year, the year ending November 30th, 2012 -- or 2013. And I don't recall prior to that.
Q. And again, in order to determine that, we would look at the records from Crystal Mountain showing which plan election you made in any given year?
A. Yes.
Q. And for all Crystal Mountain employees, to determine, you know, which plan they elected, they'd have to look at Crystal Mountain records to see whether they took the 70/30, 80/20, or the catastrophic, correct?
MR. HEDLUND: Object to the form of the question. You can, if you know the answer, you can go ahead.
A. I would think we have those records.
BY MR. GOURLEY:
Q. And if not, Priority probably would, correct?
A. I would think they would have those records.
Q. Ms. Baynard, do you have health insurance benefit packages for each plan year that explain what your coverage limitations and so forth are for that year?
MR. HEDLUND: Object to the form of the question, but if you understand, you can answer.
A. I have one for the current year.
BY MR. GOURLEY:

2008, correct, that was -- that we showed to you in Exhibit 1?

A. Exhibit 1, correct. I'm not sure it's 2008. I'm not clear on what -- it's the date of September 11th, '09.

Q. Sorry. I created some of the confusion that Dan tried to help me cure by not talking about benefit years, but if you look on page, the second page of Exhibit 1, in the middle where it's showing the accumulated deductible for the benefit year --

A. Okay, yes.

Q. -- it says: After this claim, accumulators for benefit year 2008.

A. Okay, yeah.

Q. Do you see that?

A. So they're using the start date.

MR. HEDLUND: Right, the December date.

A. Correct.

BY MR. GOURLEY:

Q. So the only documentation you've provided shows costs incurred in benefit year 2008, correct?

A. Correct.

Q. And you don't have any documentation for any other year?

A. No.

Q. From 2006 to the present using calendar years, what

hospitals have you received services from?
A. I would think just Paul Oliver and Munson. I do not recall any other hospitals.
Q. To the best of your recollection, you've received services at both Paul Oliver and Munson from 2006 to the present?
A. Yes.
Q. Do you remember offhand any particular service you received at either Paul Oliver or Munson?
A. Most every year at Paul Oliver I have my blood test, and that's the one I can -- and I have mammograms, oops, sorry, and I have occasional bone density tests all at Paul Oliver, although I did go once to Munson, but I don't know if it was in this year, this bunch of years, for a mammogram.
Q. And in order to determine where you sought services in any given year and what those services are, we'd have to look at your individual claims history, correct?
A. Correct.

MARKED FOR IDENTIFICATION:
EXHIBIT 2
10:13 a.m.

BY MR. GOURLEY:
Q. Ms. Baynard, I'm showing you what we've marked as Blue Cross Baynard Exhibit 2.

Q. So you're not seeking recovery of that?
A. No.
Q. And then check 4252 to Paul Oliver in the amount of 15.19, do you remember what that check was for?
A. I do not recall. However, at the -- because of the time of year, it's after or around when I had my physical more than likely, and it's probably my percent due for some service I had related to my physical.
Q. In order to confirm that, we'd look at the individual claims history, correct?
A. Correct.

MARKED FOR IDENTIFICATION:
EXHIBIT 3
10:18 a.m.

BY MR. GOURLEY:
Q. Ms. Baynard, I'm showing you what we've marked as Blue Cross Baynard Exhibit 3. This is a document bearing the Bates Number 000027, and what is this document?
A. This is payment for Document 1's amount that I had -- that I paid to Paul Oliver for the claims shown on Document 1.
Q. Shown on Exhibit 1?
A. Exhibit 1.
Q. Okay.

A. Yes.
Q. And that you had no role in crafting it, correct?
A. Correct.
Q. We've talked a bit about this case generally, and I just -- some of this might re-tread some territory, but what remedy are you seeking through this Consolidated Amended Complaint?
A. What remedy? Can you explain what "remedy" is?
Q. Sure. What do you want to get?
A. I would like the class to be compensated for monies that they have over-spent because of the Blue Cross Most Favored Nation agreements with hospitals in this Complaint.
Q. Ms. Baynard, which hospitals in Michigan are you alleging had MFNs in their contracts with Blue Cross Blue Shield of Michigan?
MR. HEDLUND: Objection, asked and answered, but you can answer.
BY MR. GOURLEY:
Q. Is it limited to the hospitals identified in the class certification motion?
A. Okay, what was the question?
Q. Which hospitals in Michigan are you alleging had MFNs in their contracts with Blue Cross Blue Shield of Michigan?

MR. GOURLEY: If you want a continuing objection to form, we can do it that way, too.

MR. HEDLUND: Okay, that's fine.

BY MR. GOURLEY:

Q. And even with respect to services you receive, let's say at Paul Oliver, determining that you received a knee surgery at Paul Oliver would do nothing to determine what services anybody else received at Paul Oliver or when they received them?

A. Correct.

Q. And determining the level of deductible applicable under your health insurance plan would not aid someone in determining what another potential class member's deductible amount under their health insurance plan might be?

A. Correct.

Q. And they might have a deductible limit under an Aetna contract, a Priority contract, a HAP contract, but the fact that you have a certain deductible under the Priority contract wouldn't help determine what their level of deductible is?

A. Correct.

Q. Similarly, a determination that you met or exceeded your deductible amount in any given year wouldn't help determine whether another potential class member

surpassed their deductible amount in that same year, correct?

A. Correct.

Q. And any determination that you made a direct payment to a particular hospital for services in any year would do nothing to determine whether another class member made a direct payment to that hospital or any other hospital for any services in the same year?

A. Correct.

Q. And determining that you paid for healthcare services at, let's say, Munson in any given year wouldn't help anyone in determining whether another individual paid for healthcare services at a hospital other than Munson?

A. Correct.

Q. And again, determining the type of services that you would have, that you received in one year, be they inpatient or outpatient services, wouldn't aid you in determining whether another potential class member received inpatient or outpatient services in the same year, correct?

A. Correct.

Q. And it also wouldn't aid you in determining the types of services that any other class member received in that same year, correct?

A. Correct.
Q. And in order to determine all of those issues for other potential class members, we would likely have to look at individual claims histories and coverage amounts and so forth for each person, correct?
A. I don't know how that would happen. I assume our attorneys and any experts that they might hire could do that.
Q. Do you think there would be any way for your attorneys or the experts in this case to determine the services and amounts, the services that someone received and the amounts someone paid in a given year other than looking at that individual person's claims histories?
A. I don't know methodology on that.
Q. Can you conceive of any way other than looking at an individual's claims history?
A. Maybe some kind of statistical study, some kind of analysis, but I don't know.
Q. Analysis of what?
A. Oh, I don't know. I have no idea. I don't know.
Q. With respect to the meeting that occurred at Crystal Mountain --
MR. HEDLUND: Are we, Jason, are we off that string of questions?
MR. GOURLEY: Yes.

APPENDIX 36

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

THE SHANE GROUP, et al., Plaintiffs, onbehalf of themselves and all others similarly situated,	:	Case No. 2:10-cv-14360-DPH -MKM
v.	:	
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	:	

CONFIDENTIAL

Videotaped Deposition of JEFFREY J. LEITZINGER, Ph.D.
Washington, DC
Tuesday, December 10, 2013
9:08 a.m.

Pages: 1 - 224
Reported By: Lee Bursten, RMR, CRR

think about it, no.

Q Did you analyze any conspiratorial conduct in this case?

A No. I don't understand the conduct that's alleged in this case to be -- to have involved a conspiracy.

Q And you did not analyze any, correct?

MR. SMALL: I'm going to object to the extent it calls for a legal conclusion.

A I haven't had occasion in the course of my work to go outside the allegations in this case, to somehow address or develop a conspiracy theory, no.

BY MR. STENERSON:

Q Have you ever heard of what is known as an option demand market?

A No. I don't -- I don't recall having seen that, come across that expression before.

Q You said that you had one prior case, if I understood you correctly, where the focus was on MFNs. Do you recall saying that?

A Yes.

Q What case was that?

A It was a case that involved payment cards for fueling services on the part of long-distance truckers and trucking companies.

MR. STENERSON: I'll rephrase.

BY MR. STENERSON:

Q Of the approximately 70 MFN contracts that you came to learn about in this case, how many of them have you analyzed in your report?

A Well, I haven't been doing the analysis of contracts per se. But the analysis of pricing and the impact in connection with MFNs in this case I think involves all told a dozen hospitals, something like that.

Q And how is it that you came about to focus on those dozen hospitals or so?

A They were the hospitals that were involved with the 23, I think it is, affected combinations that were used to define the class and were provided to me as part of the assignment for my report.

Q Of the hospitals that you actually analyzed, do you know how many different MFN clauses were at issue?

A The answer may depend on how you're defining difference, a difference, for purposes of your question. But I did understand that those 23 combinations included both what had been described in this case as MFN provisions and MFN Plus provisions.

Q Did you understand that any of the

clear to me that it's always been the same agreement or the same LOUs as applied to the Beaumont Grosse Pointe hospital.

BY MR. STENERSON:

Q Would it matter to your analysis whether or not Blue Cross Blue Shield of Michigan negotiated its reimbursement rates with the entire hospital system as opposed to one hospital at a time?

A No, not in -- not in any way I've identified.

Q You mentioned that you analyzed pricing in connection with the MFNs. Do you recall using that phrase?

A Yes.

Q Explain what you meant by that, please.

A Well, the issue that my report addresses in part is the economic evidence pertaining to whether or not the existence of a MFN provision had an impact on hospital reimbursement rates. And it's in that sense that I was referring to pricing.

Q You said "whether the existence of the MFN had an impact on reimbursement rates." The reimbursement rates of whom?

A The reimbursement rates between the healthcare insurers, Blue Cross, HAP, Priority and

competitive harm. The theory of competitive harm would instead get to how that conduct might -- what kind of impact it might have on competition.

Q We'll come back to the theory of competitive harm. Moving back slightly to the topic of geographic location of hospitals, okay, does the geographic proximity between the affected hospitals and the control group hospitals matter?

A Not in the -- not in the way I have done my analysis, no.

Q Do you think the location of the control hospitals are important?

A Not for the -- except, again, for the accounting I made of location in or out of the Detroit area, no, I didn't see other -- the need -- I didn't see that other locational effects were important.

Q Why not?

MR. SMALL: Objection to the form.

A I just -- I didn't see either facts or evidence or a need as an economic matter to make some accounting for that.

BY MR. STENERSON:

Q Who chose the control hospitals?

A I did.

Q And what methodology did you use -- well, strike that. If I understand your report correctly, it actually runs 23 separate regressions; is that right?

A Yes.

Q And are all the control group hospitals the same for each regression?

A No.

Q So the control group hospitals differ in each regression; is that right?

A Yes.

Q Was there a general methodology that was used to select the control group hospitals across the regressions?

A Yes.

Q What was it?

A The methodology was to use all of the hospitals that were in the same peer group as Blue Cross defines those groups that did not have MFN provisions.

Q So you've identified two criteria. One is the same peer group as the affected combination hospital; is that right?

A Yes.

Q The other criteria was that it had the same

is tainted, it doesn't matter because it's conservative?

MR. SMALL: Objection to the form.

A I'm not saying it doesn't matter. I'm just saying, yes, it may be conservative in terms of the amount of impact it shows.

BY MR. STENERSON:

Q So whether the control group hospitals is tainted matters, but you didn't determine whether they were, correct?

MR. SMALL: Objection to the form.

A It matters potentially to the size of the impact, that is, the impact could be greater than the impact that I have found in that model. That's as far as it goes.

BY MR. STENERSON:

Q So you said that an argument exists or something of the sort. Could you describe what that argument is?

A The -- and I'm -- I see this laid out in the report of Dr. Vellturo. The economic notion is that as a result of the MFNs, other competing payers, his focus was on Aetna, but potentially HAP and Priority as well, did not have the -- enjoy the same success, the same competitive vigor, that they

otherwise would have.

And as a result, in a but-for world, they would have been bigger players in the state. Their reimbursement rates would have been lower. That would have put pressure on reimbursement rates statewide, including at Blue Cross hospitals, where there were no MFNs.

Q Am I correct, however, Doctor, that you did not do any analysis of such an argument in your report?

A That's correct.

Q I'll shift back to some product market questions. Is the effect of the MFNs on the market for commercial health insurance, if any, important to your regression?

A No.

Q Is the effect if any of the Blue Cross's MFNs with Michigan hospitals important to your -- strike that. Is the effect if any of Blue Cross's MFNs with Michigan hospitals in the market for commercial health insurance important to your analysis?

A No.

Q Hypothetical. Assume for me, Doctor, that there's only a single MFN with a single hospital

MR. SMALL: I'm sorry. Can you read back that question, please.

(Requested portion of record read.)

A The regression does not show whether or not any class member paid higher insurance premiums, if that's what you're asking.

BY MR. STENERSON:

Q Are there any other anticompetitive effects you can expect to see in the markets for commercial health insurance other than higher premiums?

MR. SMALL: Objection to the form.

A Well, depending on -- on context, anticompetitive effects are sometimes understood to reflect changes in the relative position of competitors.

And so if another -- another way in which the provisions may -- the MFN scheme may have introduced anticompetitive effects in the market for commercial health insurance would be to limit the size or even the presence of competing health insurers in the state of Michigan.

BY MR. STENERSON:

Q Does your regression, Dr. Leitzinger, show an impact on hospital prices as opposed to hospital reimbursement rates?

claims data.

Q What's the difference between the effective rate and the contract rate?

MR. SMALL: Objection to the form.

A I think there are a couple of things that come into play in that regard. First, there may -- I would note initially there may not be a contract reimbursement rate. Contracts don't always specify a reimbursement rate.

However the contract operates, the result that the contract might otherwise provide and the result that appears or emerges from the analysis of the data, at least as I have done it, may be affected by timing, both in terms of the point at which the contracted terms become effective and the way that those get -- flow through into the claims data.

It may be affected as well by the existence of claims in the data where there is another insurance company that is paying part of the reimbursement. It may also be affected by just anomalies associated with the entry and maintenance of large scale data sets.

BY MR. STENERSON:

Q What if anything would your regression say about whether price went up at any hospital that's

Have you done any analysis on the relative position of Blue Cross and any of its competitors in Michigan?

MR. SMALL: You mean market share? Is that what you're talking about?

MR. STENERSON: No.

BY MR. STENERSON:

Q You mentioned earlier one of the anticompetitive effects is the potential change in relative position of competitors. I want to know if you've done any analysis of that.

A I haven't done any analysis of how that changed following the institution of the MFN scheme, no.

Q So did you do any analysis as to the relative change in position if any between Priority and Blue Cross in the state of Michigan?

A No.

Q Have you done any analysis if any as to the relative change in competitive position between Blue Cross and Aetna in the state of Michigan?

A No.

Q Have you done any analysis as to the effect if any on the change in relative position between HAP and Blue Cross in Michigan?

A No.

Q Are you giving an opinion in your report in any way that suggests that you've reached the conclusion that Priority was competitively disadvantaged in the sale of commercial insurance in Michigan?

A I don't -- I'm not giving that opinion in my report. I do by way of discussing the potential anticompetitive effects of the MFN cite some evidence that I saw in the course of my work that has to do -- having to do with Priority's initiatives to expand into the upper peninsula and the manner in which MFNs may have adversely affected that.

Q Is your regression capable of answering the question of whether or not Priority was anticompetitively disadvantaged -- strike that. Is your regression capable of answering the question of whether Priority was competitively disadvantaged in Michigan vis-à-vis Blue Cross?

A I think my regression analysis could provide some information relevant to that question, but it -- by itself it can't ultimately answer it.

Q Did you reach any conclusions or opinions as to whether or not Aetna's relative competitive position was harmed in Michigan vis-à-vis Blue Cross?

A No, I have not.

Q And same question for HAP.
A Same answer.
Q Now, as I understand your affected combinations, Doctor, HAP, Priority, and Aetna are not affected at the same hospitals in your analysis; is that correct?
A I think that's -- subject to check, I think that's right, yes.
Q Okay. And we'll spend some time with the report after lunch. But if you recall, one of the affected combinations was Priority at Allegan; do you recall that?
A Yes.
Q And what if any evidence that you found -- strike that. I think in your report you call it economic evidence.
A (Witness nods head.)
Q What's your definition of "economic evidence"?
A I use that phrase to describe the kinds of things that economists use for purposes of analyzing market behavior and outcomes.
Q And did you find there is economic evidence in this case that Priority was impacted by Blue Cross's MFN at Allegan?

A Yes.

Q And how if at all does that economic evidence relating to Priority at Allegan affect your conclusion whether or not Aetna was affected at Three Rivers Hospital?

A It doesn't.

Q And you have another combination of Aetna at Three Rivers -- or strike that, Aetna at Bronson LakeView; do you recall that?

A Yes.

Q How if at all does the economic evidence used to find impact to Priority at Charlevoix Hospital affect the ability to find impact to Aetna at Bronson LakeView?

A It doesn't.

Q And how if at all does the economic evidence for your conclusions that Priority was affected at the hospitals in your report assist you in determining whether or not for example HAP was impacted at any of the Beaumont facilities?

A It doesn't.

Q So, Dr. Leitzinger, going back to Priority, you understand that you find impact at Allegan and Charlevoix hospitals among others for Priority; is that right?

A Yes.

Q How if at all, Doctor, does the economic evidence you found to conclude that Priority had impact at Allegan help you determine whether or not Priority had impact at Charlevoix?

A It doesn't, although I -- it is I guess one thing, and I'm not sure it's what you're asking or not, but there is a -- the same model that I use, the same form of the regression analysis that I use in all of these combinations. And in that sense, there is that -- that common approach to the problem assists me in the analysis of impact in all of the combinations.

Q Thank you for the clarification. So other than the form of the model you use, do you agree with me that each finding of impact or each combination in your report is separate and apart from the other?

MR. SMALL: Objection to the form.

A I'm not sure separate and apart. But the finding as to each combination will ultimately reflect the underlying data and the impact of the MFN scheme on that combination.

BY MR. STENERSON:

Q I'm going to get this. You say the finding as to each combination will ultimately reflect the

underlying data, right? You said that?

A Yes.

Q And then the impact of the MFN scheme on that combination, right?

A Yes.

Q Okay. Is the underlying data used to determine potential impact on any affected combination the same for more than one combination?

A The same data sources are used across combinations and in the benchmarks, but the particulars of the data that come from those sources I think will in some respect be different in each combination.

Q Isn't it true, Doctor, that the underlying data in each affected combination that you used to determine MFN impact is different for each affected combination?

MR. SMALL: Objection, asked and answered.

A Some of it is. Some of it isn't.

BY MR. STENERSON:

Q What data is different?

A Well, data that would differ from combination to combination would be the reimbursement experience for the combination itself. The -- and as you move from combination to combination, there --

there will be, although not in every case, I don't believe, at least some difference in the benchmark experience that is used for that combination, although there will be some considerable overlap as well.

Q For any impact -- strike that. For any affected combination of Priority's experience that you found impact, what if any data is the same for any of the affected combinations where you found impact on Aetna?

A To the extent that the -- there is overlap in the benchmark hospitals that are used across combinations between Priority and Aetna, there will be common data used in connection with some of the variables in the regression having to do with the inpatient/outpatient ratio, the number of beds, the expenses of the hospital, those variables.

Q Am I correct in understanding that the result of any -- well, strike that. Am I correct in understanding that the conclusion you reach about impact as to any affected combination does not tell you whether or not a different combination will feel impact?

MR. SMALL: Objection, asked and answered.

A Yes, I think that's correct.

was in that document.

Q How long did you -- from the time you first received the affected combinations until the time you submitted your report, how long a period was that?

A I don't know sitting here.

Q Several months?

A No. Probably not that long. Perhaps something more like a month. And it may even have been that there was some changes in the list of affected combinations, even approaching the time of the report.

Q That was my next question. Did the affected combinations that you were pursuing an analysis of ever change during the course of your work?

A It's -- I don't have a specific recollection in that regard, but it may well have happened, yes.

Q And did you make a determination to change the affected combinations that you were analyzing?

A No.

Q Who did?

A That would have come from the lawyers.

Q And did you rely on the information from the lawyers in preparing your report?

A I did, inasmuch as that was my assignment. So yes, it determined the sort of the outlines of what I was analyzing.

Q Do you recall stopping analysis on any affected combination that you started?

A No.

Q Did you receive the affected combinations in writing from counsel?

A I'm sure we did at some point, yes.

Q Did -- strike that. Do I understand that HAP insureds are part of the class that you claim to be impacted?

A The affected combinations do include HAP's activities at several hospitals, yes.

Q Do you know how many products HAP sold over the relevant period?

A Just so I understand your question, you're talking about health insurance products?

Q Commercial insurance products. You said that's the product market at issue here, right?

A That is what is alleged, yes. No, I don't.

Q Do you know how many different types of product design HAP has in its commercial insurance products in Michigan during the relevant time?

MR. SMALL: Objection to the form.

reference to them as fierce competitors, to use your language. They both serve patients in the greater Detroit area. I would imagine there is some competition between them.

Q Is it appropriate to use a hospital as a control group that's in the same market as the affected hospital?

A I don't think there's anything inappropriate about it. Certainly, if -- but at the same time, as we talked about earlier today, I didn't see the need for the control group, to limit it just to those who were in the same area.

Q And do you agree with me that HAP and the other payers had different volume of business at different Michigan hospitals?

A Yes.

Q Did you do anything in your DID model to adjust or account for the volume of business that a payer had at a particular control group hospital?

A Yes, I think one of the -- one of the other variables in the model reflected that, the level of that activity.

Q Which one would address that?

A The variable referred to at page 33 of my report as the billed amount.

Q But as we established earlier -- well, strike that. You said you didn't find anything that conflicted. Did you reach the conclusion that these dates are in fact -- strike that.

Did you do any analysis of the financial health of any of the hospitals that are in the affected combinations you analyzed?

A No.

Q Did you do anything to control for the possibility that the hospitals in table 1, "Affected Combinations," were more likely to seek higher reimbursements than hospitals that did not have MFNs?

A I'm not sure even I understand what that would represent. But no, there isn't any variable in statistical analysis that would somehow account for a -- the likelihood or desire on the part of a hospital to achieve higher reimbursement.

Q Well, let's go to your Exhibit 9, Doctor. You've got the hospital, the MFN, the insurer, the network, and then you've got "DID MFN," asterisk, "post-period"; do you see that?

A Yes.

Q What's the number under there, the 15.8, the .9, the 2.8, what is that?

A That's the percentage points of

whether or not damages in this case can be proven on a common basis?

A I have performed analysis to determine that damages can be measured in a formulaic class-wide manner, and indeed that is what Exhibit 9 is intended to show.

Q That aggregated damages can be shown, correct?

A Yes.

Q Does this model in any way help you determine what any individual class member was harmed -- strike that. Does the model on 9 assist you in any way to determine how much any individual class member overpaid a Michigan hospital?

A Well, it certainly would provide a starting point in that regard. There are other issues, I think, and other questions that one could resolve with the data if necessary in order to come to conclusions about individual amounts of overcharges.

Q Slightly different question. It's intentional. I want to make sure you hear the difference. Is there anything on Exhibit 9 that informs you as to whether or not any particular class member actually incurred some injury at any of the affected combinations reflected here?

A It's a -- particularly the results in column 5 are a piece of the puzzle, but they do not by themselves answer that question.

Q And do the results in column 5 for any particular affected combination do anything to answer the question for any other affected combination?

MR. SMALL: Objection to the form, and asked and answered.

A No, not as I understand your question. No.

BY MR. STENERSON:

Q I think this was clear, at least we understood each other, the question is whether the transcript is clear. Let me go back to the contract question about effective dates in chart 1 that begin prior to the effective date of the written MFNs, okay? Do you recall that line of questioning?

A Yes.

Q Am I correct in understanding that in order to determine whether the MFN at Allegan had effect on Priority prior to the effective date of the Blue Cross/Allegan MFN, you would have to look at the specific, among other things, negotiations between Priority and Allegan during that pre-effective period, correct?

A No. I don't know that you would have to

look at the negotiations. For instance, it might be sufficient simply to know that there was a Priority agreement that set forth a certain reimbursement level that took effect on January 1st, 2009, and continued in that same form on the face of the agreement through 2013 or the end of the period.

Q So what you just identified is a type of evidence you might look at to support the inference at the Priority/Allegan combination, correct?

A Yes.

Q Would that same piece of evidence inform the answer to the same question about pre-MFN effect for Priority at the Mercy Health combination?

A The evidence I just described wouldn't do so, no. It might be the same kind of evidence, but it would take the form of a different agreement.

Q And a different inquiry, correct?

MR. SMALL: Objection to the form.

MR. STENERSON: Strike that.

BY MR. STENERSON:

Q An independent inquiry, correct?

MR. SMALL: Objection to the form.

A I'm not sure what "independent inquiry" means in that question.

BY MR. STENERSON:

Q One is not dependent on the other.

MR. SMALL: Objection to the form.

BY MR. STENERSON:

Q Correct?

A Yes, I think that's right. I don't know any reason that the two would necessarily go together.

Q And you could do both inquiries and come to different answers, correct? Depending on the specific evidence that you find for that combination, right?

A Well, except if the dates that are shown in table 1 are the dates of the Priority agreements, then I wouldn't expect that you would come to different answers. What you will go and find is that indeed in each case there's an agreement that started and stopped at those dates.

Q Correct. But there's nothing about either inquiry that would require you to come to the same result or find the same type of evidence to support the inference, right?

A I think this is what you're asking, but I would agree that the fact of an agreement starting in January '09 and ending out in 2012 somewhere for Allegan wouldn't by itself mean there would have to

be an agreement with the same dates for Mercy Health.

Q Right. But it's more than that. The fact of that agreement for Allegan doesn't inform whether or not there's sufficient evidence to infer early impact at Mercy Health, right?

A The fact of an agreement at Allegan wouldn't do that, as far as I know.

MR. STENERSON: Let's take a break.

THE VIDEOGRAPHER: We'll go off the record. The time on the monitor is 15:08.

(Recess.)

THE VIDEOGRAPHER: We'll go back on the record. The time on the monitor is 15:33.

BY MR. STENERSON:

Q Dr. Leitzinger, if you could go back to Exhibit 9 of your report, please.

A Yes.

Q Specifically, I direct your attention to the five columns or five rows at the top of Exhibit 9, the Blue Cross affected combinations, okay?

A Yes.

Q And the overcharge dollars, I just did a little rough justice over here, and it seems to me the dollars in those five rows add up to approximately $43 and a half million. Does that seem

84 percent at Kalkaska where the MFN rate was only 67?

A Well, at least for purposes of understanding the extent to which what I described a few moments ago was at work, yes, I think you would be looking at the same kind of evidence, which was simply what was the year-to-year pattern in the reimbursement rates that underlie the results in this exhibit.

Q I hate to be such a lawyer. Not the same type of evidence, Doctor. Would you look at the same evidence?

A It would not be the same numbers in each case. That's true.

Q It would not be the same contracts, right?

MR. SMALL: Objection to the form.

A I'm not talking about looking at contracts. But you're right, it would not be the same contracts that give rise to those reimbursement results.

BY MR. STENERSON:

Q It would not be the same data, right?

A It is the same data source, but it is not the same information in the data for each of the hospitals, that's correct.

Q And do you know what would happen to your

to Beaumont?

MR. SMALL: Objection to the form.

A No, I don't hold that opinion.

BY MR. STENERSON:

Q You said it's a possibility. Is there a -- well, strike that. Do you agree with me that to determine whether or not there is any benefit, it would be an affected combination by affected combination analysis?

MR. SMALL: Objection to the form.

A Just so I'm sure we're talking about the same thing, if one were looking to see whether there was a benefit in the nature or quality of care associated with increased reimbursement, it seems to me the answer to that question would necessarily involve a look at what happened at each of the affected hospitals.

BY MR. STENERSON:

Q And did you do anything in that regard?

A No.

Q Did you apply any analysis to all the MFN hospitals in this case, any analysis at all?

A No.

Q Are you reaching any opinions in your report or at this stage of the case about the effect

agreement at Allegan. And part of that definition involves looking at whether a patient paid a co-payment, whether it was -- and if so, whether it was fixed, and whether -- or alternatively, whether the patient paid a deductible amount, and if so, did it pay a deductible in connection with a claim that was greater in total than the deductible.

BY MR. STENERSON:

Q And those two conditions that you just walked through, that's a determination that needs to be made for each insured, correct?

A It would be a determination that would be made as to each claim associated with an insured, yes.

Q And the answer to that inquiry for one claim does not answer the inquiry for another, correct?

A Certainly across different potential class members, it does not, that's correct.

Q Were you involved -- strike that. Did you know there were additional -- strike that. Do you know who the class reps are in this case?

A I'm not sure that's finally been determined yet. I think there was an original set of class members and that the plaintiffs have now proposed to

one hospital at a time, right?

MR. SMALL: Objection, asked and answered. He just answered that.

A At least in the method that I have employed, you would apply the regression model to each of the combinations, as I have done.

MR. STENERSON: Thank you for your time.

THE VIDEOGRAPHER: If there are no other questions --

MR. SMALL: I have no questions.

THE VIDEOGRAPHER: We'll go off the record. The time is 18:13.

(Signature having not been waived, the videotaped deposition of JEFFREY J. LEITZINGER, Ph.D. was concluded at 6:13 p.m.)

APPENDIX 37

PAUL OLIVER
MEMORIAL HOSPITAL
MUNSON HEALTHCARE
P.O. Box 1063
Traverse City, MI 49685-1063

Walk-in Customer Service: 207 BEAUMONT PLACE SUITE 101 TRAVERSE CITY, MI 49684 (231) 935-6160 OR 1-800-437-3615
HOURS 8:00 AM - 5:00 PM MONDAY - FRIDAY

00746

SUSAN J BAYNARD
18357 TIMBERLINE DR
THOMPSONVILLE MI 49683-9587

Questions

Manage your account and pay your bill online!
Visit http://billing.munsonhealthcare.org

Questions about your bill? Unable to pay your bill?
For assistance, call Patient Accounts at: (231) 935-6160 or (800) 437-3615 Monday through Friday 8:00 am to 5:00 pm.

This statement represents only the hospital bill. Your personalER physician, surgeon, pathologist, radiologist, anesthesiologist, and other specialists bill separately for their services. Please contact them directly if you have any questions concerning their bill.

Important Message

Statement Date: 09/26/09

This is a statement of your account(s) with Paul Oliver Memorial Hospital. Please send payment in full for $102.26.

The services listed on the reverse side of this page are accounts with a balance due from you as well as accounts that have been billed to your insurance company. You will continue to receive a statement until your account balance(s) are paid in full. We have indicated any balances that you are required to pay. We will notify you if the insurance claim(s) is denied or if there is no timely response.

Thank you for your prompt attention and for choosing Paul Oliver Memorial Hospital for your health care needs.

Insurance Information

Patients are responsible for the charges for services received. However, to assist patients in meeting their financial obligations, the hospital will bill their health insurance carrier(s) for them, as long as a valid ID card and/or information regarding insurance coverage is presented at the time of registration.

Please see back for details...

P1016028005

PriorityHealth

Priority Health
1231 East Beltline NE
Grand Rapids, MI 49525-4501

Electronic Service Requested

5-DIGIT 49610
796 0.3584 AV 0.335

SUSAN L. BAYNARD
38357 TIMBERLINE DR
THOMPSONVILLE, MI 49683-9587

If you have any questions,
please contact Priority Health at
(616) 942-1221 or (800) 446-5674
customer.service@priorityhealth.com

Claim No.: [redacted]
Group Name: CRYSTAL MOUNTAIN WORKS
Group No.: [redacted]
Patient: SUSAN L BAYNARD
Contract Number: [redacted]
Patient Account No: [redacted]
Date Paid: 09/20/2009

ENV796 1 OF 1

EXPLANATION OF BENEFITS

Dates of Service	Proc. Code	Fee Charged	Allowed Fee	Amount Not Allowed	Reason Code	Coins. Amount	Deductible Amount	Copay Amount	Other Ins.	Provider Liability	Insurance Amount	Patient Resp.
09/11/09-09/11/09	36415/0300	13.60	11.56	0.00	PDC	0.00	11.56	0.00	0.00	2.04	0.00	11.56
09/11/09-09/11/09	80053/0301	106.70	90.70	0.00	PDC	0.00	90.70	0.00	0.00	16.00	0.00	90.70
09/11/09-09/11/09	80061/0301	68.60	58.31	0.00	PDC	0.00	0.00	0.00	0.00	10.29	58.31	0.00
	TOTAL	188.90	160.57	0.00		0.00	102.26	0.00	0.00	28.33	58.31	102.26

After this claim Accumulators for Benefit Year:2008	Met	Total
NDIVIDUAL DEDUCTIBLE PREFERRED/IN NETWO	186.22	250.00
AMILY DEDUCTIBLE PREFERRED/IN NETWORK	186.22	500.00
NDIVIDUAL OOP PREFERRED DOLLAR	0.00	500.00

Payment To	Check No.	Amount
SUSAN L BAYNARD		0.00
PAUL OLIVER MEMORIAL HOSPITAL	[redacted]	58.31

Reason Cd

PDC The charge has been reduced based on a discount arrangement with the provider of service

*** You are entitled to a review of this benefit determination if you have any questions or do not agree. Most issues can be resolved informally by our Customer Service Department at (616) 942 -1221 or (800) 446-5674. You can also request a formal review of your issue. Priority Health has a two-level formal review process. To initiate the 1st level, call Customer Service and a representative will assist you in filing a formal "grievance" form. (You have two years from the date you learn of an issue to file a grievance with us.) Your grievance will be reviewed by a committee. If you disagree with the 1st level determination, you can request a 2nd level review by filing an "appeal" form. A different committee will then review your request for appeal. In most cases, a final determination will be made on your issue within 35 calendar days of the initial grievance request. At both levels, you can submit written comments, documents, and other information. You can also designate another party to represent you throughout the process. At any time, you can request access to and copies of information relevant to your claim denial. If you are not satisfied with Priority Health's final determination, you can request that the Office of Financial and Insurance Services complete a subsequent review. After exhausting both levels of Priority Health's review, you can also bring a civil court action under § 502(a) of ERISA. To obtain a complete copy of Priority Health's Grievance Procedure and Grievance Filing Form, or to find out more about your appeal rights, please contact Customer Service. You should also refer to the "Inquiry and Grievance Procedure" section of your Certificate of Coverage for further details.

*** THIS IS YOUR ONLY COPY. PLEASE RETAIN FOR YOUR RECORDS

This is NOT a Bill

Hospital Services - Summary of Charges

Guarantor Number: [redacted]

Accounts With Patient Balance

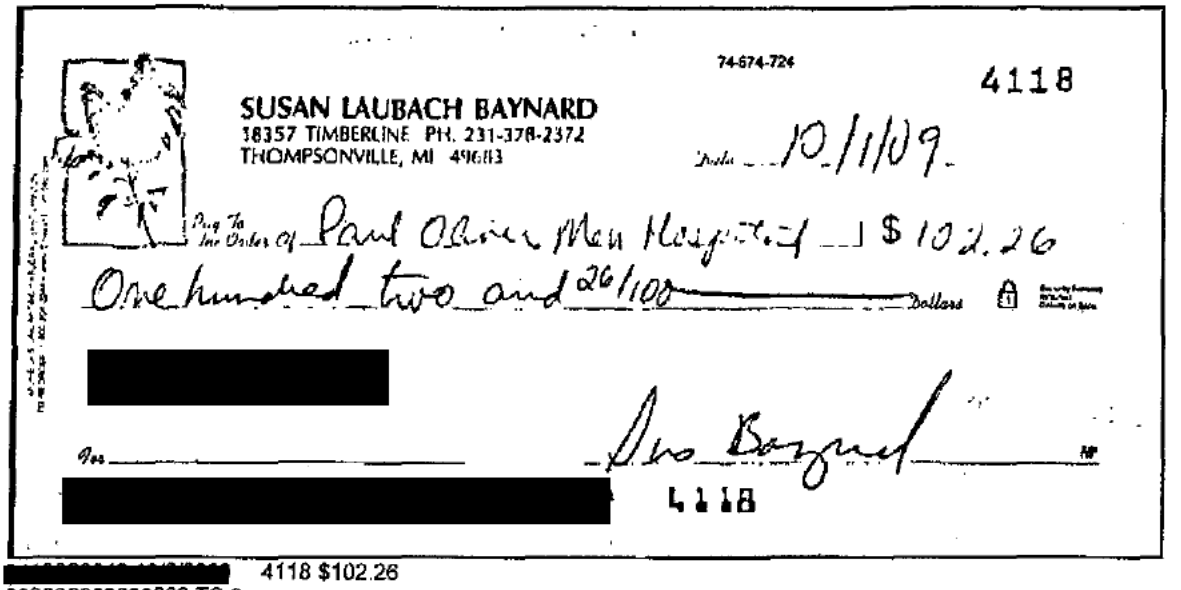
ACCOUNT NO.	PATIENT NAME/DESCRIPTION	ADMIT DATE/AMT.	INSURANCE	SERVICE TYPE
[redacted]	SUSAN J BAYNARD	09/11/09	PRIORITY HEALTH	O/P LABORATORY
	Total Charges	188.90	PRIORITY HEALTH PC 1500	
	09/25/09 PRIORITY HEALTH PMT	86.64CR		
	Total Insurance Payment	86.64		
	Total Patient Payment	0.00		
	Account Balance	102.26		
	Patient Balance Due upon Receipt	102.26		

Accounts Pending Insurance

Your insurance payment is pending on the account(s) listed below. This could become your responsibility. Please call your insurance company for prompt payment.

ACCOUNT NO.	PATIENT NAME/DESCRIPTION	ADMIT DATE/AMT.	INSURANCE	SERVICE TYPE
[redacted]	SUSAN J BAYNARD	09/14/09	PRIORITY HEALTH	BRC
	Total Charges	550.20	PRIORITY HEALTH PC 1500	
	Total Insurance Payment	0.00		
	Total Patient Payment	0.00		
	Balance pending with Insurance	550.20		

APPENDIX 38



74-674-724

4118

SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683

Date 10/11/09

Pay To The Order Of Paul Oliver Mem Hospital $ 102.26

One hundred two and 26/100 Dollars

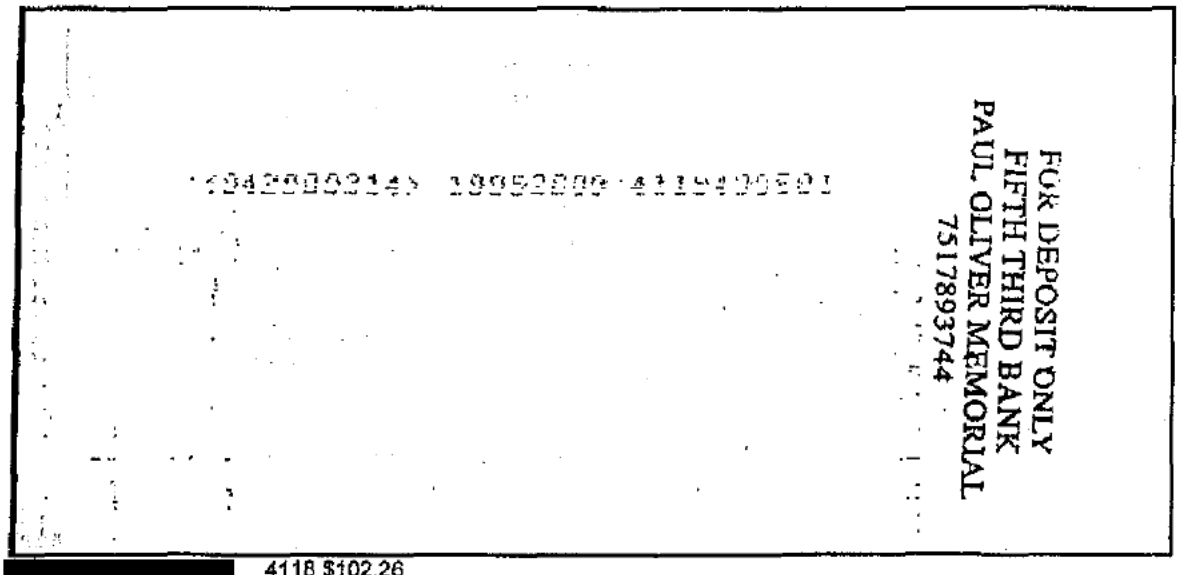
[redacted]

For [redacted]

Susan Baynard

[redacted] 4118

[redacted] 4118 $102.26
999090002032833 TC 0



FOR DEPOSIT ONLY
FIFTH THIRD BANK
PAUL OLIVER MEMORIAL
7517893744

[redacted] 4118 $102.26
999090002032833 TC 0

Δ π EXHIBIT 3
Deponent Baynard
Date 1-13-14 Rptr. Sao
WWW.DEPOBOOK.COM

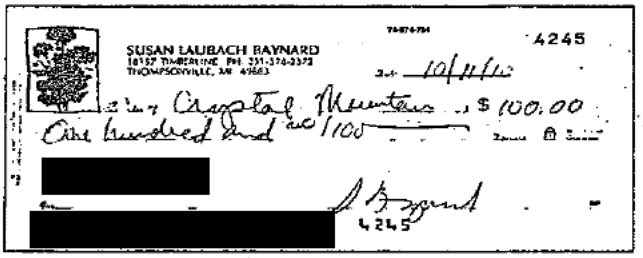
Confidential

Baynard000027

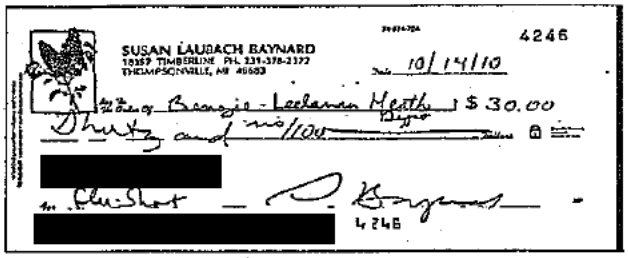
APPENDIX 39

[redacted]

TDate: 1/14/10 Page: 3 of 3
Primary Account: [redacted]


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4245
10/14/10
Pay Crystal Mountain $100.00
One hundred and no/100
[redacted]
4245

Ck# 4245 Date 10/15/2010 $100.00


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4246
10/14/10
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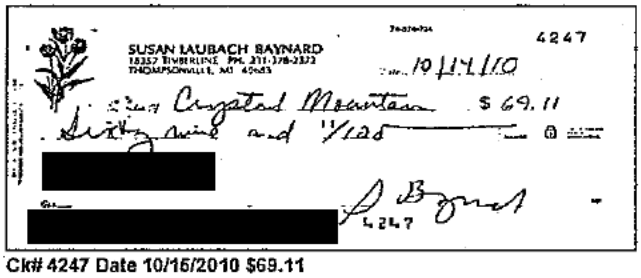
Thirty and no/100
[redacted]
4246

Ck# 4246 Date 10/18/2010 $30.00


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4247
10/14/10
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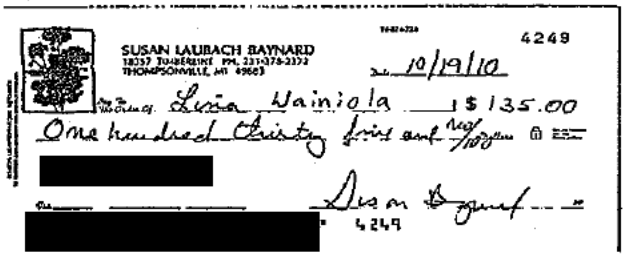
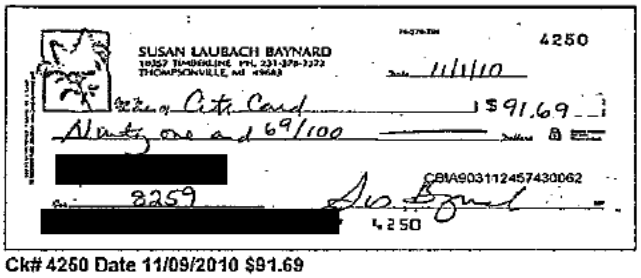
Sixty nine and 11/100
[redacted]
4247

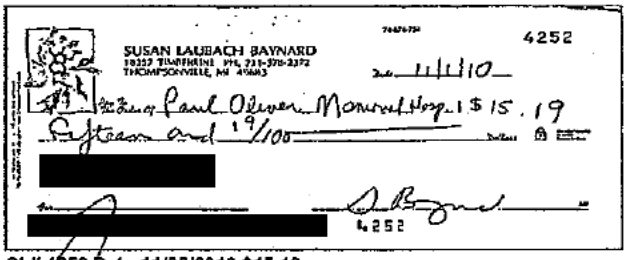
Ck# 4247 Date 10/16/2010 $69.11


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4249
10/19/10
Pay Livia Wainiola $135.00
One hundred thirty five and no/100
[redacted]
4249

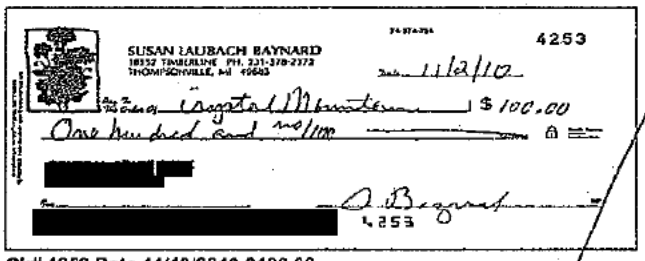
Ck# 4249 Date 10/21/2010 $135.00


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4250
11/1/10
Pay Citi Card $91.69
Ninety one and 69/100
[redacted]
CBA903112457430062
3259
4250

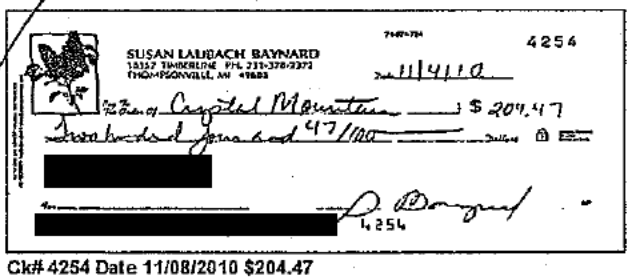
Ck# 4250 Date 11/09/2010 $91.69


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4252
11/1/10
Pay Paul Oliver Memorial Hosp. $15.19
Fifteen and 19/100
[redacted]
4252

Ck# 4252 Date 11/05/2010 $15.19


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4253
11/2/10
Pay Crystal Mountain $100.00
One hundred and no/100
[redacted]
4253

Ck# 4253 Date 11/10/2010 $100.00


SUSAN LAUBACH BAYNARD
18357 TIMBERLINE PH. 231-378-2372
THOMPSONVILLE, MI 49683
4254
11/4/10
Pay Crystal Mountain $204.47
Two hundred four and 47/100
[redacted]
4254

Ck# 4254 Date 11/08/2010 $204.47